



House of Commons
Health Committee

Modernising Medical Careers

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Volume I

Report, together with formal minutes

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The Health Committee

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Footnotes

In the footnotes of this Report, references to oral evidence are indicated by 'Q' followed by the question number, and these can be found in HC 25–III. Written evidence is cited by reference in the form 'Ev' followed by the page number; Ev x for evidence published in HC 25–II, Session 2007–08, on 14 November 2007, and MMC x for evidence to be published in HC 25–III.

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Summary

For many years there have been concerns about the UK medical workforce, in particular the postgraduate medical training system. The most prominent of these centred on the poor training and indifferent career prospects experienced by some doctors at Senior House Officer (SHO) level and by many of those in Staff Grade and Associate Specialist (SAS) posts.

The Modernising Medical Careers (MMC) programme of work was established in 2003 to address these difficulties. A new Foundation programme was introduced in 2005, the Specialty Training system was reformed and the SHO grade scrapped in 2007. As a result of inadequate preparation during the implementation of the reforms, in 2007 the MMC programme plunged into crisis. The new centralised recruitment system, the Medical Training Application Service (MTAS), proved highly unpopular with both candidates and assessors. The number of applicants was also much higher than expected, creating fierce competition for posts in many areas and making thousands of doctors deeply anxious about their future prospects.

Following intense public pressure and major demonstrations by junior doctors, the Department set up the Douglas Review Group to make changes to the recruitment system. Several senior resignations, a legal challenge, two major security failures and a number of emergency statements by the then Secretary of State followed, however, as the crisis deepened. Elements of the MTAS system were subsequently abandoned and, although most training posts were eventually filled, the events of 2007 proved a disaster both for the Department of Health and for the medical profession itself.

The Government acknowledged that its new systems were flawed and apologised on several occasions to the thousands of doctors affected. The Secretary of State commissioned a major inquiry, led by Sir John Tooke, to examine the 2007 crisis. The Tooke Inquiry reported in January 2008 and called both for major changes to the structure of training and for the creation of a new body, NHS Medical Education England, to oversee medical education. The Department deferred decisions on whether to implement the Tooke Inquiry's most significant proposals.

Like the Tooke Review, the Committee's inquiry exposed serious problems with the management of the MMC reforms, and particularly the introduction of MTAS, by the Department of Health and its partners. A divided and inappropriate governance structure, flawed project and risk management and poor communication with junior doctors were the most serious failings. Co-ordination between the Department of Health and the Home Office on restricting medical migration was also woefully inadequate. These practical shortcomings were responsible for some of the direct causes of the 2007 crisis, including the defective application form and other aspects of the short-listing process, the unsafe computer system and the failure to limit the number of applications from overseas doctors.

Our inquiry also uncovered wider problems with policy development and leadership for MMC. The specific changes introduced by MMC often conflicted with the programme's stated aims, for instance through the universal introduction of run-through training in 2007, which created a more rigid rather than a more flexible training system. The leadership shown by the Department of Health was totally inadequate. Despite being the architect of the reforms, the Chief Medical Officer chose not to take on a clear leadership role and thus did not accept responsibility for the 2007 crisis. The medical profession was often more concerned by factional interests than by the common good. This confusion and incoherence exacerbated the 2007 crisis and prevented MMC from achieving many of its original aims, most notably increasing flexibility and reforming the SAS grades.

We make a number of recommendations for change and improvement in response to the shortcomings which undermined MMC. The Department of Health must address its weaknesses in project and risk management. It should strengthen and increase the independence of the MMC Programme Board and work more effectively with the medical profession on future education policy. A number of improvements to project management and to performance management of Strategic Health Authorities by the Department are also required. Employers and training providers should play a bigger role in decisions about the future of training while partnerships between the health and education sector must be revitalised.

The future structure of the training system itself must above all be made more flexible. This means allowing individual specialties to decide what length and type of training posts they offer, rather than continuing to impose one-size-fits-all solution from the centre. We therefore support the current "mixed economy" of specialty training schemes and recommend that this approach is maintained and extended. We suggest a similarly flexible approach to future recruitment processes and recommend that the Department devolve all responsibility for recruitment and selection to Postgraduate Deaneries and employers.

Devolving these detailed responsibilities to local level will allow the Department of Health to focus on more important policy questions affecting the medical workforce. Most pressing of these is how to restrict access for non-EEA doctors to UK training posts, a necessity in light of the recent expansion of UK medical schools. The Government has comprehensively failed to address this issue to date and its future policy is now reliant on a legal judgement by the House of Lords. The Department of Health and the Home Office must work together to resolve this embarrassing problem as a matter of urgency.

Finally, we recommend that the Department of Health address policy issues relating to the wider medical workforce, one of the unrealised ambitions of MMC. Reform of the SAS grades in particular is vital: the Department should aim to develop SAS posts into a genuine and valuable alternative to the formal training system, rather than the

educational backwater in which they currently remain. We also propose the introduction of a hierarchy within the consultant grade. In addition, we call on the Department to resolve the key questions affecting the size and nature of the medical workforce, including whether care is to be consultant-led or consultant-delivered in future.

1 Introduction

1. In March 2007, thousands of junior doctors took part in public demonstrations in London and Glasgow. Their protests were followed over the next few weeks by the resignation of several leaders of the medical profession, a legal challenge to the Secretary of State for Health, and a series of emergency statements in parliament. The source of this acrimony was a new recruitment system for selecting junior doctors for training places, the Medical Training Application Service (MTAS). The introduction of MTAS was part of a wider reform programme known as Modernising Medical Careers (MMC).

2. MMC, established in 2003, was a set of changes aimed at addressing long-standing problems with the UK medical education system and the wider medical workforce. MMC aimed to address the uncertain career prospects of the “lost tribe” of Senior House Officers and to make medical training more flexible and more streamlined. The implementation of the initial phase of change was relatively successful, with a new Foundation Programme established in 2005 for medical graduates.

3. The subsequent introduction of new arrangements for hospital specialty training in 2007, however, ran into serious difficulties. The MTAS national selection system was seen as unfair by many applicants and suffered serious operational problems. Large numbers of overseas doctors were allowed to apply freely for UK training posts, creating intense competition in many areas. The rigidity of the new “run-through” training system and the lack of planning for transition left many UK doctors facing the apparent prospect of long-term unemployment.

4. The Department of Health acknowledged problems with the recruitment system and established a Review Group to consider the future of the selection process. The Review Group decided not to scrap the MTAS system altogether, but made repeated changes to recruitment, heightening uncertainty. A legal challenge by the pressure group RemedyUK called for the recruitment process to be abandoned; the challenge was unsuccessful but the High Court verdict described the new recruitment system as “disastrous”. Following serious security problems, the on-line recruitment system was subsequently discarded anyway. The majority of training posts were eventually filled in advance of the 1 August deadline, but many doctors were left with uncertain future prospects and bitterness and resentment of the new selection system remained rife.

5. The 2007 crisis was the subject of intense media coverage and caused a breakdown of relations between the Department of Health and the medical profession, as well as considerable strife within the profession itself. In response, the Department established an independent inquiry led by Professor Sir John Tooke to look at the causes of the 2007 problems and the changes required to restore confidence in the MMC programme. At the end of July 2007, the Committee agreed to hold an inquiry to examine MMC and to consider the findings of the independent Tooke Inquiry. We announced an inquiry with the following terms of reference:

- What are the principles underlying MMC and are they sound;
- To what extent the practical implementation of MMC has been consistent with the programme’s underlying principles;

- The strengths and weaknesses of the MTAS process;
- What lessons about project management should the Department of Health learn from the failings in the implementation of MMC;
- The extent to which MMC has taken account of the supply and demand of junior doctors and the number of international medical graduates eligible for training in the UK;
- The degree to which current plans for MMC will help to increase the flexibility of the medical workforce; and
- The roles of the Department of Health, Strategic Health Authorities, the Deaneries, the Royal Colleges and the Postgraduate Medical Education and Training Board in designing and implementing MMC.

6. We received more than 60 written memoranda from wide range of organisations and individuals and held six oral evidence sessions between November 2007 and February 2008. We took evidence from a range of groups involved with medical training, including Royal Colleges, Postgraduate Deaneries, the Postgraduate Medical Education and Training Board (PMETB), the BMA and RemedyUK. We also heard from officials from the Department of Health, the Home Office and the Foreign and Commonwealth Office, and from the Secretary of State.

7. The first three chapters of our report describe the complex events which surrounded the high-profile crisis of 2007. We look in turn at:

- The background and early stages of the MMC programme (Chapter 2);
- The 2007 crisis itself (Chapter 3); and
- The initial response to the crisis and the outcome of the independent inquiry (Chapter 4).

8. In the final four chapters we look thematically at the key issues raised by the 2007 crisis and by the Tooke Inquiry. We build on the fine analysis provided by the Tooke Review but do not cover all of the same ground. We also discuss many of the Review's recommendations, particularly for changes to the structure and organisations of postgraduate training. We examine in particular:

- The medical workforce, including debates about the structure of the training system and of the wider medical workforce (Chapter 5);
- The supply of doctors to the UK, focussing particularly on the role of overseas doctors (Chapter 6);
- The management of the MMC programme by the Department of Health (Chapter 7);
- The roles of other organisations involved with medical training, such as the Postgraduate Deaneries and PMETB (Chapter 8).

9. The Committee would like to thank everybody that gave evidence. We are particularly grateful for the expert advice which we received from our specialist advisors: Professor Charles Easmon, Dr Fiona Moss and Professor Morris Brown.

2 The gathering storm: 2003–2007

Box 1: Key events in the development of *Modernising Medical Careers*

August 2002 – *Unfinished business* (written by Sir Liam Donaldson, Chief Medical Officer for England) calls for reform of the Senior House Officer (SHO) grade.

February 2003 – *Modernising Medical Careers* (jointly published by the 4 UK Health Ministers) sets out initial plans for reform of medical training.

July 2003 – *Choice and opportunity: Modernising medical careers for Non-Consultant Career Grade doctors* (by the Department of Health for England) is published.

April 2004 – *MMC: The next steps* (jointly published by 4 the UK Health Ministers) sets out details of the new structures for medical training.

June 2005 – Curriculum and operational framework for Foundation Training published.

August 2005 – Start of new 2-year Foundation programme across the UK

March 2006 – End to “permit-free” training for non-EEA doctors announced

January 2007 – Start of recruitment to new GP and hospital Specialty Training jobs

June 2007 – Publication of “Gold Guide” to Postgraduate Specialty training

August 2007 – Start of new GP and Specialty Training jobs.

10. This chapter examines the origins of the Modernising Medical Careers (MMC) programme, the case for changing the postgraduate medical education system and career structure, and the planning which preceded the introduction of the new systems for Specialty and General Practice training in 2007. We look in particular at:

- The rationale for the MMC programme, derived from problems affecting Senior House Officer (SHO) and Staff Grade and Associate Specialist (SAS) doctors, and other factors which influenced the programme, such as the need to comply with European Working Time Directive regulations ; and
- How the principles established in *Unfinished Business*, the 2002 document establishing the case for change, were translated into a set of practical plans for reform, implemented through the new Foundation Programme, which began in 2005, and new Specialty and GP training programmes from 2007.

Rationale for change

The Calman training system

11. The most recent significant reforms to the postgraduate medical training system prior to MMC took place during the 1990s and were instigated by then Chief Medical Officer Sir Kenneth Calman. The Calman reforms were initiated by the publication in 1993 of *Hospital Doctors—Training for the Future* and were mainly concerned with improving specialist hospital training. This led to the introduction from 1996 of Specialist Registrar posts with explicit curricula, regular assessments of progress, and limited to a maximum of seven years.¹ The reforms also introduced the Certificate of Completion of Specialist Training, awarded by the General Medical Council (GMC).² No changes were made at this time to the Pre-Registration House Officer and Senior House Officer (SHO) grades which preceded the new Specialist Registrar grade in the training system.

12. The shape of the training system following the implementation of the Calman reforms is shown in the diagram below:

Postgraduate training—pre-MMC

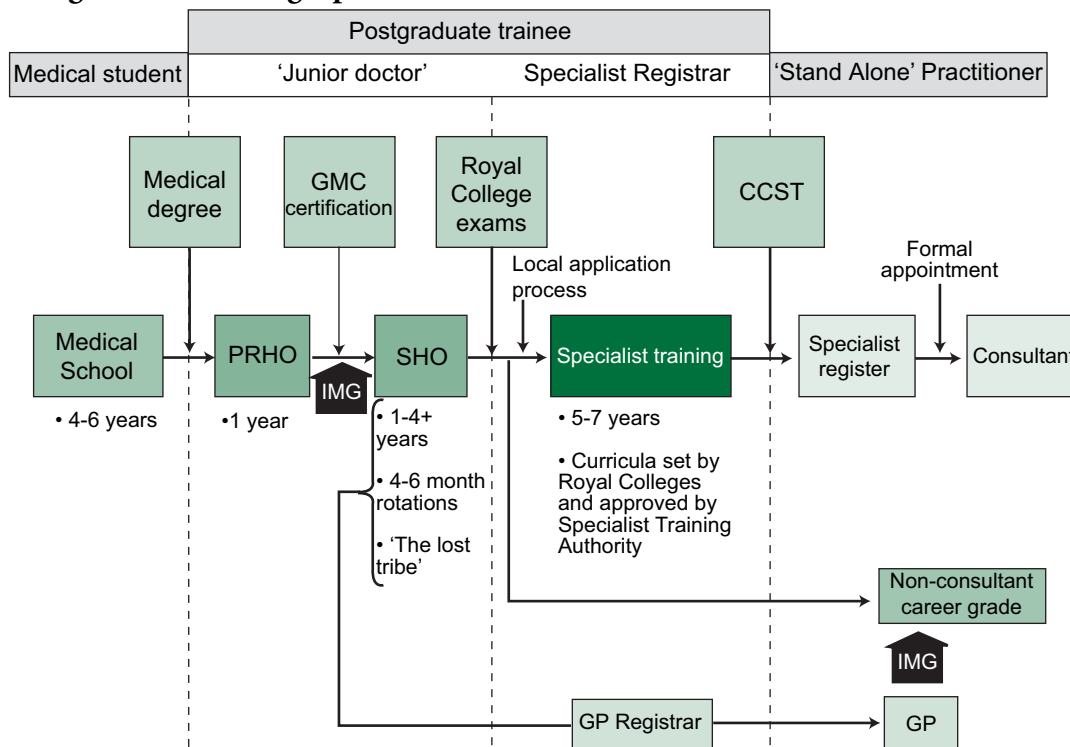


Figure 1: UK Medical training system following the Calman reforms
 Source: *Aspiring to Excellence* (October 2007), p.32. See Glossary for details of abbreviated terms.

“Unfinished Business” and the “lost tribe”

13. In August 2002, the Chief Medical Officer for England, Sir Liam Donaldson, published a consultation paper on medical training. The paper, *Unfinished Business*, described a

1 The Specialists Registrar post replaced the previous Registrar and Senior Registrar posts.
 2 *Aspiring to Excellence*, p.31

number of problems experienced by some doctors in the junior training grades, and particularly at SHO level. In particular, *Unfinished Business* highlighted:

- The lack of a defined career structure for SHOs, leaving many in short-term posts and without a formal training programme;
- The lack of a defined end-point or time limit for the SHO grade, resulting in many doctors stranded for long periods, even up to ten years, at SHO level and unable to progress into more specialised training—this problem led to the well-known description of SHOs as the “lost tribe”;
- A lack of supervision and careers advice for SHOs and of clear competences to define the requirements for training, as well as a lack of flexible training opportunities; and
- An increasing workload, leading SHOs to be termed the “workhorses of the NHS”.³

14. *Unfinished Business* set out five principles for the reform of the SHO grade: training should be programme-based, time-limited, broad-based to begin with, flexible and tailored to individual needs. To achieve this, the consultation proposed the introduction of a 2-year “foundation programme” to immediately follow graduation from medical school, followed by broad-based “basic specialist training programmes” in around eight different specialty areas, including general practice. *Unfinished Business* stressed that the new programmes should allow trainees the flexibility to leave and then re-enter training and should address the needs of non-UK graduates.⁴

15. The possibility of integrating the various training programmes into a single, unified training grade was also mooted in *Unfinished Business*. The report stated:

The advantages of moving to a single training grade encompassing: foundation; basic specialist; general practice; higher specialist; and individual training programmes should be urgently explored. In such an arrangement doctors in training would move seamlessly through the grade subject to satisfactory performance and assessment. This could not be implemented immediately and some element of application and competition may still need to be retained to meet the needs of the service and availability of training places. This should be explored specialty by specialty.⁵

“Choice and Opportunity”

16. In July 2003, less than a year after *Unfinished Business*, the Department of Health published another consultation paper, *Choice and Opportunity*. This paper addressed difficulties experienced by the large and diverse group of doctors in Staff grade and Associate Specialist (SAS) posts, a term applied to doctors outside the formal training

3 *Unfinished Business*, p.4

4 *Ibid*, pp.5–6

5 *Ibid*, p.6

system and without consultant or GP status.⁶ *Choice and Opportunity* described a number of problems affecting SAS doctors, also known as Non-Consultant Career Grade (NCCG) doctors, including:

- The lack of a recognised career structure for SAS doctors: the Department commented that these posts “have been regarded as a professional cul de sac”;
- Variation in the type of work done by SAS doctors and the level of training and professional development available;
- Stigma attached to the SAS grades;⁷ and
- Lack of information about SAS doctors, including total numbers, though the Department estimated that there were around 12,500 SAS doctors in 2003.

17. *Choice and Opportunity* established principles for reforming the careers of SAS doctors: there should be clear criteria for doctors entering SAS posts to fulfil, as well as the possibility of career progression through the acquisition of recognised competencies. In addition, doctors in SAS posts should have access to training, continuous professional development and careers advice, and SAS posts should be recognised as valid career choices in their own right.⁸ The report proposed 14 detailed recommendations for changing SAS posts in line with these principles.⁹

Other influences on training reform

18. *Unfinished Business* and *Choice and Opportunity* made a direct case for the reform of the medical workforce, describing specific problems experienced by groups both inside and outside the training system: SHOs and SAS doctors respectively. In addition, there were several other factors and trends, often less explicitly related to medical education, which influenced the design and implementation of MMC:

- The **NHS Plan** (2000) set out a commitment to a health service increasingly delivered by fully trained doctors rather than those in training. This created pressure to reduce the minimum training times for completion of specialist training and to reduce the large amounts of patient care traditionally provided by doctors in training posts, and particularly by “workhorse” SHOs. The *NHS Plan* also promised to increase the self-sufficiency of the NHS workforce, underpinned by a major expansion in undergraduate medical school numbers, a process which had begun in 1997. Medical school student numbers rose by around 60% between 1999 and 2005; several new medical schools were created as part of this expansion.
- The implementation of **European Working Time Directive** (EWTD) reforms restricted junior doctors to a maximum of 58 hours per week by 2004, with a further reduction to 48 hours by 2009. Many doctors, particularly in SHO grades,

6 The level of seniority and range of activities performed by SAS doctors both vary widely. Some SAS doctors are trained to the same level as consultants, while others have no more formal training than SHOs.

7 Department of Health, *Choice and Opportunity*, pp.1–4

8 Ibid, p.5

9 Ibid, pp.9–13

had traditionally worked much longer hours. The EWTD changes further reduced the degree to which the NHS could rely on SHOs and other doctors in training for service delivery, and decreased the amount of time junior doctors would have available for training;

- The emergence of **widespread deficits** across the NHS in 2004–05 put pressure on all NHS organisations to reduce expenditure; the drive to reduce costs was at its height during the final stages of implementation of MMC in 2006 and 2007. The ring fence around education budgets, which had existed since the creation of the national training levies in 1996, was removed by DH in 2006 leaving Strategic Health Authorities (SHAs) free to reduce their commitments to funding education and training during this period, which many did; and
- The **structural re-organisation** and reduction in number of SHAs and Primary Care Trusts (PCTs), which took place in 2006, created further uncertainty and distraction for NHS organisations during the planning and implementation of the reforms.¹⁰
- A **new regulator for postgraduate medical training**, the Postgraduate Medical Education and Training Board (PMETB), was created in 2003. This was part of a more general move away from a self-regulated medical profession in light of high profile failings, for example at Bristol Royal Infirmary and Alder Hey. PMETB, which began work in 2005, was given responsibility for establishing and maintaining standards in order to protect the public. The creation of PMETB led to changes to the responsibilities of other bodies involved with postgraduate medicine, such as the Royal Colleges and Postgraduate Deaneries.¹¹

Turning principles into practice

“MMC: The next steps”

19. *Unfinished Business* received widespread support during the consultation process and in February 2003, the four UK health departments published *Modernising Medical Careers*, a joint initial response to *Unfinished Business*.¹² The document endorsed both the principles and many of the practical proposals set out in *Unfinished Business*, including the creation of a two-year Foundation programme. A review of the content and length of specialty training programmes was called for, though it was stressed that this should be done “on a specialty by specialty basis”. *Modernising Medical Careers* also set out plans to review the SAS grades, something underpinned in England by the publication of *Choice and Opportunity* later in 2003.¹³

10 The number of SHAs was reduced from 28 to 10 with effect from July 2006. The number of PCTs was reduced to 150 with effect from October 2006.

11 *Aspiring to Excellence*, pp.29–30

12 A summary of the 254 responses to *Unfinished Business* was set out by the Department of Health in a *Consultation outcome* published in February 2003. The Department commented that “There was little deviation from the view that the SHO grade was in need of reform...” and that “The vast majority welcomed the broad thrust of the proposed changes.”

13 Department of Health, *Modernising Medical Careers*, pp.2–6

20. A UK Strategy Group was formed in October 2003 by Sir Liam Donaldson to coordinate and oversee the introduction of the MMC reforms. This was followed in April 2004 by the publication of *MMC: The next steps—The future shape of Foundation, Specialist and General Practice Training Programmes*. The report set out clear plans for new Foundation Programmes, which it promised to implement from August 2005 onwards.¹⁴

21. Crucially, *The next steps* also signalled the intention to adopt “a single, run-through approach” to the delivery of Specialist and GP training programmes. The report explained:

Specialist Programmes and the General Practice Programme will, therefore, be developed to provide a seamless training process which will see all those emerging from Foundation Programmes entering a training Programme leading directly to the award of a CCT (Certificate of Completion of Training). Entry will be competitive but, subject to satisfactory progress, no further competition will be needed before the completion of training...Special pathways for academics will be designed. We have moved, therefore, from initial proposals which accepted a separation of basic and higher specialist programmes to a system which sees the progressive acquisition of basic and higher specialist competencies in a single programme.¹⁵

22. The MMC training system, comprising the two-year Foundation programme followed by run-through training, was later set out in the following diagram:

UK MMC Career Framework

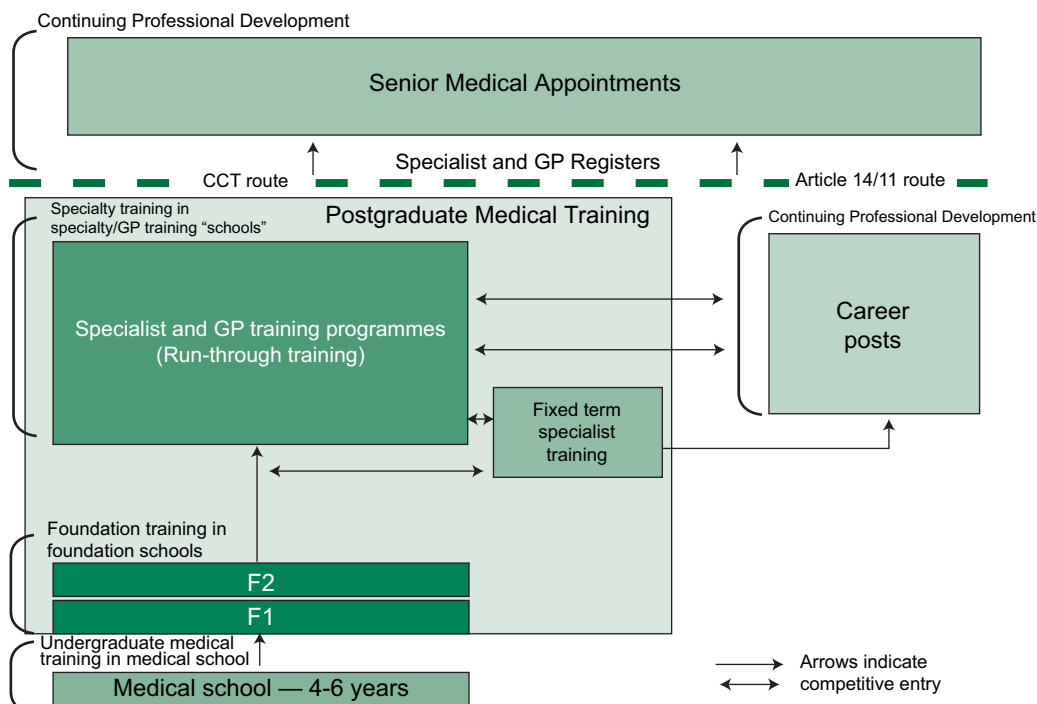


Figure 2: Structure of medical training system to be established by MMC
 Source: Department of Health Modernising Medical Careers team, November 2005

14 Department of Health, *MMC: The next steps*, pp.2-6

15 Ibid, p.7

23. *The next steps* also set out a simplified set of principles to govern the introduction of the new Programmes. These principles, which became known as the “seven pillars of MMC” established that the new training systems should be:

- “Trainee-centred;
- Competency-assessed;
- Service-based;
- Quality-assured;
- Flexible;
- Coached; and
- Structured and streamlined.”

24. We consider the implications of these principles and what they meant to the different parties involved with MMC in Chapters 5 and 7.

The Foundation programme

25. The broad aims of the new two-year Foundation Programmes were set out in *MMC: The next steps*. The first year of the programme (which became known as FY1) would be regulated by the GMC and would bring trainees up to the standards required for full GMC regulation, mirroring the previous PRHO year. The second year (FY2), overseen by the new PMETB, would give candidates a range of practical, communication and decision-making skills.¹⁶

26. The importance of setting up and evaluating pilot schemes prior to introducing the new programmes was emphasised in *Modernising Medical Careers* in February 2003.¹⁷ A number of pilots for the Foundation Programme were therefore established: a 2004 survey by the British Medical Association listed a total of 17 pilot schemes; the majority were trials of the FY2 programme and most pilots were carried out in London.¹⁸ Many pilots were not completed and evaluated until after the Foundation Programme had begun in 2005.¹⁹

27. The curriculum and operational framework for the Foundation Programme were published in June 2005. A total of 23 Foundation Schools were subsequently established across England, bringing together local medical schools, Postgraduate Deaneries and trusts to deliver the new programmes.²⁰ The introduction of the Foundation Programme was also underpinned by significant financial investment. The first cohort of medical school

16 Department of Health, *MMC: the next steps*, p.2

17 Department of Health, *Modernising Medical Careers*, p.6

18 BMA, *Foundation programme pilot schemes monitoring report to the Junior Doctors Committee and the Medical Students Committee*, May 2004.

19 See, for example, *An evaluation of four foundation programme pilots in Kent, Surrey and Sussex* by Graeme Dewhurst, Pam Shaw and David Wood published in the *British Journal of Hospital Medicine* on 1 January 2006.

20 See <http://www.foundationprogramme.nhs.uk/pages/home/deaneries-foundation-schools> for more information.

graduates entered the new Foundation Programmes in August 2005; they would complete the courses in August 2007.

Plans for Specialty and GP training

The new structure

28. PMETB, the regulator for GP and Specialty training programmes, began operating on 30 September 2005.²¹ One of PMETB's main initial tasks, carried out in conjunction with the Royal Colleges and Specialist Societies, was to establish new curricula for run-through training programmes across the 59 different medical specialties prior to the introduction of the new programmes in August 2007. This work was accompanied by the publication in June 2007 of the "Gold Guide" to specialty training, the operational framework for specialty training produced by the four UK health departments.

29. More detailed plans for the structure of the new training system also emerged in this period. The new curricula covered training from the first year of the new run-through programmes (known as ST1 for hospitals doctors, GPR1 for GPs), through to the completion of training, (typically at ST6 or ST7, or GPR3). The first two years of run-through training, ST1 and ST2, would be roughly equivalent to former SHO posts; while ST3 to ST7 training would mirror Specialist Registrar posts. A number of Fixed-Term Specialist Training Posts (FTSTAs) were created for doctors to take up for one or two years during the transition to the new system. The central role of Specialty Training within the new system is demonstrated in the diagram below:

21 See *Preparing doctors for tomorrow: about PMETB* for more information.

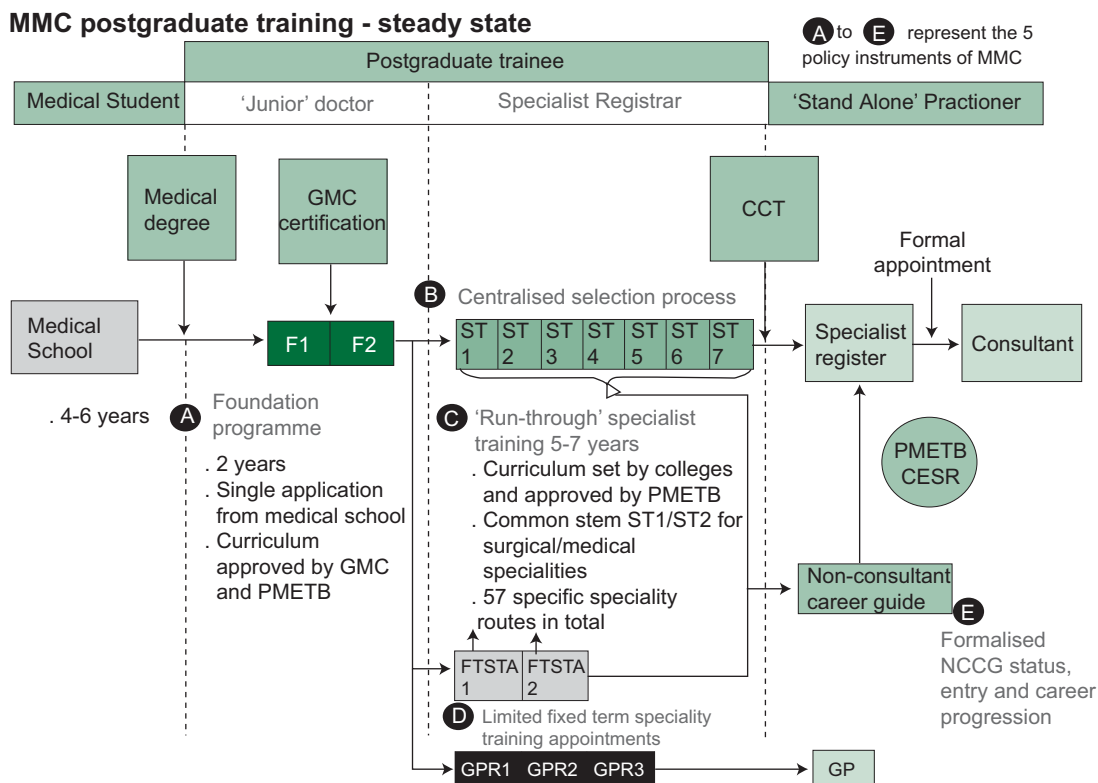


Figure 3: MMC training system: role of Specialty training programmes

Source: *Aspiring to Excellence* (October 2007), p.34

Plans for transition

30. All of the new Specialty and GP training programmes were to be introduced simultaneously in August 2007. Recruitment to Specialist Registrar posts was therefore curtailed from January 2007, with all SHO posts scheduled to end in August 2007. Existing Specialist Registrars were given the option to assimilate into the new system in 2007 or 2008.²² Doctors would enter the new training system at all levels, though in 2007 the vast majority would come in at the lower levels, between ST1 and ST4. No formal pilots of the new training programmes were carried out prior to implementation.

31. To support the transition to the new system and the major selection process needed in the first year, the Department of Health set out plans in late 2006 for a nationally co-ordinated selection process, known as the Medical Training Application Service (MTAS) to run between January and August 2007. The MTAS system would comprise two consecutive recruitment rounds and all candidates would apply through an electronic portal. Candidates could apply to up to four different training programmes and would be short-listed using nationally agreed application forms and a national shortlisting scoring system. Short-listed candidates would then be interviewed and offers made to successful candidates after all the interviews had been completed. Unfilled vacancies from round one would be made available in the second round of recruitment and some candidates would be offered one-year FTSTA posts, rather than run-through training posts.²³

²² Department of Health, *A guide to postgraduate specialty training in the UK*, p.13

²³ See MMC—Statement on recruitment and selection to Specialty Training programmes in 2007

Warning signs

32. A number of concerns were raised during 2006 from both within and outside the MMC programme about the lack of progress on planning for implementation in 2007. The timescale for developing the MTAS national recruitment system was short: the development of the new computer software began in March 2006 and of the new national application form in May 2006, just a few months before recruitment was due to begin. The development of the national selection system was therefore given a “red” risk rating by Departmental project managers from May 2006 onwards, an indication of serious concern. The “red” rating remained in place up to and beyond the start of recruitment in January 2007.

33. Further concerns were raised by the Junior Doctors Committee (JDC) of the BMA, which issued a “Call for Delay” in June 2006, arguing for the introduction of the new programmes to be postponed for a year. The JDC re-iterated its call for delay in October 2006, setting out a number of reasons not to introduce the new Speciality training arrangements in 2007. These included:

- Serious concerns about the MTAS recruitment process including the “worryingly short timetable” for selection to take place. The JDC raised questions about the short-listing process and warned that “the application forms questions do not seem to be searching enough”;
- “Deep concern” about the inflexibility of the training structure due to be introduced in 2007, in particular because of the application of the run-through training concept across all specialty areas; and
- Predictions of “a shortfall” in the number of available training posts compared with the expected number of applicants.²⁴

34. Revealingly, the BMA’s concerns were shared by the leaders of MMC itself. Professor Alan Crockard, National Director for MMC, told us that he himself raised serious doubts himself during this period about the readiness of the new systems. Professor Crockard stated that his concerns were ignored by officials at the Department of Health and that he therefore expressed his “total frustration” with the planning for 2007 through a number of other channels in late 2006:

We saw the situation unfold from fairly well back; I had tried very hard to make this known to the SRO [Senior Responsible Officer or Owner] to whom I was accountable in terms of MMC, and to the DCMO [Deputy Chief Medical Officer]...from October to December, I had actually spoken to the regulator, to people from the Treasury, to the advisors to Ministers and to the NAO about my concerns.²⁵

24 British Medical Association Junior Doctors Committee, “Call for Delay”, October 2006

25 Q 266; the terms Senior Responsible Owner and Senior Responsible Officer are used interchangeably by the Department of Health

Supply and demand

35. Further doubts about the transition to the new training system were created by uncertainties about the likely number of applicants and the number of posts that would be available. The potential applicant pool would comprise not only those doctors completing the Foundation Programme and those in existing SHO and SAS posts in the UK, but also overseas applicants, both from within and outside the European Economic Area (EEA). On 1 February 2007, it was announced that a total of 18,000 Specialty and GP training posts would be available in England. Lord Warner, then the responsible Minister, commented that:

We anticipate that there will be around 16,000 -17,000 doctors in England eligible to apply for these positions, but we do not yet know how many doctors will apply from the EEA and overseas.²⁶

36. Fears about a possible shortage of training posts in 2007 and beyond were exacerbated by the ongoing expansion of UK undergraduate medical school places. Although the move to increase self-sufficiency had begun in 2000, it was not until 2006 that the Department of Health made attempts to restrict access to training posts for doctors from outside the EEA. To this end, the Home Office announced in March 2006 that arrangements whereby non-EEA doctors did not require work permits to take up UK training posts, known as “permit-free training” would be ended.²⁷

37. The decision to end permit-free training, however, which took effect in April 2006, did not resolve the problem. As 2006 progressed, applications to medical training posts through the Highly Skilled Migrants Programme (HSMP), an alternative entry route for non-EEA doctors, rose sharply. In order to address the spike in HSMP applications, the Department of Health issued guidance to NHS employing organisations later in 2006. The guidance, which stated that HSMP applicants could not be offered training posts unless there was no suitable applicant from within the UK or EEA, aimed to protect opportunities for the growing number of UK graduates.

38. The guidance, which would in effect limit opportunities for non-EEA doctors to those in the least popular specialties, was challenged in the High Court by the British Association of Physicians of Indian Origin (BAPIO), a professional representative body. BAPIO’s case was heard in the High Court in December 2006 but no judgment was passed until February 2007. Thus thousands of non-EEA doctors with HSMP status submitted applications when the MTAS system opened in January 2007, even though the legal status of such applicants remained unresolved.

Conclusions

39. The initial implementation of the Modernising Medical Careers (MMC) programme went relatively smoothly through the introduction of the new Foundation programme in 2005. As the Department prepared for the subsequent reform of Specialty Training, however, a number of warning signs indicated that all was not well.

²⁶ Department of Health, *18,000 new specialty training opportunities for 2007*, 1 February 2007

²⁷ Ev 19

Concerns were raised both within and outside the Department about the inflexibility of the new training system, the inadequacy of the new national recruitment system, and a possible shortage of training posts. In spite of these issues, and heedless of the warnings of the Royal Colleges and of an official “Call for Delay” by the BMA, the Department pressed ahead with its plans for wider reform in 2007. We recommend that the Department ensures that it heeds such warnings in future.

3 The 2007 crisis

Box 2: Implementation of MMC and MTAS: Timeline of key events in 2007

22 January – MTAS computer system opens for Specialty Training applications.

9 February – High Court rules that DH guidance on HSMP applicants is legal; British Association of Physicians of Indian Origin (BAPIO) launches appeal; DH decides not to enforce guidance in 2007 because of ongoing appeal.

5 March – The interview panel for ST3 level General Surgery in the West Midlands decides not to proceed with interviews due to “serious procedural flaw” with short-listing; DH announces “Douglas Review” review of ongoing ST selection process.

17 March – Junior doctors demonstrate in London and Glasgow about the MTAS system

31 March – Alan Crockard, head of MMC, resigns, blaming lack of leadership of and confidence in MMC and MTAS; National Clinical Advisor Shelley Heard also resigns.

4 April – The Douglas Review announces changes to the selection process: at least one interview is guaranteed for each candidate in an extended first round.

24 April – Sir John Tooke asked to lead independent inquiry into implementation of MMC and MTAS.

26 April – MTAS website is suspended following two separate security breaches which make some candidates details publicly available; the system is subsequently abandoned.

20 May – James Johnson, chairman of the BMA, resigns, following criticism of the organisation’s failure to adequately represent junior doctors’ interests.

23 May – RemedyUK’s legal challenge is rejected at the High Court; however, the judgement describes MTAS as a flawed system and acknowledges the “disastrous consequences” of MTAS.

8 June – Revised plans for Round 2 of recruitment are announced; applicants are guaranteed employment in existing posts until the end of October 2007.

22 June – Round 1 selection is completed, more than 2 months behind schedule.

12 July – The final report of the Douglas Review is published, describing ST selection as “the biggest crisis within the medical profession in a generation”.

1 August – Those accepted into run-through and FTSTA posts in Round 1, and those in GP training posts, begin their new programmes.

Introduction

40. The unheeded warning signs which appeared in 2006 were rapidly translated into crisis in 2007. The introduction of the new Specialty training arrangements in 2007 was strongly and widely criticised, both at the time and in subsequent reviews and reports. The Douglas Review described the events as “the biggest crisis within the medical profession in a generation”.²⁸ The independent Tooke Review called the “failure and abandonment” of the national recruitment process “a deeply damaging episode for British Medicine”.²⁹ The May 2007 judicial review described MTAS as a “flawed system” whose “premature introduction” had “disastrous consequences”.³⁰ The Chief Medical Officer acknowledged that it was “a traumatic and highly unsatisfactory experience” and that “the technical aspects of implementation clearly went badly wrong.”³¹ This chapter examines the causes of the crisis and the key events of 2007.

Causes and triggers

41. The crisis of confidence in the MTAS system was caused by a number of interacting weaknesses in the planning and design of the national recruitment process. The most significant failing which, we examine below, were:

- Serious flaws in the **short-listing process**;
- An **excess of eligible applicants** because of the last-minute failure to restrict applications from non-EEA doctors; and
- Problems with the design of both MMC and MTAS, leading to the perception of MTAS as a “**one strike and you’re out**” process.

It was the combination of these shortcomings which plunged the recruitment process into crisis in March 2007.

The short-listing process

42. The national on-line specialty training recruitment system opened for applications on 22 January 2007. Candidates were given until 4 February to make up to four separate applications, choosing among the 59 specialties, 16 regional areas, and four levels of seniority available. This deadline was subsequently extended until 5 February after operational problems with the on-line system.³² The short-listing process was carried out by consultants across the country over the next few weeks, with the interview process scheduled to take place in March and April. Round 1 of recruitment, intended to fill half of the available posts, was scheduled to finish by the end of April. A second round, beginning

28 Final Report of the Douglas Review group, 12 July 2007, p.14

29 *Aspiring to Excellence*, pp. 10 and 13

30 Judicial Review Verdict, 22 May 2007, paragraph 139

31 Qq 2–4

32 Ev 14

in May, would give candidates the opportunity to compete for the remaining posts prior to the start of the new programmes in August 2007.³³

43. During February, there were widespread complaints both from candidates and assessors about the MTAS application form and the short-listing process. The key problems included:

- The applications forms relied too heavily on “white space” questions, whereby candidates were asked to give examples of how they satisfied the particular competencies required for the post, rather than verifiable achievements or traditional CV-based information; Furthermore CVs were not available to assessors alongside application forms;³⁴
- The short-listing scoring system gave undue weight to “white space” answers relative, for example, to educational qualifications;
- “White space” answers could easily be plagiarised: there were reports of websites offering “model” answers to applicants;³⁵
- There was a lack of information, training and time for assessors to carry out short-listing, as well as inconsistencies in the approach to assessment;³⁶ and
- The same application form design and scoring methodology were used for candidates at all levels (i.e. from ST1 up to ST4), even though they were particularly unsuited to distinguishing between more experienced candidates.³⁷

44. Witnesses were especially critical of the use of the same type of application form, relying heavily on “white space” questions, for short-listing process at all levels of the MTAS system. Work Psychology Partnership, the company responsible for the design of the application forms, pointed out that their product was only intended for the short-listing of relatively inexperienced doctors applying for ST1 posts:

...we were asked to deliver a shortlisting process for ST1. We were not asked to deliver the selection methodology for doctors in ‘transition’ via ST2, ST3, ST4 and FTSTAs.³⁸

The Yorkshire Deanery described the decision, made by the Department of Health, to extend the approach used in ST1 selection to higher levels of the training system as a “fatal mistake”.³⁹ Officials did not clearly explain why, or by whom, this decision was made.⁴⁰

33 See MMC—*Statement on recruitment and selection to Specialty Training programmes in 2007*

34 “White space” questions asked candidates to describe, for example, a situation where they had worked under pressure or made a complex clinical decision in 150 words of prose

35 Ev 123

36 For example, forms were marked “vertically” in some areas, with one assessor marking the whole of each form, and “horizontally” in others, with each assessor marking a particular question on each form. Assessors also complained of difficulties printing out application forms, inconsistent pagination, and lack of time to complete assessments, in particular because the short-listing period coincided with the half-term holiday.

37 Q55

38 MMC 52 - WPP

39 Ev 70

45. The medical profession was more generally critical of the short-listing process. The Royal College of Surgeons dismissed short-listing as “fundamentally flawed”, while the Royal Colleges of Radiologists called the application form “useless”.⁴¹ The BMA stated that the criteria for short-listing “were not acceptable to the profession”.⁴²

46. The Chief Medical Officer acknowledged the inadequacy of the application form, commenting that “serious aspects...were not fit for purpose, particularly for judging more senior trainees”. The Department of Health stated in its evidence that:

Some consultants shortlisting for interview said they found it difficult to differentiate between applicants on the basis of the form. It was also felt that insufficient weight was given to academic achievement in the national shortlisting scoring. The high volume of applications exacerbated these problems...This led to serious concerns that some of the best applicants were not being shortlisted for interview.

Department of Health officials did not explain why they pressed ahead with the introduction of the new recruitment system in spite of these inadequacies.

BAPIO’s legal challenge

47. Problems with short-listing were compounded by a surge in the number of eligible applicants in February 2007. The failure in previous years to establish which candidates were eligible to apply for training posts, which we describe in Chapter 2, meant that the status of non-EEA applicants was not resolved when Round 1 of applications opened at the end of January. This planning error had profound consequences: on 9 February, the High Court ruled that the Department’s employment guidance giving preference to UK and EEA applicants was lawful but granted BAPIO the right to appeal against its verdict.⁴³ Because the appeal was not heard until October 2007, the Department was unable to implement its guidance during Round 1 of the 2007 recruitment process:

The Court’s judgement was received after the recruitment process had started (9 February). It would have been logistically difficult, but possible and legally justified, to implement the guidance at this late stage. However, as shortlisting and invitations to interview were already underway, it was judged that the disruption would be too much, particularly given that Round 1 was expected to fill only 50 per cent of the posts and the option still remained to apply the guidance in Round 2.

48. The Department’s decision made it possible for doctors from anywhere in the world who had gained HSMP status by the time applications opened to compete for UK training posts on an equal footing with UK and EEA doctors in 2007. This caused an immediate mismatch between the number of applicants and the number of available training posts, raising the prospect of large numbers of UK-educated doctors being unable to continue into specialist training. Figures from the Tooke Review show that the inclusion of overseas

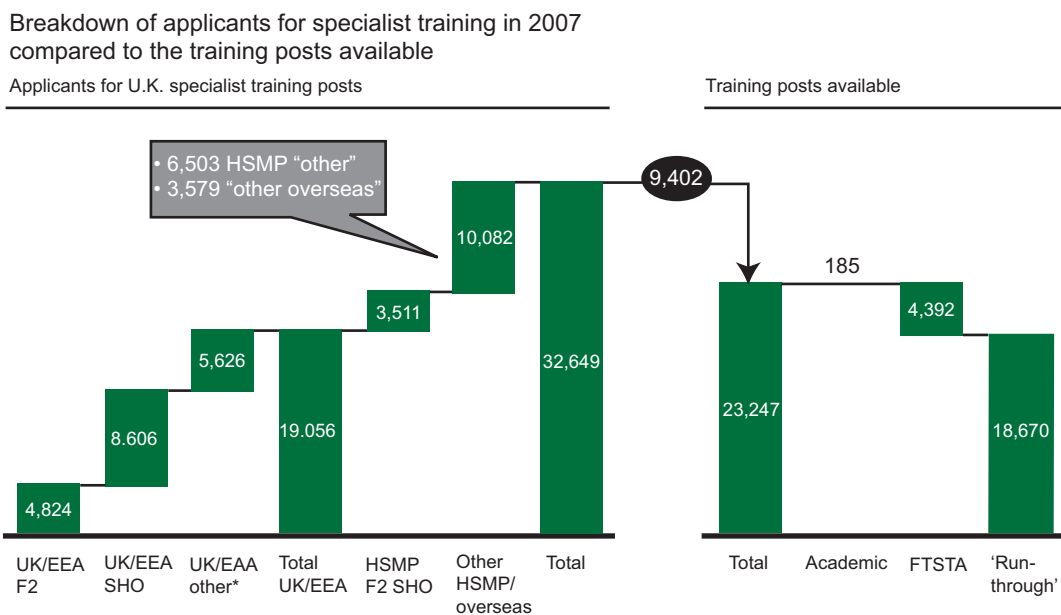
40 See Q11: Sir Liam Donaldson stated that “It was a conscious decision to change it”, but did not say who made the decision.

41 See Ev 114 and Ev 52 respectively

42 Ev 135

43 See <http://www2.bailii.org/ew/cases/EWHC/Admin/2007/199.html> for full details of the High Court verdict

doctors meant there were almost 10,000 more applicants than training posts in 2007, an excess of more than 40%:



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

Figure 4: Comparison of applicants and training posts in Round 1 of 2007 MTAS process

Source: *Aspiring to Excellence*, p.67

49. This unanticipated level of competition for training posts radically changed the function of the MTAS selection system, and particularly the short-listing process. As Work Psychology Partnership stated:

WPP were told that the competition ratios would not be too high and so short listing would be relatively 'light touch'. The actual numbers of applicants was vastly underestimated...In fact, the shortlisting system had to sift over 128,000 applications for approximately 20,000 posts. This inevitably meant that several thousand competent doctors would not be invited to interview, let alone offered a post.⁴⁴

50. In effect, the MTAS system had been designed to match candidates to posts on the assumption that there would be enough training posts for everyone. As Figure 4 demonstrates, there would have been more posts than candidates had non-EEA doctors been prevented from applying in 2007. With 10,000 non-EEA applicants, however, the system was required to operate a highly competitive selection process, especially in the most popular specialties and Deanery areas. This process was very different to the matching process for which MTAS had been designed, and for which it was used more successfully during Foundation programme recruitment. Thus the inclusion of non-EEA doctors exacerbated and drew attention to the weaknesses in the short-listing process for specialty training described above.

“One strike and you’re out”

51. The inadequacy of the short-listing process and the unexpected inclusion of non-EEA applicants were the principle causes of the 2007 crisis. Other elements of the design of the MTAS system and the structure of MMC further compounded these problems, however, by fuelling the perception that Round 1 of the 2007 recruitment process would be the only opportunity for many candidates to enter the training system:

- First, the “preferencing system” allowed each applicant four applications during Round 1. Given that the number of interviews available was fixed, this meant that many applicants received four interviews, reducing the number of opportunities for other candidates, and leaving many with no interview.⁴⁵
- Secondly, there was a widespread lack of understanding outside the Department of Health that only 50% of posts were intended to be filled in Round 1 of the process, with the remainder available in Round 2.⁴⁶ This increased the anxiety of candidates who were not offered interviews in Round 1.
- Thirdly, the centralised application process meant candidates could only make one main application during the whole year, making this a particularly “high stakes” process. This contrasted starkly with the previous system where applicants could apply to many different jobs at many points during the year.
- Fourthly, run-through training contracts, lasting up to seven years, were offered in all specialties. This added to the impression that unsuccessful candidates would not get a second chance to enter the training system. The prospect of guaranteed long-term employment also increased the number of applications from overseas doctors.⁴⁷
- Finally, a significant proportion of the available posts in 2007, around 23%, were in FTSTA posts, usually lasting for only one year. It was not clear to candidates offered FTSTA posts whether and how they would remain in the training system after these posts expired. Witnesses described the combination of run-through and FTSTA posts as a “two tier system”, and characterised doctors in FTSTA posts as “the new lost tribe”.⁴⁸

52. Each of these elements of the design and structure of MTAS and MMC contributed to the impression of a “one strike and you’re out” system, leaving many candidates who did not receive interviews in Round 1 feeling that they had been permanently excluded from the training system. Because of the perceived inadequacy of the short-listing process upon which decisions to offer interviews were based, many candidates felt that they had been unfairly prevented from continuing their careers. This increased the sense of outrage amongst applicants and assessors alike.

45 Ev 143

46 Q 97

47 Q 582

48 Ev 190

Key events in 2007

The crisis erupts

53. During February 2007, there were widespread reports of high-quality candidates not receiving any invitations to interview. On 27 February, the day before interviews were due to begin, the BMA issued a statement condemning the “shambolic recruitment system” which had “descended into pandemonium”. It called for the interview process to be suspended until it could be shown that short-listing had been “consistent and fair”.⁴⁹ Several days later, a letter from a large group of senior doctors to the British Medical Journal argued that profession had been “torn apart by an Exocet we should have seen coming”. The group, which later formed the organisation Fidelio, commented on “top juniors flung on the scrap heaps after a decade of training” and was highly critical of the leadership of the medical profession, describing them as “hand-maidens to their own apocalypse”.⁵⁰

54. Strong words from the profession were soon accompanied by strong actions. On 5 March, an interview panel for ST3 general surgery posts in the West Midlands refused to conduct scheduled interviews. The panel stated that “the MTAS procedure for recruitment to ST3 in General Surgery, has not been implemented according to agreed guidelines. We have therefore declined to continue with the interviews today.”⁵¹ The group cited a range of specific problems, including unrealistic deadlines, unexpected numbers of applications, inconsistent marking and problems with the reliability of the computer system. It concluded that:

We owe it to our patients and the profession that we are able to select and appoint the best candidates to surgical training posts and felt strongly that this was impossible today.⁵²

55. In response to the increasing levels of criticism, and in particular to the suspension of the interview process in the West Midlands, the Secretary of State held emergency meetings with leaders of the profession on 5 March. The following day, the Department of Health issued a statement commenting that:

It is clear that there have been a number of problems with MTAS, and that the process as a whole has created a high degree of insecurity amongst applicants and, indeed, more widely in the profession.⁵³

In light of the concerns, the Department announced an immediate review of Round 1 of the selection process, to be completed by the end of March 2007.

49 BMA Press Release, *BMA calls for delay to shambolic recruitment system*, 27 February 2007

50 *Raging against MTAS*, 7 March 2007

51 Official West Midlands Deanery statement, 5 March 2007

52 Ibid

53 Department of Health, *DH announces review of modernising medical careers applications*, 6 March 2007

The Douglas Review

56. The Review Group was chaired by Professor Neil Douglas, Vice Chair of the Academy of Medical Royal Colleges. Its 16 members comprised representatives from the Department of Health, including the Chief Medical Officer and the head of the MMC Team, the Royal Colleges and the BMA. The group's task was to assess what had gone wrong with the selection process and to identify changes to be made both during Round 1 and in subsequent rounds.⁵⁴

Whether to continue with MTAS

57. The immediate question facing the Review Group was whether to abandon the MTAS process altogether because of the reported inadequacy of the short-listing system. Professor Douglas told us that this option was seriously considered, describing it as “a very close call on several occasions”.⁵⁵ However, the Review Group ultimately decided to proceed with Round 1 of recruitment. Department of Health officials argued that “on balance, the benefits of continuing far outweighed the benefits of stopping the process” and stated that the leaders of the medical profession had led the decision to continue with MTAS.⁵⁶ Professor Douglas confirmed this:

The consensus from the colleges and from the BMA and from the postgraduate deans—those being the members of the medical profession on the team—was always, at the end of the meeting—not always at the beginning—that we should continue to go forward...⁵⁷

The Review Group's first statement therefore announced that the recruitment process would continue.

58. Some witnesses expressed considerable surprise that the Review Group did not agree to halt the recruitment process.⁵⁸ Fidelio, for example, stated that:

It is incredible that, once the short-listing arm of MTAS was admitted to be flawed, the Review Body took more than 10 milliseconds to decide whether the whole process was flawed—and still made the wrong decision!⁵⁹

59. Several days later, on 17 March, thousands of junior doctors took part in demonstrations in London and Glasgow.⁶⁰ The protests, organised by the increasingly active junior doctors' pressure group RemedyUK, called for the recruitment system to be

54 Douglas Review Group, *Review of the medical Training Applications Service and selection process*, 9 March 2007

55 Q 672

56 Qq 107 and 115

57 Q 672

58 Officials argued (Q 109) that the Douglas Review was right not to halt the recruitment process because large number of interviews had taken place, because good (though not necessarily the best) candidates had been short-listed, and because stopping the process would have created further uncertainty for applicants. Fidelio disagreed, arguing (Ev 190) that the acknowledged flaws in the short-listing process fundamentally undermined the entire recruitment system, which should therefore have been abandoned.

59 Ev 190

60 According to RemedyUK, 12,000 people attended the protests—see Ev 145

scrapped. The London demonstration was addressed by the Leader of the Opposition, who described the application system as an “utter shambles”.⁶¹

Reforming the recruitment process

60. The Review Group did, however, announce changes on 9 March “to strengthen the interview process” in Round 1, including making CVs available to interviewers. It also offered candidates not selected for interview in Round 1 the opportunity to have their application form reviewed, with the possibility of an interview subsequently being offered. The group also announced changes to the short-listing process to take effect from the beginning of Round 2.⁶²

61. The Douglas Review announced a number of further changes to the recruitment system during March and April. On 16 March, all eligible candidates for ST3 and ST4 posts were offered a single guaranteed interview, regardless of their short-listing score, while further reviews of applications forms were offered to ST1 and ST2 candidates.⁶³ On 22 March, the offer of one guaranteed interview was extended to all eligible candidates in England.⁶⁴ Applicants in Scotland, Wales and Northern Ireland, meanwhile, were guaranteed interviews for all four of their selected posts.⁶⁵ Further details were announced on 4 April: additional interviews would take place in May and Round 1 would be extended until the end of June, delaying the beginning of Round 2.⁶⁶ These week-by-week adjustments to the active recruitment process had profound implications for all applicants, making this a period of particular uncertainty and anxiety.

62. The guaranteed interview scheme was the most significant change introduced by the Review Group. The offer of at least one interview to all candidates mitigated the impact of the flawed short-listing process, but also created a need for thousands of additional interviews to take place. This extra burden was concentrated in popular areas such as London and the West Midlands and caused Round 1 to be significantly extended. This in turn meant that Round 2 was significantly delayed and the number of posts available significantly reduced. 85% of posts were ultimately filled in Round 1 in England, rather than the 50% originally intended.⁶⁷ Thus the Douglas Review ensured that the MTAS process would continue, but in a significantly adapted form.

63. Later in April, the Secretary of State announced a separate independent inquiry to look in more detail at the 2007 problem and to recommend changes to both MMC and MTAS for 2008 and beyond. The independent inquiry was to be led by Sir John Tooke, then Chair of the Medical Schools Council.

61 *Junior doctors protest over jobs*, BBC News Website, 17 March 2007

62 *Ibid*

63 Douglas Review, *Review of Modernising Medical Careers: Announcement to applicants*, 16 March 2007

64 *Statement by the review of recruitment and selection for Specialty and GP training*, 22 March 2007

65 The reasons behind the guarantee of only one interview for candidates in England, compared with four in the Devolved Administrations, seem to have been purely practical: because of the much higher volume of applications in England, it would have been impossible to carry out enough interviews within the time available.

66 *Statement by the review of recruitment and selection for Specialty and GP training*, 4 April 2007

67 Ev 38

Resignation fever

64. The decisions of the Douglas Review in March and April were not only unpopular with many doctors, but also with some members of the Review Group itself. Professor Alan Crockard, National Director of MMC and a member of the Review Group, resigned on 31 March 2007. His resignation letter stated that the programme “has lacked clear leadership from the top for a very long time”.⁶⁸ Several days later, MMC’s National Clinical Adviser, Professor Shelley Heard, also resigned after criticising the decisions and the outlook of the Review Group.⁶⁹ Professor Heard later told us that RemedyUK’s proposal that all appointments in 2007 be for a maximum of one year alone should have been adopted by the Review Group.⁷⁰

65. Further resignations from senior medical leaders followed in May. On 17 May, James Johnson, Chair of Council at the BMA, and Dame Carol Black, Chair of the Academy of Medical Royal Colleges, wrote jointly to *The Times*. Their letter endorsed the principles of MMC and expressed support for the Chief Medical Officer and the decisions of the Review Group. Following widespread criticism of the timing and content of the letter, Dr Johnson resigned as head of the BMA on 20 May, acknowledging that he had failed to represent the anger and uncertainty felt by most doctors at the time.⁷¹ Dame Carol Black did not resign; she later told us that she was asked to write the letter by Professor Douglas.⁷² Around the same time, Mr Bernard Ribeiro, President of the Royal College of Surgeons, resigned from the Review Group, criticising the “scandalous failure” to address problems with the training system.⁷³

The judicial review

66. Still more uncertainty was created when RemedyUK sought a judicial review of the MTAS process, asking for the decisions of the Douglas Review to be quashed. At the review, heard in the High Court on 17 May, RemedyUK argued that the changes to MTAS made by the Review Group were “conspicuously unfair”⁷⁴ and called either for the recruitment process to be abandoned, or for all posts offered in 2007 to be limited to a maximum of one year.⁷⁵

67. The judicial verdict was passed just days before the first Round 1 posts were finally due to be offered to successful candidates. Thus applicants were unclear until the very last minute whether any valid offers would be made in 2007 and the length of the training

68 See <http://www.telegraph.co.uk/news/main.jhtml?xml=/news/2007/03/30/ndocletter130.xml> for more details.

69 Professor Heard stated in her resignation letter that “...the Review Group has become so immersed in the detail that it cannot see a way ahead which will be both equitable to doctors and support the aims of MMC...I find myself able to support few of the decisions that the Review Group has taken since they undermine principles which are at the core of MMC.”

70 Q 267

71 Mr Johnson stated on 20 May that “It is a matter of regret that I am having to resign because I have lost the confidence of a very large number of members of the BMA council. But this is no ordinary political situation. The medical profession is on the edge.”

72 Q 531

73 See <http://news.bbc.co.uk/1/hi/health/6695605.stm> for more details

74 Judicial Review Verdict, 22 May 2007, paragraph 13

75 Ev 145

contracts which might be offered.⁷⁶ The High Court's decision was made public on 22 May: RemedyUK's application was refused and the legality of the Review group's decisions was upheld. Mr Justice Goldring concluded that the Douglas Review had been tasked with satisfying "irreconcilable" competing interests and that the guaranteed interview system was "a possible rational solution and not conspicuously unfair".⁷⁷ His judgement was, however, strongly critical of the wider MTAS system:

The premature introduction of MTAS has had disastrous consequences. It was a flawed system... This judgement does not mean I agree with the decision of the review group; merely that it was one the review group was entitled to come to.⁷⁸

The suspension of aspects of the MTAS system

68. At the same time as RemedyUK's legal challenge was taking place, another serious problem with the recruitment system emerged: the on-line application system suffered two security lapses. On the morning of 25 April, candidates' personal details were made available to employers through the MTAS website without adequate password protection. The breach, which made private details publicly available, was discovered in the early afternoon by Channel 4 News, which later informed the Department of Health. The details were subsequently removed and the Secretary of State later informed the House that:

There is no evidence that members of the public or other commercial interests, apart from staff at ITN and Channel 4 News, accessed the site. None the less, it was an extremely serious breach of security, as a well as a breach of contract between the IT provider and the Department of Health.⁷⁹

69. The provider in question was Methods Consulting, the company responsible for building and operating the online applications system. Methods' Managing Director, Mark Johnston, later blamed the security failure on human error:

...through a very untypical mistake a senior member of my team put them [files containing personal details] in place in a way which was not secure enough... It was a simple mistake... he made a call in doing something, which was very untypical of him and he was very tired from working very hard, and that is what caused it.⁸⁰

70. The following day, 26 April, a second, unrelated security lapse was discovered. Applicants with secure access to the MTAS system were able to randomly access confidential messages, for example regarding interview appointments, sent to other candidates. Following this second security problem, the MTAS website was suspended to allow a full security review to take place.⁸¹

76 DH letter to applicants

77 Judicial Review Verdict, 22 May 2007, paragraph 29

78 Judicial Review Verdict, 22 May 2007, paragraph 31

79 Ministerial statement, 1 May 2007

80 Q 468

81 Ministerial statement, 1 May 2007

71. A subsequent Ministerial Statement on 15 May announced that the security review had been completed and that “appropriate and sufficiently comprehensive action has been taken” to address the problems. However, the Secretary of State announced that while the MTAS website would be re-opened for internal use by the Postgraduate Deaneries, it would no longer be used as part of the Specialty training recruitment system. Instead:

...the current round will be managed locally by individual deaneries... Given the continuing concerns of junior doctors about MTAS, the system will not be used for matching candidates to training posts.⁸²

72. The decision to abandon aspects of the MTAS system meant that Round 1 had to be further extended, this time until late June, meaning in turn that Round 2 could not be completed before the 1 August deadline. The change also created large amounts of unexpected work for Postgraduate Deaneries who had only a few weeks to design and coordinate a fair and efficient process for making offers to candidates, something which was intended to be done by the national online system.⁸³ The London Deanery told the Committee that its staff worked a total of 7,500 hours of overtime to implement the revised 2007 recruitment system.⁸⁴

The final scramble

73. Following the changes made by the Douglas Review, the decision to scrap aspects of the national application system, the resignations of the leaders of MMC and the completion of the judicial review, the first offers were made to Round 1 candidates on 25 May 2007, more than four months after the application system opened. The offers process, conducted locally by the Postgraduate Deaneries, continued until 22 June 2007 when Round 1 was completed, only a few weeks before successful candidates were to begin in their new posts.⁸⁵ The delayed and drawn-out nature of the process meant many candidates were forced to decide whether to accept offers in their second-choice post before knowing the outcome of their first choice application.⁸⁶

74. On 8 June, the MMC team set out revised arrangements for Round 2 of recruitment. The process would be run entirely by Postgraduate Deaneries, using revised short-listing and application systems. 215 extra run-through training posts were to be created, although the total number available would still be far less than originally planned, due to the expansion of the Round 1 process by the Douglas Review. The over-run to the Round 1 process also meant that Round 2 would be conducted in large part after the 1 August deadline. The Department of Health therefore made a comprehensive commitment that all

82 Ministerial statement, 15 May 2007

83 The decision also meant that offers would be made gradually rather than on a single date, raising the prospects of candidates being asked to accept job offers before knowing the outcome of other applications.

84 Ev 122

85 MMC letter, 25 May 2007

86 This problem particularly affected the many candidates who selected GP training as a back-up option. The GP offers process was concluded in May while many candidates did not hear the outcome of their specialty training applications until late June.

NHS doctors applying to Round 2 would have their contracts extended to cover the time taken by the recruitment process.⁸⁷

75. Following the completion of Round 1 in late June, a Ministerial Statement on 12 July announced that 85% of available posts in England had been filled. Predictably, the fill rate for run-through training posts was higher (91%) than that for FTSTA posts (64%). In academic medicine, an area particularly badly affected by the weaknesses of the selection system, only 57% of posts were filled.⁸⁸ Nonetheless, on 1 August 2007, successful candidates in GP and Specialty training posts began work across the country.

Conclusions

76. The introduction of the new Specialty Training arrangements in 2007 was disastrous. The failure to restrict overseas applicants and the manifest weakness of the national recruitment system made the collapse of confidence in the selection process inevitable. The design of the initial application forms was particularly inappropriate, failing to recognise doctors' key achievements and giving undue weight to "white space" questions. The short-listing process, critical to the futures of so many, therefore descended into little more than a creative writing exercise. Candidates and assessors alike were justifiably outraged by the sheer inadequacy of MTAS.

77. The period between February and August 2007 was characterised by unrelenting chaos and severe anxiety for thousands of junior doctors. The repeated changes to the recruitment system, a High Court challenge and the failure to protect the privacy of candidates' personal information ensured that the process was miserable for all the applicants involved. The Review Group, faced with an impossible situation, was unable to restore confidence in the recruitment system. The wave of resignations by senior medical leaders and series of emergency Ministerial statements which followed were both acutely embarrassing for the Government. The reputations of both the Department of Health and the leaders of the profession were severely diminished by the events of 2007.

87 MMC letter, 8 June 2007. This decision was criticised by Queen Victoria Hospital NHS Foundation Trust which argued that "...as a Foundation Trust we do not consider it appropriate or acceptable that this guarantee was made on our behalf without any reference to or consultation with our organisation."

88 Ministerial Statement, 12 July 2007

4 2007–08: Fall-out

Introduction

78. Despite the many problems experienced during Round 1 of recruitment, the majority of training posts were filled by 1 August 2007. The chaos and confusion of the previous six months, however, and the obvious inadequacy of the selection process, had raised serious questions about the future of the MMC programme. A new round of selection was set to begin in January 2008 and it was unclear how this would be managed in light of the woeful performance of the recruitment system in 2007. In this chapter we look at how the Department of Health and others responded to the fall-out from the 2007 crisis. We then examine the findings of the independent Tooke Review into the implementation of MMC, which published its interim conclusions in October 2007.

Aftermath of the 2007 crisis

New governance arrangements

79. One of the Department's immediate responses to the problems of 2007 was to make significant changes to the governance arrangement for MMC. The Douglas Review group, which had been the main decision-making body for both MMC and MTAS since its creation in March 2007, published its final report on 12 July, after which it ceased to exist.⁸⁹

80. On 25 July, a newly constituted MMC Programme Board met for the first time, chaired by the Deputy Chief Medical Officer. The new post of Chief Operating Officer for MMC was also created at this time. The new Programme Board contained representatives from a range of interested parties including the Royal Colleges, the BMA, NHS organisations and the Department of Health. Many of the Board's members had sat on the Douglas Review group and the medical profession and junior doctors themselves were well represented.

81. The Secretary of State described the introduction of the new Programme Board with significant professional representation as “the most important innovation” in the immediate aftermath of the 2007 crisis.⁹⁰ Others were more doubtful: Dr Ian Wilson, a BMA representative on the Programme Board, told us that the new Board risked repeating the mistakes of 2007 by ignoring the views of the medical profession. Such doubts appeared to be confirmed in January 2008 when several Programme Board members from the Royal Colleges wrote to *The Times* to complain about the allocation of training places for 2008. The continuity of Department of Health representation on the Programme Board was also affected when MMC's Senior Responsible Officer, Martin Marshall, resigned in late 2007.⁹¹

89 The Review Group's report acknowledged the “major crisis” caused by the new Specialty training recruitment system (p.3), labelled the planning for MTAS “overambitious” and criticised the lack of consultation with the profession regarding the details of the recruitment process (p.12).

90 Q 844

91 MMC's Chief Operating Officer, Terry Hanafin, was also replaced in late 2007

82. The main immediate tasks facing the new Programme Board were to oversee the completion of Round 2 of the 2007 recruitment process and to advise Ministers on arrangements for the 2008 recruitment process. Longer-term decisions about the future of the MMC programme were largely deferred until after the publication of the Tooke Review. On 11 October, the Round 2 interview process was further extended with the current jobs of Round 2 applicants guaranteed until 31 December.⁹² Thus the Round 2 process was only finally completed a few days before the 2008 selection process began.

The status of non-EEA doctors

The situation in 2008

83. The new Programme Board also had the task of addressing the future of non-EEA applicants. As described in Chapter 3, the failure to resolve the status of overseas applicants prior to the start of recruitment was one of the main causes of the 2007 crisis. In an attempt to prevent this problem from recurring, the Department of Health published a consultation paper on 8 October 2007, setting out options for managing non-EEA applications in 2008. In spite of BAPIO's ongoing legal appeal, the Department's preferred option was to restrict applications from overseas doctors in 2008 by enforcing its guidance to employers:

The Department's preferred option is to re-implement the long-standing policy guidance, that doctors from outside the EEA with limited leave to remain in or enter the UK should be considered for post-graduate medical training places in the NHS, only if there is no suitable UK or EEA applicant.⁹³

84. The Department's consultation paper estimated that the decision not to implement its guidance in 2007, which we describe in Chapter 3, would eventually leave 1,200 UK medical school graduates without a training post.⁹⁴ This was the first time that the impact of open competition in 2007 had been quantified; the Department later increased its estimate to more than 1,300 UK-trained doctors "displaced" in 2007.⁹⁵ The Department went on to predict that if its guidance was not applied in 2008 and subsequent years "around 1,000 to 1,500 UK medical school graduates are likely to be displaced and unable to secure a training place".⁹⁶

85. Thus the Department's plans for 2008 were reliant on the Court of Appeal upholding the legality of its employment guidance. BAPIO's case was heard in October 2007 and on 9 November the Department's guidance was declared unlawful. Lord Justice Sedley concluded that the guidance contradicted existing Immigration Rules and should not have been promulgated without Parliamentary approval. He concluded:

92 MMC Team letter, 11 October 2007

93 Department of Health, *Recruitment to foundation and specialty training - Proposals for managing applications from medical graduates from outside the European Economic Area*, 8 October 2007, pp.10–11

94 *Ibid*, p.8

95 Department of Health, *Recruitment to foundation and specialty training—Proposals for managing applications from medical graduates from outside the European Economic Area*, 6 February 2008, p.9

96 Department of Health, *Recruitment to foundation and specialty training—Proposals for managing applications from medical graduates from outside the European Economic Area*, 8 October 2007, p.8

Very properly, the guidance has been put on hold pending these proceedings. I would declare it to be unlawful and of no effect.⁹⁷

86. The Department subsequently requested a review of the Court of Appeal's decision by the House of Lords. The House of Lords' verdict was scheduled for publication in May 2008, however, meaning that the Department was again unable to apply its guidance when the 2008 selection process began in January. Just as in 2007, non-EEA doctors who had gained HSMP status were free to apply on an equal footing with UK and EEA doctors in 2008. According to the Department itself, this would mean there would be three applicants for every available training post in 2008, a higher competition ratio than in 2007, and up to 1,500 UK graduates displaced from the training system.⁹⁸

The situation in 2009 and beyond

87. Undeterred, the Department released a further consultation paper in February 2008, examining options for managing non-EEA applicants in 2009. Once again, the Department proposed to implement its employment guidance, provided that the House of Lords declared it lawful in May 2008.⁹⁹ The Secretary of State told the Committee that he was "quite confident" the House of Lords would uphold the Department's appeal.¹⁰⁰ He also stated, however, that the guidance would not be applied retrospectively if it was found to be lawful, meaning that its full impact would not be felt until 2009.¹⁰¹

88. The Secretary of State also described some of the other options available for managing non-EEA applications in 2009 and beyond:

If it [the guidance] is upheld I doubt whether we will need any further requirements... If the guidance is not upheld then we will continue to look at other options... I mentioned one, which is a fees regime. The other is to see whether we could pass into legislation from my Department something that would cover this...¹⁰²

89. To ease the situation, the Home Office introduced restrictions to its new immigration system in February 2008, preventing any overseas doctors acquiring HSMP status in the future from applying for training posts. This change, to be implemented gradually in 2008, would not affect existing HSMP doctors but would prevent non-EEA doctors from applying through the HSMP route from 2009 onwards.¹⁰³ The Department of Health stressed, however, that this represented only a partial solution: the applicant pool in 2009 would be reduced by 3,000 to 5,000, but the 10,000 HSMP doctors already in the UK would

97 High Court Ruling, 9 November 2007, paragraph 55.

98 Department of Health, *Recruitment to foundation and specialty training—Proposals for managing applications from medical graduates from outside the European Economic Area*, 8 October 2007, p.8

99 Department of Health, *Recruitment to foundation and specialty training—Proposals for managing applications from medical graduates from outside the European Economic Area*, 6 February 2008, pp.14–16

100 Q 913

101 Q 911

102 See Q 907 and Qq 912–913

103 MMC 60 Home Office

be unaffected.¹⁰⁴ The Home Office also emphasised that the change represented a “stop gap” solution to allow the Department “to find its own sustainable solutions to workforce planning problems”.¹⁰⁵

The 2008 recruitment process

90. Alongside these faltering efforts to resolve the status of non-EEA doctors, the Department set out detailed plans for the 2008 recruitment process, strongly influenced by recommendations from the new Programme Board. A consultation paper published on 12 September 2007 proposed a recruitment process delivered largely by local Postgraduate Deaneries and without using the national on-line computer system.¹⁰⁶ Other features of the 2008 system included:

- Candidates were permitted to make as many applications as they wished;
- New applications forms and short-listing systems were used, designed locally by Deaneries and giving more prominence to CV-based questions, and with different forms for candidates applying to different levels of the training system;
- Local timetables for completing the main selection process were established, within a national timetable running from January to May 2008, with two further small recruitment rounds thereafter; and
- Variation between the selection processes used by different specialty areas with a small number, including General Practice, Histopathology and Public Health, running a national recruitment system.¹⁰⁷

91. Representatives of Postgraduate Deaneries told the Committee in January 2008 that the recruitment process was running more successfully than in 2007. Professor Elisabeth Paice, Dean Director for the London Deanery, even commented that in spite of the inclusion of non-EEA doctors, the number of applicants had not overwhelmed the selection system:

...one might have feared a tidal wave of applications, but that has not happened. Obviously, people are targeting the post they want...they are spreading their applications so that across the country people are getting applications in the thousands, though not tens of thousands. Therefore, so far so good...¹⁰⁸

The Tooke Review

92. At the same time as the 2008 recruitment process was being planned and implemented, the independent Tooke Review published its findings and recommendations for the reform programme for 2009 and beyond. The Tooke review panel published an interim report,

104 Department of Health press release, *New immigration rules for international medical graduates*, 6 February 2008

105 MMC 60 Home Office

106 Department of Health, *Recruitment to specialty training—proposals for improvements in 2008*, 12 September 2007

107 See <http://www.mmc.nhs.uk/default.aspx?page=321> for further details

108 Q 581

Aspiring to Excellence, in October 2007.¹⁰⁹ Following a consultation period, a final report was produced in January 2008. The inquiry's findings, which have significant implications for the MMC programme, future recruitment systems and the wider medical workforce, are set out in more detail below.

The diagnosis

93. One of the key tasks of the Tooke Inquiry was to establish why the crisis of 2007 occurred. The review looked widely at the development of the MMC reforms, as well as specifically at the MTAS recruitment process, in order to answer this question. Its main conclusions were:

- The **policy objectives** for MMC were poorly defined with “no definitive description of MMC and what it embraced”. The original principles of *Unfinished Business* “were eroded and over time subsumed by workforce objectives” during implementation. For example, the creation of run-through training programmes contradicted the principle of increasing the flexibility of the training system.¹¹⁰
- **Governance structures** for MMC were inappropriate “with complex and ambiguous accountability structures for policy development and very weak governance and risk management process”. Crucially, responsibility for the national recruitment system and for resolving the status of non-EEA doctors “lay outside the MMC management framework”.¹¹¹
- The implementation of MMC, and particularly MTAS, was hampered by poor **project management**, including unrealistic timescales, a failure to pilot, poor risk management and the over-ambitious decision to introduce all the changes in the same year.¹¹²
- These problems were compounded by **weak leadership** on the part of both the Department of Health and the medical profession. Regarding the latter, the report commented that “...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.”¹¹³
- Lines of accountability, funding and incentives for some of the **key organisations** in medical education were flawed or inadequate. The report particularly highlighted problems affecting Postgraduate Deaneries and PMETB.¹¹⁴
- **Ineffective workforce planning** during the development of MMC created further problems. The “rigidity” of the run-through training system, the uncertainty

109 Tooke Inquiry, *Aspiring to Excellence: Findings and recommendations of the independent inquiry into Modernising Medical Careers*, October 2007

110 *Aspiring to Excellence*, p.11

111 *Ibid*

112 *Ibid*, pp.43–50

113 *Ibid*, p.12

114 *Ibid*

surrounding FTSTA posts and the failure to resolve the status of non-EEA doctors were all the product of poor workforce planning.¹¹⁵

The treatment: structural change

94. In response to these numerous and serious problems, the Tooke Review made a total of forty-seven recommendations for change, many of which we discuss in more detail in subsequent chapters.¹¹⁶ Amongst the most significant of these were proposals for a further restructuring of the medical training system. *Aspiring for Excellence* called for the two-year Foundation programme to be split and for run-through programmes to be un-coupled into “Core” and “Higher” specialist training schemes, changes which would reverse the two key structural reforms brought in by MMC. The Review also proposed integrating academic medicine programmes with mainstream training, substantially changing recruitment and selection techniques and increasing the length of GP training from three to five years. The new training structure proposed by the Tooke Review is shown below:

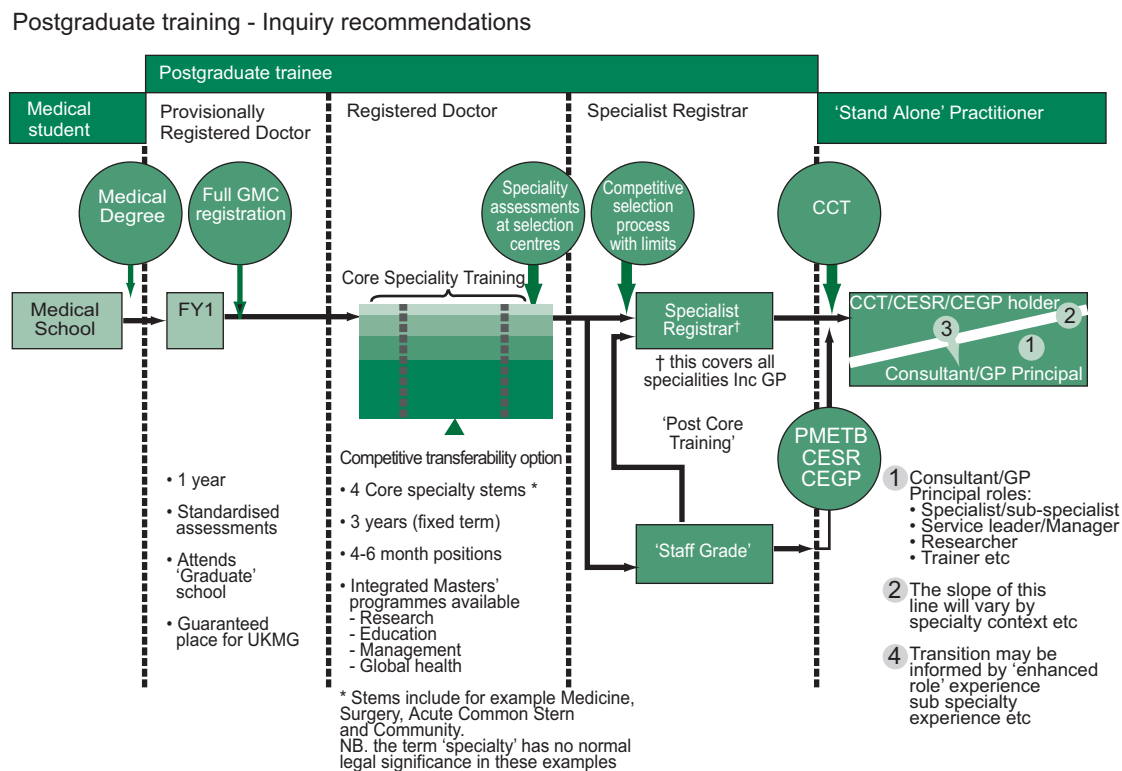


Figure 5: Future structure of medical training recommended by the Tooke Review

Source: *Aspiring to Excellence*

95. *Aspiring to Excellence* suggested that the implementation of these changes should begin in 2009.¹¹⁷ We examine the structure of the medical training system and the Tooke Review’s proposals in more detail in Chapter 5.

115 Ibid, pp.11–12

116 45 recommendation appeared in the interim report in October 2007, with a further 2 recommendations (along with revisions to the original 45) appearing in the final report in January 2008.

117 Ibid, p.46

The treatment: organisational change

96. *Aspiring to Excellence* also made a number of recommendations for reform of the organisations responsible for postgraduate medical training. In particular, it proposed:

- That a new body, **NHS Medical Education England** (NHS:MEE), be created to co-ordinate post-graduate medical education, define the principles to underpin training, and oversee the implementation of future reforms. NHS:MEE would hold the budget for postgraduate medical education, which would be ring-fenced, and would scrutinise the commissioning of training by Strategic Health Authorities.¹¹⁸
- That a review of the role of **Postgraduate Deaneries** be carried out, particularly as the inquiry found that Deaneries were often poorly integrated with local providers and Universities.¹¹⁹
- That the postgraduate regulator, **PMETB**, be absorbed by the GMC, the regulator for undergraduate training, to improve and integrate the regulation of medical training.¹²⁰
- That the **Department of Health** improve policy development, governance and project management for medical education while devolving detailed operational responsibilities to NHS:MEE.¹²¹ The Review also recommended that the Chief Medical Officer should be the Department's Senior Responsible Officer for medical education with responsibility for liaising with NHS:MEE.¹²²

97. The Tooke Review also recommended improvements to medical workforce planning and called for a wide-ranging debate on the role that doctors should play at different stages of their career. Finally, *Aspiring to Excellence* was critical of the undue focus on measuring “competence” which characterised the MMC reforms, arguing that this was an inappropriate foundation for the medical education system:

...the Independent Inquiry Panel was clear: mechanisms that smacked of an aspiration to mediocrity were inadmissible. Put simple, “good enough” is not good enough. Rather, in the interests of the health and wealth of the nation, we should aspire to excellence.¹²³

Responses to the Tooke Review

The general response

98. The response of the main stakeholders in postgraduate medicine to the Tooke Review was extremely positive. The Royal Colleges, the BMA, NHS Employers and Fidelio all

118 *Aspiring to Excellence*, pp.64–65

119 *Ibid*, p.41

120 *Ibid*, p.44

121 *Ibid*, pp.22–23

122 *Ibid*, p.22 and p.40

123 *Ibid*, p.5

expressed strong general support for the inquiry's findings. RemedyUK, the most active opponent of the 2007 reforms, urged that all of the recommendations in *Aspiring to Excellence* be implemented.¹²⁴

99. In addition, a formal consultation on *Aspiring to Excellence* was conducted between October and November 2007. A total of 1,440 respondents stated whether they agreed with each of the interim report's 45 recommendations: an overwhelming level of support was expressed. Sir John Tooke told the Committee in November that:

...there is 87% agreement or strong agreement across the 45 recommendations and only 4% disagreement... For each of the recommendations there is a majority opinion in favour. In my experience of consultation exercises I do not believe I have ever seen that degree of overall support for a set of recommendations...¹²⁵

100. Witnesses did raise concerns, however, about some of the Review's specific recommendations. The BMA and Postgraduate Deans, for example, disagreed with the recommendation that the two-year Foundation programme be split.¹²⁶ Meanwhile, Representatives from NHS Employers, SHAs and Postgraduate Deaneries all expressed concerns about the creation of NHS:MEE.¹²⁷

The Department of Health's response

101. The Chief Medical Officer accepted many of the criticisms made by the Tooke Review and described *Aspiring to Excellence* as "an excellent report". He warned, however, that "there are some differences of view on the proposals".¹²⁸ The Secretary of State commented in February 2008 that the independent inquiry had made "an enormous contribution" to the task of resolving the 2007 crisis.¹²⁹

102. On 28 February, the Department published its formal response to the Tooke Review. The Secretary of State welcomed the report, calling it a "careful and balanced analysis and diagnosis" and "a significant step in moving forward" in response to the 2007 crisis.¹³⁰ The Department accepted a number of the Review's recommendations:

- 24 of the Tooke Review's 47 recommendations were accepted. Many of the recommendations accepted, however, were qualitative changes with no timetable or way of measuring progress indicated.¹³¹

124 Ev 140

125 Q 155

126 See Q 413 and Q 602 respectively

127 See Q 722, Q 718 and Q 607 respectively. Witnesses pointed out that as it only appeared in the inquiry's final report, published in January 2008, the proposal to create NHS:MEE had not been subjected to consultation

128 Q 120

129 Q 844

130 Department of Health, *The Secretary of State for Health's Response to Aspiring for Excellence*, p.1

131 For example the Department agreed to redefine the principles underpinning medical training (Recommendation 1), to consult with the medical profession on future policy changes (Recommendation 3), and to strengthen its links with education and research (Recommendation 8)

- The recommendation to merge PMETB with the GMC was accepted, although the Department stated this would not take place until at least 2010.¹³²

103. However, the Department deferred decisions on whether to accept the Review's other 23 recommendations, which included the most significant changes proposed:

- The Department deferred decisions on changes to the structure of medical training, including whether to split the Foundation programme and un-couple run-through training. It cited the need for more time to evaluate the new schemes and to consider the Tooke Review's proposals, calling for a "period of stability" before introducing further changes.¹³³
- The decision about whether to set up NHS Medical Education England was also deferred. The Department stated that this question would be considered as part of the *NHS Next Stage Review*, due for publication in June 2008.¹³⁴

Conclusions

104. **The independent Tooke Inquiry produced a perceptive and comprehensive analysis of the problems which affected the MMC programme and the causes of the 2007 crisis. The Secretary of State was right to quickly accept many of the Inquiry's recommendations for change and improvement. Decisions on the Inquiry's most significant and far-reaching proposals, however, were deferred. We recommend that the Department publish an updated response to the Tooke Inquiry, setting out its final decisions on all 47 recommendations, immediately after the Darzi review has been published.**

132 Department of Health, *The Secretary of State for Health's Response to Aspiring for Excellence*, pp.42–43

133 Ibid, pp.47–49

134 Ibid, pp.54–55

5 The medical workforce

Introduction

105. The MMC programme set out to make major structural changes to the UK medical training system through the introduction of the new Foundation training programme followed by the seamless run-through training grade. The implementation of these structural changes coincided with a new approach to selection through the national MTAS recruitment system. MMC was also initially intended to resolve problems affecting the wider medical workforce, including non-training grades.

106. In the wake of the 2007 crisis, there have been widespread calls for many of the changes introduced by MMC to be reversed, or for further changes to be made. The Tooke Inquiry called for significant reform of the structure of training, further changes to recruitment and selection, and for a range of issues outside the training system to be addressed. In this chapter, we look first at the training system, examining debates about the future structure of training and processes for recruitment and selection. We then look at issues affecting the wider workforce, including Staff Grade and Associate Specialist doctors and the consultant grade itself.

The training system

107. The Tooke Inquiry recommended significant changes to the structure of medical training envisaged by MMC. Its proposals, including splitting the two-year Foundation programme and “un-coupling” the run-through grade, were widely supported at consultation.¹³⁵ In its response to the Tooke Inquiry, however, the Secretary of State deferred deciding on changes to the training system, calling instead for a “period of stability”.¹³⁶ In this chapter we examine the case for further change, looking in particular at:

- The future of the two-year **Foundation programme**;
- The **specialty training system**, particularly in light of the 2007 crisis;
- The training system for **academic medicine**; and
- Processes for **recruitment and selection** of doctors to the training system.

The Foundation Programme

108. Prior to the introduction of MMC, doctors began their careers by completing a single “pre-registration house officer” (PRHO) year upon graduating from medical school.¹³⁷ Following their PRHO year, doctors achieved full GMC registration and could then apply for SHO posts. MMC replaced the PRHO year with the two-year Foundation programme,

¹³⁵ *Aspiring to Excellence*, pp.118–136. See Chapter 3 for more details

¹³⁶ Department of Health, *The Secretary of State for Health’s Response to Aspiring for Excellence*, pp.47–49

¹³⁷ It is notable that the traditional PRHO year generally gave new graduates experience only of general medicine and general surgery and that it did not have a formal curriculum

first implemented in August 2005. The Foundation scheme was to be made up of six four-month placements, including one in General Practice, with GMC registration awarded after the first year.

109. As we have seen, the Tooke Inquiry recommended splitting the Foundation programme and reverting to the training structure which was in place prior to MMC.¹³⁸ The inquiry called for a single year of employment upon graduation, followed by GMC registration and then competitive entry into three-year “Core” specialist training programmes. The Department of Health has yet to decide whether to implement this change. In this section we therefore examine the Foundation programme to date and the debate about its future.

Benefits from the Foundation programme

110. Many witnesses, including representatives from the medical profession, praised the new Foundation programme. Postgraduate Deaneries, the organisations with the main responsibility for delivering the new schemes, were particularly positive. The English Postgraduate Deans stated that:

In general this MMC linked reform has worked well and has adhered to the key MMC principles. It has an explicit curriculum with a well developed, though incomplete, assessment framework. It has been generally welcomed by senior clinicians and trainees alike... The first full 2 year cycle of posts has generally been deemed a success.¹³⁹

111. The Northwest Deanery also deemed the programme “a success”, underlining the benefits of exposing more candidates to GP training at an early stage in their career.¹⁴⁰ The London Deanery pointed out that appropriate funding and piloting prior to introduction had helped to ensure that the programme worked well.¹⁴¹ Peter Rubin from PMETB, the body responsible for regulating the second year of Foundation training, also noted that there was “something of considerable value” in the new schemes.¹⁴²

112. Unsurprisingly, such witnesses opposed the proposal that the Foundation programme be split. Professor Elisabeth Paice, Dean Director for the London Deanery, stated that “in general postgraduate deans are very sad about the proposal to break up the foundation year.”¹⁴³ Professor Alan Crockard, former National Director for MMC, also supported the continuation of the two-year programme, arguing that it would help to support “a vitalisation of primary care” by promoting General Practice as a career choice.¹⁴⁴

¹³⁸ The inquiry’s interim report, published in October 2007, criticised the lack of relevance of some Foundation placements and inadequate assessment processes for trainees

¹³⁹ Ev 74

¹⁴⁰ Ev 87

¹⁴¹ Ev 121

¹⁴² See Q 660. Professor Rubin is head of the Education Committee of the GMC as well as being chair of PMETB

¹⁴³ Q 602

¹⁴⁴ Q 305

113. The BMA also disagreed with the Tooke Inquiry's proposal. Dr Ian Wilson stated that the BMA supported the continuation of the two-year Foundation programme:

We actually think that of all this period the foundation year appears to have been one of the successes—the two years. I think we disagree that separating the two parts out would be a good thing.¹⁴⁵

Problems with the Foundation programme

114. Some witnesses, however, cited problems with the new Foundation programme. The Royal College of GPs and Committee of GP Education Directors (COGPED) both pointed out that the goal of providing at least one General Practice placement for all Foundation doctors had not been achieved.¹⁴⁶ The RCGP stated that fewer than 50% of doctors had access to a GP placement during Foundation training:

Over half of all doctors graduating from the Foundation Programme are denied vital early clinical experience of caring for patients in their usual community based environment. As a result, they are denied the opportunity to see natural history, care pathways, multiple morbidity and chronic disease management.¹⁴⁷

115. The National Association of Clinical Tutors described other shortcomings in the Foundation programme, including inadequacies with assessment processes and a lack of career guidance for doctors.¹⁴⁸ This problem was also highlighted by the interim report of the Tooke Inquiry, which set out a range of concerns with the Foundation scheme:

...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 FY2.¹⁴⁹

The need for evaluation

116. Other witnesses argued that it was too early to judge whether the Foundation programme had been an overall success, pointing out that the first cohort of Foundation trainees only completed the scheme in August 2007. Professor Neil Douglas commented on the lack of opportunity to evaluate the programmes:

...some of us were surprised that the recommendation [in *Aspiring to Excellence*] to split F1 and F2 was not really compatible with recommendation 2, which is that everything should be evidence based, because the evidence is not in.¹⁵⁰

145 Q 413

146 See Ev 130 and Ev 185

147 Ev 185

148 See Ev 100–101

149 *Aspiring to Excellence*, p.43

150 Q 659

117. Dr Bill Reith of the Royal College of GPs made a similar point, arguing that there was not yet enough evidence upon which to assess the Foundation programme.¹⁵¹ The Department of Health's response to the Tooke Review agreed, citing mixed and incomplete evidence as a justification for deferring its decision on the future of the Foundation programme:

There have been representations from the organisations responsible for managing the delivery of training that report encouraging feedback from foundation trainees and have requested a full five years of development and evaluation for the current Foundation Programme.¹⁵²

The legal situation

118. The final report of the Tooke Review, however, raised a fresh problem with the Foundation programme by questioning the legality of the current arrangements. *Aspiring to Excellence* pointed out that UK medical schools must offer their graduates the opportunity to achieve GMC registration. UK graduates, however, cannot in theory be guaranteed a place on the Foundation scheme, making it impossible for universities to discharge this obligation:

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. 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.¹⁵³

119. The Tooke Review argued that this situation could only be addressed by splitting the Foundation programme:

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.¹⁵⁴

120. Others, however, questioned the Tooke Review's assertions. David Sowden, former chair of the English Deans and now SRO for MMC at the Department of Health, raised doubts about whether the Tooke Inquiry's recommendations were themselves legally sound:

From a deanery perspective, there are also particular issues around the proposals on foundation programme training and its linkage to the guarantee of employment for

151 Q 534

152 Department of Health, *The Secretary of State for Health's Response to Aspiring for Excellence*, p.48

153 *Aspiring to Excellence*, p.46

154 Ibid

UK graduates. There is some doubt about the legality of that particular statement and therefore we are concerned about it.¹⁵⁵

121. NHS Employers called for an “urgent review” of the Foundation training arrangements, in light of the questions about their legality.¹⁵⁶ The Department of Health did not comment in its response to the Tooke Review on the specific questions about the legality of the Foundation programme.

Conclusions and Recommendations

122. The implementation of the new two-year Foundation programme did not suffer from the errors which marked that of specialty training. We heard evidence of significant benefits from the new schemes as well as a number of continuing problems. It is too early to judge whether the new Foundation programme has proved an overall success and we therefore recommend that the current two-year scheme is retained while a full evaluation of its impact is carried out in due course.

123. We note the Tooke Inquiry’s concern that the current arrangements for the Foundation programme are not legally sound. We recommend that the Department address this question as a matter of urgency and, if necessary, consider introducing legislation to safeguard the legality of the current two-year programme. Only if no lawful alternative can be found should the Tooke Review’s recommendation to split the Foundation programme be accepted.

Specialty training

124. The most radical changes attempted by the MMC programme were those made to Specialty training in 2007. MMC set out to replace the previous SHO and Specialist Registrar grades with a single seamless “run-through” training grade, taking doctors from the end of Foundation training through to eligibility for consultant appointments. Run-through training posts, lasting from five to seven years, were offered in all fifty-nine specialty areas from August 2007. A number of one-year Fixed-Term Specialty Training Appointments (FTSTAs) were also offered, in order to create additional capacity during the transition period.

125. Although the new national MTAS recruitment system was largely to blame for the 2007 crisis, the situation was exacerbated by the creation of run-through and FTSTA posts. As a result, the Tooke Review called for run-through posts to be “un-coupled” and for a “Core” specialist training programme to be put in place, followed by a separate “Higher” training scheme. We consider below the problems caused by the 2007 structural changes and the options for future change.

155 Q 602

156 Q 729

Run-through training

126. Witnesses consistently emphasised that the creation of a single run-through grade, without opportunities for candidates to switch between different run-through schemes, contradicted MMC's aim of increasing flexibility. The excess rigidity of the new arrangements was emphasised by the BMA, the Royal College of Physicians, the Yorkshire Deanery and RemedyUK.¹⁵⁷ These groups pointed out that run-through arrangements forced candidates to make their choice of future career too early, and did not provide adequate opportunities to switch to a different career, or to leave and re-enter the training system. The Royal College of Psychiatrists described the run-through system as “rigid beyond imagination”.¹⁵⁸

127. Further criticism was levelled by the NHS Workforce Review Team, which pointed out that the intention to create competencies that could be transferred from one run-through training scheme to another had not been realised. The Review Team commented that this would make it more difficult to respond to future service needs:

Despite new competency-based curricula, the system is less flexible as it does not yet have the ability for trainees to take competences, or better capabilities, from one specialty to another. Therefore, there are now 59 separate training systems rather than the original intention of six to eight base specialties, with later ability to specialise as the workforce needs arise.¹⁵⁹

128. The Department of Health acknowledged that the run-through scheme introduced in 2007 had made the training system more inflexible. It accepted that few doctors were equipped to make long-term career decisions by the end of the Foundation programme and that competencies could not yet be transferred between different run-through schemes. The Department concluded that:

...the principle of seamless specialist training has been implemented in run-through training programmes that do not currently provide the level of flexibility originally envisaged.¹⁶⁰

Fixed Term Specialty Training Appointments

129. The creation of one-year FTSTA posts, of which more than 4,000 were offered in 2007, was also consistently criticised. In particular, witnesses pointed out that FTSTA doctors had no guarantee that they could continue their training, making their future career prospects very uncertain. Some predicted that many doctors would end up moving from one FTSTA post to another without being able to progress to run-through training. NHS Employers described FTSTAs as “a second-rate career path, unpopular and

¹⁵⁷ See Ev 133, Ev 154, Ev 71 and Ev 140 respectively

¹⁵⁸ Ev 164

¹⁵⁹ Ev 66

¹⁶⁰ Ev 10

hard to fill”.¹⁶¹ RemedyUK was blunter still, calling FTSTAs “dead-end” jobs.¹⁶² The Royal College of Surgeons warned that:

Trainees in FTSTAs complete a one year training post and then have to re-apply for run-through training alongside all the other eligible candidates...This creates potential for an exponential growth in the number of trainees competing for run-through posts each year...¹⁶³

130. The Tooke Inquiry, the Royal Colleges of Surgeons and RemedyUK all warned that FTSTAs were at risk of becoming a new “lost tribe”.¹⁶⁴ Fidelio vividly described the two-tier system created by the simultaneous introduction of run-through and FTSTA posts:

In reality, RT has become a cage which keeps those inside safe from preying FTSTAs, but also stops those inside from getting out...¹⁶⁵

“Core” and “Higher” training

131. In order to address the problems created by the new structures for Specialty training, the Tooke Review recommended “un-coupling” run-through training programmes to create separate “Core” and “Higher” training schemes. *Aspiring to Excellence* recommended that:

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...Core Specialty Training will typically take three years and will evolve with time typically to encompass six six-month positions.¹⁶⁶

132. The Tooke Review also emphasised that doctors in “Core” training should have the flexibility to leave and re-enter the training system and to switch between different training schemes.¹⁶⁷ Royal Colleges representing a number of major specialties, including Surgery, Radiology and Psychiatry, expressed support for the idea of un-coupling run-through programmes.

The case for a mixed economy

133. Anticipating the Tooke Review’s proposals, many specialties un-coupled their run-through training programmes prior to the 2008 recruitment process, offering two or three years of “specialty core training” instead. Core programmes were offered in Medicine, Psychiatry, Anaesthetics and most surgical specialities. Run-through training posts continued to be offered in General Practice, Paediatrics, Obstetrics and a number of

161 Ev 172

162 Ev 142

163 Ev 114

164 See *Aspiring to Excellence*, p.88, Ev 114 and Ev 142 respectively

165 Ev 190

166 *Aspiring to Excellence*, p.53

167 See *Aspiring to Excellence*, p.146. The Inquiry stated that some specialties should be continue to offer run-through contracts for a limited period, but only during the transition to the new system.

smaller specialties. This compromise arrangement was termed a “mixed economy” of training programmes by the Department of Health.¹⁶⁸

134. The Royal College of Paediatrics and Child Health strongly defended its continued use of run-through training contracts, arguing that this still allowed for considerable flexibility within its specialty area:

We have always envisaged there would be the possibility to move between specialties and our flexible length of training programme allows this to happen...We believe within paediatrics we have within our allocation to subspecialty training a system that is very sensitive to workforce needs. In this we adjust the numbers entering subspecialty training according to predicted vacancies in the subspecialty that are likely to occur in 2-3 years time.¹⁶⁹

135. In its response to the Tooke Review, the Department defended the “mixed economy” and asserted that the run-through training model continued to meet the needs of some specialties. The decision on whether to implement the Tooke Review’s recommendation for “Core” training across all specialties was therefore deferred:

...some specialties believe that run-through training will best meet their needs beyond the ‘transition period’ suggested... This was demonstrated in the DH consultation in September 2007, which gave a broad consensus on the proposals that will be implemented in August 2008 for a ‘mixed economy’ of training structures... Those specialties which most need flexibility have already started the process of decoupling. Consequently, it seems sensible to evaluate whether the MMC 2008 model of training meets the needs of stakeholders before making further changes.¹⁷⁰

Conclusions and Recommendations

136. It is clear that the creation of run-through posts across all specialties in 2007 was a serious error. The rigidity of many 2007 run-through schemes contradicted MMC’s principles of increasing flexibility and providing a broad-based beginning to specialty training. Run-through training was especially unsuited to the needs of a number of large specialties, include general medicine and surgery. Such specialties have already un-coupled their run-through programmes for 2008 and we support this development.

137. We do not agree, however, with the Tooke Review’s recommendation that un-coupling should take place across the board. It is clear that the run-through model has advantages for some specialty areas and may help to attract doctors to traditional shortage specialties. It is also evident that flexibility can be built into run-through schemes, as the case of Paediatrics has demonstrated. Most persuasively, it was the imposition of a “one size fits all” structure which caused such problems in 2007. Forcing all specialties to un-couple would risk repeating this mistake. We therefore

168 For full details, see *GUIDANCE FROM THE DEPARTMENT OF HEALTH TO SHAs ON MANAGING LOCAL RECRUITMENT TO SPECIALTY TRAINING IN 2008*, 23 January 2008, p.3. It is notable that while there was a mixed economy *between* different specialties in 2008, there was no mixed economy *within* specialties.

169 Ev 111

170 Department of Health, *The Secretary of State for Health’s Response to Aspiring for Excellence*, p.48

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. We further recommend that specialties be permitted to offer a mixture of run-through and un-coupled training posts where this best meets their needs.

Academia

The impact of the 2007 reforms

138. The introduction of the MTAS selection system and the new structures for Specialty training in 2007 appears to have had a particularly negative impact on the training system for academic medicine. The Academy of Medical Sciences expressed “grave concern” that the rigidity of run-through training schemes made it very difficult for doctors to pursue academic activities, particularly because of the lack of opportunities to take time out of training in order to conduct research.¹⁷¹ Fidelio described academic medicine as “an apparently small but vital piece of the jigsaw” which was badly overlooked during the introduction of MMC.¹⁷²

139. The Tooke Review warned that a “binary divide” was being created between the academic and non-academic training systems and pointed out the lack of opportunities for “broader clinical involvement in academic activity”.¹⁷³ It concluded that:

...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. 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.¹⁷⁴

140. This conclusion was borne out by Department of Health statistics which showed that only 57% of academic training posts were filled during Round 1 of recruitment in 2007. This was considerably lower than the overall average fill rate (85%), and lower even than the fill rate for FTSTA posts (64%).

Strengthening academic medicine

141. In order to revitalise the academic training system, Fidelio called for more opportunities for doctors to enter and leave clinical training, particular in order to conduct research activities. Fidelio also recommended that the number of academic training posts be expanded to compensate for the training opportunities which were lost when MMC was introduced.¹⁷⁵ The Tooke Inquiry made similar recommendations, urging that:

171 Ev 54

172 Ev 192

173 *Aspiring to Excellence*, p.58

174 *Aspiring to Excellence*, p.68

175 Ev 192

Integrated clinical academic training pathways in all specialties including general practice should be flexibly interpreted and transfer to and from conventional clinical training pathways should be facilitated.¹⁷⁶

142. In its response to *Aspiring to Excellence*, the Secretary of State expressed support for this recommendation and pledged to provide more effective academic training opportunities in future. The response called for medical schools to become more involved in delivering academic training and stated that:

The academic clinical training programme will continue to evolve to ensure that supportive career management and mentoring of junior doctors is core to the programme.¹⁷⁷

Conclusions and Recommendations

143. **Academic medicine is a vital part of the training system which appeared to be badly neglected and damaged by the MMC reforms. Research opportunities should be accessible to all doctors in training, while dedicated academic training posts must be made more attractive. To this end, 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. We further recommend that the number of centrally funded academic training posts be increased and that the academic training system run parallel to that for mainstream clinical training.**

Recruitment and selection

144. We saw in Chapter 3 that the introduction of the national MTAS recruitment system was at the heart of the 2007 crisis. A flawed short-listing system, rushed and inconsistent assessment processes, and the eventual abandonment of the central IT system were among the most prominent failings. We look more closely at how such an inadequate system came to be introduced in Chapter 7; in this section, meanwhile, we look at how the recruitment process itself can be improved.

Centralised or localised recruitment?

145. We have seen that the centralised nature of the MTAS recruitment system caused major problems in 2007. Key aspects of the national system, comprising a central computer portal, a nationally agreed application form and a single national timetable with one starting date per year, were ultimately abandoned for specialty training. Responsibility for arranging interviews and making offers to candidates were devolved to local Deaneries in May 2007. This trend continued when Deaneries were given responsibility for leading the 2008 specialty recruitment process and the Department confirmed that the central IT system would not be used for specialty selection in 2008.¹⁷⁸

176 *Aspiring to Excellence*, p.147

177 Department of Health, *The Secretary of State for Health's Response to Aspiring for Excellence*, p.51

178 Department of Health press release, *LOCALLY LED, STAGGERED RECRUITMENT FOR SPECIALTY TRAINING IN 2008*, October 2007

146. Some specialties nevertheless opted to maintain a nationally co-ordinated selection system for 2008. These included Paediatrics, Obstetrics, Public Health and several surgical specialties.¹⁷⁹ A central recruitment process will also be run for General Practice in 2008, following the relative success of a new selection system in 2007.¹⁸⁰ As with the structure of specialty training itself, a “mixed economy” of recruitment systems is therefore operating in 2008. It is notable that several traditional “shortage” specialties have chosen to run a national recruitment system and to continue to offer run-through training posts in 2008. A central recruitment system also continues to operate in support of the Foundation training system.¹⁸¹

147. Many witnesses had no objection in principle to the use of centralised systems to support the selection process, but asserted that the specific arrangements for specialty recruitment in 2007 were ill-conceived and prematurely introduced. The Royal College of Paediatrics pointed out the advantages of centralised recruitment for rationalising the workload of assessors.¹⁸² Fidelio, by contrast, opposed the future use of centralised recruitment methods, warning against introducing “a son-of-MTAS that quietly sweeps this year under the carpet.”¹⁸³

Staging the recruitment process

148. While different views were expressed about how centralised the recruitment process should be, witnesses consistently opposed another feature of the 2007 system: the introduction of a single date (1 August) for doctors to move to their new jobs. Sir Jonathan Michael emphasised the disadvantages, and potential impact on patient safety, of having only one change-over date per year:

They are significant because of the implication for service delivery and training. Employers are required to provide mandatory training and induction programmes. If everybody changes on the same day employers will struggle to maintain effective services during the initial few days or couple of weeks.¹⁸⁴

149. Sir John Tooke agreed, stressing the importance of returning to a staged recruitment process with posts beginning at several points in the year. He also pointed out that this would make it easier for doctors to leave and re-enter training, describing staged recruitment as “another dimension of flexibility”.¹⁸⁵ The Royal College of Surgeons concluded that:

The flexibility offered by having more than one recruitment round per year would be welcomed both by trainees (because they will have more than one opportunity to

179 These include Cardiothoracic Surgery, Plastic Surgery and Neurosurgery

180 See <http://www.mmc.nhs.uk/default.aspx?page=321> for further details

181 Q 477

182 Ev 108

183 Ev 189

184 Q 180

185 Q 181

compete in a year) and by employers (a staggered start for the new intake of trainees would reduce the impact on the service).¹⁸⁶

150. The principle of returning to a staged recruitment process was supported by the Department of Health. The arrangements for 2008 recruitment allowed for up to three selection rounds within the year, although the 1 August recruitment round remained the largest.¹⁸⁷ In his response to the Tooke Review, the Secretary of State acknowledged the need to stage the recruitment process, pointing out that this was a stated goal of the MMC Programme Board.¹⁸⁸

New selection methods

151. Some witnesses advocated the introduction of new methodologies to the selection process, provided that suitable piloting and evaluation were carried out first. The idea of using a national “metric”, based perhaps on scores in standardised tests or exams, to support the short-listing process was widely suggested. Professor Elisabeth Paice suggested that this would help to distinguish between large volumes of applicants much more effectively than the “white box” questions widely used in 2007:

... there should be some kind of test that provides a baseline; otherwise, we cannot cope with volume applications, and we are likely to get them from within Europe if we make our training as good as we would like it to be.¹⁸⁹

152. The introduction of a new “metric” was strongly supported by Professor Neil Douglas, who stated that this idea had been suggested in 2005, when it was rejected by the Postgraduate Deans.¹⁹⁰ Anne Rainsberry from NHS London was also positive about the proposal.¹⁹¹ Professor Paice pointed out that a machine-marked test had successfully been used to support the GP recruitment process in 2007.¹⁹²

153. In its response to the Tooke Review, the Department stated that “a programme of recruitment and selection pilots” was currently being undertaken by the MMC Programme Board with a view to introducing some new selection methods. The Department described pilot schemes looking at two new recruitment methods:

...machine-markable tests: invigilated shortlisting ranking tests that are machine-marked, similar to the CPS test developed for GP training selection...[and] selection centres: a combination of selection methods used together to assess an applicant against defined requirements.¹⁹³

186 Ev 114

187 Department of Health press release, *LOCALLY LED, STAGGERED RECRUITMENT FOR SPECIALTY TRAINING IN 2008*, October 2007

188 Department of Health, *The Secretary of State for Health’s Response to Aspiring for Excellence*, p.51

189 Q 589

190 Q 669

191 Q 740

192 Q 561

193 Department of Health, *The Secretary of State for Health’s Response to Aspiring for Excellence*, p.21

Conclusions and Recommendations

154. The crisis of 2007 was caused in large part by the failure of the recruitment system for specialty training. In response, the Department has handed control of recruitment back to the Postgraduate Deaneries who largely reverted to traditional selection processes in 2008. We support this move and recommend that the Department devolve all responsibility for recruitment to Deaneries as soon as possible, including allowing them to set their own timetables. Deaneries should in turn do more to involve local employers and individual consultants in the design and implementation of selection systems.

155. The delegation of responsibility for recruitment to regional and local organisations should not prevent Deaneries from organising national selection processes when this approach best meets the needs of particular specialties. Nor should it stop Deaneries from using centralised infrastructure, including IT software, where they consider it necessary to improve recruitment and when adequate piloting has taken place.

156. The imposition of a single start date for all training programmes in 2007 was a serious error which reduced the flexibility of the recruitment system and had the potential to compromise patient safety. We recognise that a staged approach to recruitment has been introduced in 2008 and we support this move. We recommend that a staged recruitment process, with at least three substantial recruitment rounds per year, be established in the future.

157. The serious problems experienced in 2007 should not prevent Deaneries from exploring future changes to selection methods. It is vital, however, that such changes are carefully tested and evaluated prior to implementation. We note that the MMC Programme Board has established a pilot programme for new selection methods and we support this approach. In particular, a recognised national test or exam, also referred to as a national “metric”, has the potential to increase the objectivity of short-listing and to make recruitment more efficient. We recommend that the Programme Board consider the case for introducing a national “metric” as a matter of priority.

The wider medical workforce

158. We saw in Chapter 2 that part of the rationale for the MMC programme was the *Choice and Opportunity* paper, which highlighted the problems experienced by doctors outside the formal medical training system. Its very title, focussed on “careers” rather than on “training”, implied that MMC would seek to address some of these wider workforce issues. In practice, however, the initial reforms focussed largely on changes to the structure and content of training. This focus further intensified in the wake of the 2007 crisis and the Tooke Inquiry, whose remit related mainly to the training system. In this section, we move away from the training system and examine MMC’s impact on the wider medical workforce. We look in particular at:

- The situation of **Staff Grade and Associate Specialist** doctors;¹⁹⁴ including progress on resolving the issues described in *Choice and Opportunity*; and
- Debates about the future role of the **consultant workforce** in light of MMC and other developments.

Staff Grade and Associate Specialist doctors

Changes to date

159. The problems affecting Staff Grade and Associate Specialist (SAS) doctors were articulated in *Choice and Opportunity* which criticised the absence of a recognised career structure and the lack of formal training available for SAS doctors, as well as the stigma attached to SAS posts. It recommended both that SAS doctors be allowed to acquire formal competencies to help with career progression and that more consistent training and careers advice to be provided.¹⁹⁵

160. Witnesses argued that some progress had been made in improving the SAS grades since 2003. Dr Moira Livingston, who previously worked at the Department of Health to implement *Choice and Opportunity*, described the achievements to date:

...there are some things that we did manage to achieve. One was to bring together a body of evidence for the employer to understand how to ensure that doctors in these roles could fully reach their potential...and how employers could view them differently in terms of their contribution as clinical leaders within organisations, so their role as managers, teachers, their role in research.¹⁹⁶

161. Meanwhile PMETB pointed out that the introduction of a separate route to achieving specialist registration, by-passing the formal training system, had improved prospects for SAS doctors. The Certificate of Eligibility for Specialist Registration (CESR), established in 2005, was praised by PMETB:

Doctors who have not completed a full training programme can seek to demonstrate to the Board that they have the same level of skills and knowledge as a doctor who has successfully completed a specialist training course leading to the award of Certificate of Completion of Training (CCT). If their application is successful then they will be entered on to the specialist register and be eligible to compete for consultant posts within the NHS.¹⁹⁷

Limitations of progress

162. Despite these changes, however, the Committee heard that overall progress on the reform of SAS posts had been distinctly limited. Most importantly, Dr Moira Livingston

194 Staff Grade and Associate Specialist doctors are described in more detail in Chapter 2

195 Department of Health, *Choice and Opportunity*, pp.1–4. See Chapter 1 for more details

196 Q 752

197 Ev 105

argued that the MMC programme had failed, and continued to fail, to prioritise the reform of the SAS grades:

the reaffirmation of the principles of the MMC Programme Board [in 2007], which were deemed MMC principles, actually are MMT principles and actually modernising medical training principles because they do not take account of *Choice and Opportunity*, which was a key part of the whole programme...¹⁹⁸

163. Dr Livingston also acknowledged specific limitations to progress. She stated that the development of transferable competencies and a “credentialing” system for SAS doctors, which would allow experience gained in SAS posts to be recognised alongside formal training, had not yet been achieved. The absence of a “credentialing” system has limited the impact of the development of the new CESR route, as there is no clear system whereby SAS doctors can demonstrate that they meet the CESR requirements. Dr Livingston stated that:

Where we were unable to gain any momentum was around the issue of credentialing. The origin aspiration had been that doctors in the new career post would be able to get the credentialing as they progressed within their job learning as they go for new competences that they have gained, and there just is not a regulatory structure in place to support that....¹⁹⁹

164. Dr Livingston pointed out that the planned implementation of a new contract for SAS doctors had been delayed, preventing other changes from being introduced:

...there has been a delay in that we felt that the new contract was an essential component of *Choice and Opportunity*, and whilst waiting for that to be agreed there has been a hold on the publication of the work that we did within the MMC team...²⁰⁰

165. The Tooke Inquiry also argued that the failure to agree the new SAS contract had hampered progress. It stated that the SAS grade would continued to be regarded as “a diversion into a cul de sac” if further changes were not made.²⁰¹ *Aspiring to Excellence* made recommendations which echoed many of those put forward in *Choice and Opportunity* four years earlier:

Staff grade positions must be destigmatised and contract negotiations rapidly concluded...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.²⁰²

198 Q 752

199 Q 752

200 Q 752

201 *Aspiring to Excellence*, p.47

202 *Aspiring to Excellence*, p.146

The new SAS contract

166. Sian Thomas of NHS Employers told the Committee that the new contract for SAS doctors had been agreed in principle by the BMA and the Department of Health in November 2006. She pointed out, however, that the Government did not ratify the contract until more than a year later in December 2007.²⁰³ In March 2008, 60% of SAS doctors voted to accept the new contract with effect from April 2008.²⁰⁴

167. The Secretary of State acknowledged that ratifying the contract had taken longer than expected, blaming this problem on wider restrictions on public sector pay increases.²⁰⁵ He argued, however, that the new contract would bring significant benefits for SAS doctors:

I am not suggesting that everything now is coming up smelling of Chanel for this particular group but I do say that we have paid some attention to their concerns and sought to get a fair deal with their representatives which means that they are not forgotten or left out of the huge changes and improvements that have gone on in the NHS over the last ten years.²⁰⁶

Linking SAS posts to the training system

168. Witnesses emphasised that the ultimate aim of the new contract and other changes to the SAS grade should be to develop such roles into an effective supplement or alternative to the formal training system. The Tooke Inquiry argued that SAS posts should become a “parallel alternative career route”.²⁰⁷ *Aspiring to Excellence* pointed out the potential benefits to training doctors of working in SAS posts:

The advantages of the grade (accrual of experience in chosen area of practice, consistent team environment) need to be made clear.²⁰⁸

169. Dr Moira Livingston made a similar point, arguing that the creation of a viable alternative to the specialty training system would strengthen the medical workforce and make reform of the training system less controversial.²⁰⁹ The English Postgraduate Deans agreed, but argued that progress on achieving this had been limited:

...some trainees need an alternative career structure within Medicine to that offered by the route to CCT or CESR/CEGPR...The Staff and Associate specialist (SAS) grade offers a potential alternative route but the present impasse over the SAS contract is having a very negative effect on junior doctor’s perception of this grade.

203 Q 755

204 BMA Press Release, *SAS Contract Vote*, 17 March 2008

205 Q 941

206 See Q 939. Officials stated (Q 938) that the new contract would offer 10% pay increases of 10% for Staff Grade and 4% for Associate Specialist doctors

207 *Aspiring to Excellence*, p.47

208 *Aspiring to Excellence*, p.146

209 Q 752

Choice and Opportunity offered a mechanism to explore the educational infrastructure to support this grade but this remains largely unexplored.²¹⁰

170. As we have seen, Dr Livingston stated that little progress had been made on such infrastructure developments, such as the introduction of transferable competencies for SAS doctors. She told the Committee that changes of this type would help to develop the SAS grade as an alternative to training but had been prevented by the lack of clarity regarding regulatory responsibility for SAS doctors:

Because the doctors in the career posts are not part of the training structure...they fell outwith the remit of PMETB and, although we did work with Skills for Health to look at a structured framework for their development, again it was something that could not sit with the GMC in its remit and could not sit with PMETB.²¹¹

Conclusions and Recommendations

171. **Reforming the Staff Grade and Associate Specialist (SAS) grades was one of the original aspirations of the MMC programme. To this end, the establishment of a new way of achieving specialist registration, the CESR route, is a welcome development. Wider progress, however, has been limited and access to training and CPD remains patchy. In particular, the failure to implement a “credentialing” system has prevented training and experience gained by SAS doctors from being formally recognised, meaning that SAS posts continue to be regarded as inferior to traditional training posts. The introduction of a new contract for SAS doctors has also been delayed, further hampering progress. We recommend that the introduction of this new contract be given a high priority by the Department.**

172. **The failure to substantially reform the SAS grade is highly disappointing, in particular because SAS posts have the potential to provide an attractive alternative to the formal training system. This potential must be realised in the future. Such a development would not only belatedly improve prospects for SAS doctors themselves, but would also reduce pressure on the traditional training system. In order to achieve this, we recommend that:**

- **The remit of the MMC Programme Board be widened to include reform of the SAS grade;**
- **Responsibility for regulating the training received by SAS doctors be given to PMETB, and subsequently to the GMC;**
- **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; and**

210 Ev 76

211 Q 752

- **Employers make use of the new SAS contract to ensure consistent access to and funding for training and development and to develop extended roles for SAS doctors.**

173. These changes would ensure that the SAS grades become a recognised part of the training system, providing a genuine alternative to traditional training posts and giving doctors the opportunity to develop specific skills to a very high standard. This would significantly increase the overall flexibility of the training system and greatly reduce the need for temporary FTSTA posts. It would also ensure that the UK no longer has a two-tier medical workforce and that in future all doctors are either in training or fully trained.

The consultant grade

174. The principal aim of the specialty training system is to produce doctors suitable for appointment as consultants. Witnesses stressed that changes to the training system and the SAS grade would in turn create a need for changes to the consultant grade. Others called for reform of the consultant grade in response to wider changes to the medical workforce and the health system.

Differentiation within the consultant grade

175. Sir John Tooke explained to the Committee how the role of the consultant has changed in recent years, arguing that the breadth of responsibilities covered by individual consultants had decreased:

When I became a consultant in a district general hospital nearly 20 years ago I was the only specialist in the two specialties that I served...Therefore, I had to lead the profession and run the training. I also ran a research programme...In my service there are now five of me. We do not all do those things; some operate as sub-specialists, some major on research and so forth.²¹²

176. He went on to argue that this change had created a need for increasing differentiation, and the development of distinct levels of seniority, within the consultant grade:

It is likely that there will need to be some differentiation at the top end of the profession. It seems unlikely to me that you can have the majority workforce made up of autonomous practitioners operating in precisely the same role...A useful analogy that has been put forward is that in clinical academia you recognise at consultant level that you can have a senior lecturer, reader and a professor. Therefore, there is a differentiation within that hierarchy.²¹³

177. Some witnesses felt that the best way to address this issue would be to create a separate grade below the current consultant grade. Professor Stephen O’Rahilly proposed that a

212 Q 197

213 Ibid

“sub-consultant or specialist grade” be created for doctors to enter immediately upon completing training.²¹⁴

178. Representatives of the BMA agreed on the need for differentiation within the consultant grade, but did not feel that the creation of a separate “sub-consultant” grade would be the best way to achieve this. Dr Ian Wilson argued instead that senior consultant posts should be created to offer the possibility of progression within the grade:

What we believe ...is rather than creating a second grade which actually achieves nothing and delivers nothing and has no place that cannot be dealt with in existing structures is to create a portfolio within the consultant grade.²¹⁵

179. Mr Bernard Ribeiro agreed, pointing out that at present most consultants remain in much the same job role for the whole of their working life. Like the BMA, he argued that differentiation would best be achieved by introducing senior positions above the existing consultant level:

We are more inclined... to look at how we can take the established consultant body and look at means of progression, not take the view that a consultant appointed at 35 will practise in the same way throughout the whole of his career. He will have to demonstrate why that progression should occur. That might well give some structure to the consultant level.²¹⁶

Consultant-led or consultant-delivered care?

180. Witnesses also emphasised the importance of deciding what proportion of care which should be provided by consultants. It was stressed that if the NHS were to move from a primarily consultant-led to a primarily consultant-delivered service then this would significantly reduce the amount of care delivered by doctors in training.²¹⁷ It would also affect the overall number of consultants and training doctors required by the NHS. A consultant-led service would also increase the ratio of consultants to doctors in training, increasing the number of consultants available to teach and supervise.

181. The Royal College of Surgeons argued that the 2000 *NHS Plan* had envisaged the creation of a consultant-delivered NHS. However, it warned that this commitment was now in doubt:

The unprecedented growth in the medical workforce offers a remarkable opportunity for the NHS to be a consultant-delivered service. This was aspired to in the 2000 NHS Plan and has the full support of the medical profession. Despite this, the uncertainty created by current NHS reforms and the focus on fiscal matters has jeopardised the chance to achieve a consultant delivered NHS...There needs to be

214 Q 217

215 Q 416

216 Q 543

217 “Consultant-led” care would traditionally be provided by a team of junior doctors, including doctors in training, working under a single consultant. “Consultant-delivered” care would be provided directly by consultants themselves.

agreement and clarity from the Department of Health...as to whether the NHS should be a consultant-delivered service or a consultant-led service.²¹⁸

182. When questioned by the Committee in 2007, David Nicholson, NHS Chief Executive, stated that the issue of whether to move towards consultant-delivered care was still being considered by the Department of Health:

There are some really important issues here that have not finally been teased out. The most obvious one is what is the nature of the service that we are going to be taking forward in the future? Is it going to be a consultant-led service or a consultant-delivered service? That has a big impact in terms of the numbers of staff that you want. We have not come to a conclusion on all of that...²¹⁹

183. The Secretary of State denied that the Department's policy had changed since 2000, commenting cryptically that care would be "clinician-led and locally driven" in the future.²²⁰ He subsequently stated that the specific question of whether to offer consultant-led or consultant-delivered care would be considered by the NHS Next Stage Review.²²¹

Conclusions and Recommendations

184. The changes introduced by MMC also have significant implications for the consultant workforce. Shorter overall training times and increasing sub-specialisation both point to a need for greater differentiation within the consultant grade. 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.

185. We were surprised that the Secretary of State was not able to say whether he remains committed to the *NHS Plan* aspiration of moving from consultant-led to consultant-delivered care in the NHS. This is a critical question with fundamental implications for the size and nature of the consultant workforce, and for the role of the training system. We recommend the Department resolve this issue 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, potentially throwing medical workforce planning into still more confusion and further damaging relations with the medical profession. This decision should not be taken lightly.

186. We are also concerned by the apparent absence of any systematic basis for calculating postgraduate training numbers, something which should have been established as part of the MMC reforms. It is unclear whether the number of training posts is determined by the number of doctors seeking training, by the current capacity for training in the NHS, by the future clinical needs of the health service, or by some combination of these factors. We agree with Professor Tooke that "workforce policy

218 Ev 115

219 Public Expenditure Questionnaire 2006–07, Q54

220 Public Expenditure Questionnaire 2006–07, Q258

221 Q 947

objectives must be integrated with training and service objectives”. 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.

6 The supply of doctors

Introduction

187. This chapter looks at the supply of doctors to the UK training system, and therefore to the NHS as a whole, examining recent efforts to protect opportunities for UK medical graduates and to restrict access to training posts for doctors from outside the European Economic Area (EEA). As described in Chapter 3, the unexpected failure to limit applications for training posts from non-EEA doctors was one of the principal causes of the 2007 crisis. We saw in Chapter 4 that non-EEA applications were again unrestricted in 2008 and that no definitive solution is in place for 2009 and beyond. Resolving the status of non-EEA doctors was described as an “urgent” priority by the Tooke Review, particularly as the output of UK medical schools continues to increase.²²²

188. In this chapter we examine:

- The debate about whether to restrict training opportunities for non-EEA doctors and the Department of Health’s recent efforts to do this; and
- Present and future options for managing the entry of non-EEA doctors to the UK.

The current situation

Self-sufficiency and its implications

189. Increasing the self-sufficiency of the UK for its medical workforce has been a long-standing policy of the Department of Health. In pursuit of self-sufficiency, a sharp rise in the number of UK medical school places took place from 1999 onwards:

Year	1999	2000	2001	2002	2003	2004	2005	% Increase: 1999–2005
UK medical school intake	3,972	4,300	4,713	5,277	6,082	6,294	6,298	58.6%

Table 1: UK medical school numbers: 1999–2005

Source: Department of Health

190. As most undergraduate medical training courses last six years, the output of medical graduates did not begin to increase until around 2005. Thus the number of UK graduates starting initial training increased from 2005 onwards, while the number seeking specialist training expanded from 2007, coinciding with the introduction of the new Foundation and Specialty training programmes respectively.

191. The rapid growth in the number of UK graduates had significant implications for the postgraduate training system, which had traditionally recruited large numbers of doctors from overseas, and particularly from non-EEA countries such as India.²²³ The move

²²² *Aspiring to Excellence*, p.5

²²³ European law prevents the UK from making any restrictions on non-UK doctors from within the EEA. Officials (Q 896) pointed out that this group tends in any case to represent a small proportion of training applicants, typically around 5%.

towards self-sufficiency raised serious doubts about whether non-EEA doctors should continue to be actively recruited, and about whether such doctors should be permitted to take up UK training posts. Given the substantial cost to the taxpayer of training UK graduates, estimated at more than £250,000 each by the Department of Health, there was a significant economic case to protect training opportunities for UK doctors.²²⁴ This section is therefore concerned in large part with the debates about whether and how training opportunities for non-EEA doctors should be restricted.

The case for limiting non-EEA applications

192. The NHS is in effect a monopoly provider both of patient care and of clinical training in the UK. As a result, a shortage of NHS training places for UK doctors would prevent many home-grown doctors from continuing with their careers without moving abroad.²²⁵ The majority of witnesses therefore accepted the need for the policy of self-sufficiency to be complemented by the protection of training opportunities for UK graduates. Dame Carol Black emphasised the consequences for UK graduates of excess competition for training places:

If the UK is to achieve self-sufficiency by continuing to attract able young UK nationals into UK medical schools and, in turn, the NHS, there must be good prospects of completing training after graduation. Significant denial of training opportunities for UK medical graduates, and subsequent unemployment, would be a waste of major investment in talented people who have already undergone highly competitive selection.²²⁶

193. Bernard Ribeiro pointed out that allowing non-EEA doctors the freedom to apply for UK training places also had serious negative implications for countries outside the UK:

Coming from a third-world country where you see resources being removed in the way of doctors—I come from Ghana where most doctors leave the country and the health service in a poorer state—I am not keen on IMGs coming to the UK to support first world services, thank you very much. You should produce your own doctors to do it.²²⁷

194. The Secretary of State also acknowledged the lack of coherence between the Department's goal of self-sufficiency and the continuing open competition for training places in 2007 and 2008:

...you cannot have an open door policy and a self-sufficiency policy; the two things are diametrically opposed and I want the self-sufficiency policy.²²⁸

224 Department of Health, *Recruitment to foundation and specialty training—Proposals for managing applications from medical graduates from outside the European Economic Area*, p.10

225 As well as representing a waste of public investment, arranging to continue training overseas is not necessarily straightforward for UK medical graduates. UK graduates have relatively limited clinical skills and experience upon graduation, and are therefore suitable only for junior training posts. Posts of this kind are not always available in overseas health systems.

226 MMC 56A

227 Q 547

228 Public Expenditure Questionnaire 2005–06, Q 239

The case for open competition

195. Some witnesses did, however, point out the advantages of allowing non-EEA doctors to compete freely for training places, arguing that this would ultimately improve the quality of the doctors appointed. Sir Jonathan Michael, former Chief Executive of Guy's and St Thomas' NHS Foundation Trust, argued that opportunities for non-EEA doctors gave employers more choice.²²⁹ NHS Employers pointed out that the success of many non-EEA doctors in securing training posts in 2007 demonstrated that restricting competition would reduce the quality of doctors:

Initial indications from 2007 Round 1 recruitment suggested that 70 per cent of training posts were secured by UK graduates compared with 30 per cent by graduates from EEA and non-EEA medical schools. This ratio is good but not good enough to exclude overseas trained HSMPs from applying for specialty and GP training in the near future.²³⁰

196. Dr Ramesh Mehta of BAPIO also argued that free competition would improve quality:

Professor Tooke mentioned excellence; excellence will come from competition, so we and our [UK] graduates have to be open to the competition. We as an organisation believe that our home grown graduates are trained extremely well and there is absolutely no reason why they should fear any competition.²³¹

The need for sensible competition levels

197. Ultimately, however, witnesses accepted that, notwithstanding the benefits of competition, the sheer number of non-EEA applications for training posts in 2007 and 2008 was undesirably high, leading to wasted investment in UK trainees. Sian Thomas of NHS Employers argued that a “modest over supply” would produce healthy competition but that the current situation was unacceptable because of the scale of over supply:

...we cannot have the situation we now have, which is not a modest over supply, it is, in fact, a huge over supply of very expensive trainees, and I think that is why this question, which is really a question for wider government policy-makers, needs to be resolved...²³²

198. Sir John Tooke also emphasised the need to restrict opportunities for non-EEA graduates in order to protect the UK's investment in self-sufficiency:

We are on track for self-sufficiency. We have had an expansion in medical undergraduate education in this country in line with such a policy. We need

229 Q 177

230 Ev 173

231 Q 378

232 Q 728

consistent policies through the rest of training which support that if society is to see the value of the very considerable investment in medical undergraduate education.²³³

199. Even Dr Mehta from BAPIO acknowledged that “there has to be some sort of regulation of overseas doctors coming into the country”.²³⁴ Thus a broad consensus emerged on the need to limit non-EEA applications in some way, even extending to opponents of some of the specific measures attempted by the Government. In the following section we therefore look at how the Department has responded to the need to restrict opportunities for non-EEA doctors.

The Government’s efforts to date

Limiting opportunities for non-EEA doctors

200. The Department of Health’s attempts to change the status of non-EEA doctors during the implementation of MMC are provided in Chapters 2, 3 and 4. The main efforts made by the Department and others in 2006, 2007 and 2008, and the reasons they were largely unsuccessful, are summarised below:

- In March 2006, the Home Office announced the immediate end of “permit-free training” arrangements, potentially preventing non-EEA doctors from obtaining training posts. Although highly unpopular, this measure ultimately had little impact as thousands of non-EEA doctors were subsequently accepted on to the Highly Skilled Migrants Programme (HSMP), allowing them to compete freely for training posts.
- In June 2006, the Department of Health asked the Home Office to restrict opportunities for HSMP doctors through changes to the Immigration Rules. The Home Office did not comply with this request until February 2008.
- Later in 2006, the Department issued employment guidance instructing NHS organisations not to consider non-EEA doctors, including those with HSMP status, for training posts unless no suitable UK or EEA applicant was available. The guidance did not take effect in 2007 due to an ongoing legal challenge.
- In October 2007, the Department issued a consultation proposing to implement its employment guidance from 2008 onwards. The following month, however, the Court of Appeal upheld BAPIO’s challenge to the guidance and declared it unlawful. Thus in 2008, non-EEA doctors were again allowed free access to training posts.
- The Department appealed against the Court of Appeal’s decision and a final verdict on the legality of the guidance is expected from the House of Lords in May 2008. In February, the Department issued another consultation proposing to implement the guidance from mid-2008 onwards, providing it is upheld by the House of Lords.

233 Q 176

234 Q 378

- Also in February 2008, the Home Office made changes to its Immigration Rules, originally requested in 2006, preventing doctors gaining HSMP status in future from applying for training posts. The Department of Health acknowledged that this change would not have any impact until 2009 and would only then make a limited difference. The Home Office emphasised that this was a temporary “stop gap” measure.

201. Thus, in spite of significant activity by both the Department of Health and the Home Office, no restriction on non-EEA applications was successfully made in 2007 and 2008, while limiting applications in 2009 and beyond currently depends on a legal decision by the House of Lords.

Criticism of the Government

202. Despite the general consensus that opportunities for non-EEA doctors should be limited, attempts to put this into practice have so far proved unsuccessful. Given this context, it is hardly surprising that witnesses were strongly and frequently critical of the Department of Health and the Home Office’s handling of the issue. Professor Alan Crockard, former National Director for MMC, confirmed that the issue had been raised at the beginning of 2006:

We raised concerns right back from February 2006 about what to do with regard to international medical graduates. We were assured that that was all being taken care of; well, unfortunately, as it turned out, it was not taken care of...²³⁵

203. Witnesses emphasised the slow response to the need to manage the number of non-EEA doctors. Dame Carol Black argued that the first attempts to resolve the problem in 2006 came almost a decade too late:

I think it is a calamitous situation which came about because in 1997 the government decided we should become more self-sufficient in the production of doctors. That was the time when they should have been in discussion with the Home Office and other relevant departments of government to ensure there was a transition...²³⁶

204. According to Dr Jo Hilborne of the BMA, the lateness of the Government’s response was compounded by the introduction of unexpected measures without proper consultation, such as the decision to end permit-free training. Dr Hilborne pointed out that such last-minute decision-making was highly unfair on non-EEA doctors:

...it was wholly wrong, immoral, unethical and unfair to entice doctors here on a promise, make them spend a fortune getting here, sitting the required exams, uproot their families and then when they have been here for six months, a year, two years, say, “Actually we have changed our minds, we do not want you; go away again.”²³⁷

235 Q 274

236 Q 545

237 Q 366

205. The confusion and lack of co-ordination surrounding Government policy in 2006 and 2007 was emphasised by Postgraduate Deaneries, who described receiving conflicting messages from the Department of Health and the Home Office. Lis Paice, Dean Director for the London Deanery recounted the chaotic communication by the Government:

We were told by the Department of Health that this guidance was that the HSMPs should not be in the first round of applications [in 2007]... We then got a message in an email from the Home Office... to say we could not do that because it would not be legal. Next, we got a message to ignore that because the department's advice was more important. Then we were told it was really up to local decision...²³⁸

206. The Tooke Inquiry was also strongly critical of the Government's efforts, pointing out that planning on the issue of non-EEA doctors was not co-ordinated with overall planning for the introduction of MMC:

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...²³⁹

207. Further criticism of the failure to co-ordinate policy between the Department of Health and the Home Office was levelled in the Court of Appeal's November 2007 judgment. Lord Justice Maurice Kay stated that discussions were held between the two Departments in 2006, during which the Home Office expressed doubts about the legality of restricting non-EEA applicants through employment guidance. He concluded that "the Department of Health decided to 'go it alone'" in spite of the Home Office's concerns.²⁴⁰

208. Lord Justice Sedley pointed out that it was the very contradiction between the Department of Health's guidance and existing Home Office legislation which made the former unlawful:

Put in terms which political science, though not the common law, would recognise, the acts of both ministers are acts of the state; and in terms which the common law, though probably not political science, would recognise, the state cannot be heard to say that its left hand does not know what its right hand is doing.²⁴¹

209. Home Office officials also pointed out that the Treasury had been involved in decision-making about whether and how to change the Immigration Rules. Lorraine Rogerson, Director of Policy at the Border and Immigration Agency, described the Treasury as "closely involved in all of the development of proposals for the points-based system".²⁴² Foreign Office officials confirmed this.²⁴³ The Committee asked the Treasury to provide evidence on this subject, but it refused to do so.

238 Q 585

239 *Aspiring to Excellence*, p.68

240 Court of Appeal verdict, 9 November 2007, paragraph 61

241 *Ibid*, para 54

242 Q 836

243 Q 837

210. Opinions of the Government’s overall performance were aptly summarised by BAPIO, which described the planning for the increase in UK medical school output as “horrendous”. When asked to comment on the Government’s efforts, the Chief Medical Officer stated that he did not have “sole or overall responsibility” for attempts to restrict applications by non-EEA doctors.²⁴⁴

Future policy options

211. In spite of repeated efforts by two Government departments, the status of non-EEA doctors remains largely unresolved, particularly as the legality of the Department of Health’s employment guidance is yet to be established. In this section, therefore, we look at the current options for limiting non-EEA doctors’ access to UK training posts. We consider the advantages and disadvantages of:

- Implementing the Department’s employment guidance;
- Making further changes to the Immigration Rules through Home Office legislation; and
- Other policy options.

Guidance to employers

212. Issuing employment guidance to NHS employing organisations was the Department of Health’s “preferred option” for restricting non-EEA applications in both 2007 and 2008.²⁴⁵ The proposed guidance instructs employers not to consider non-EEA applicants for training posts unless there is no suitable UK or EEA candidate. Thus it does not prevent non-EEA doctors from taking up training posts in “shortage” specialty areas or from applying for Non-Consultant Career Grade posts. The guidance would not apply to refugee doctors or non-EEA doctors trained at UK medical schools; both of these groups would be able to freely apply for training posts.²⁴⁶

Advantages

213. It is clear that implementing its guidance remains the Department of Health’s preferred option for managing non-EEA numbers in the future. In its February 2008 consultation, the Department argued that the guidance offered the best way to balance the interests of UK graduates and non-EEA doctors:

UK displacement would be minimised and migrant doctors would be able to take up training places in shortage specialties and locations.²⁴⁷

244 Q 147

245 See, for example, Department of Health, *Recruitment to foundation and specialty training—Proposals for managing applications from medical graduates from outside the European Economic Area*

246 *Ibid*, p.14

247 *Ibid*, p.12

214. The Department pointed out that respondents to its October 2007 consultation had “overwhelmingly supported” the introduction of the guidance as the best way to protect opportunities for UK graduates.²⁴⁸ In addition, the Secretary of State argued that the guidance would provide a comprehensive solution to the issue of non-EEA applications, eliminating the need for further measures.²⁴⁹

215. Importantly, the use of the Department’s employment guidance to restrict non-EEA applications was also supported by other Government departments. Home Office officials pointed out that the use of employment guidance would mitigate the need for further changes to the Immigration Rules.²⁵⁰ The Foreign and Commonwealth Office (FCO) emphasised the benefits of allowing non-EEA doctors to continue to apply for posts in shortage specialties:

Of the various options considered, the use of the DH guidance would have been our preference because it would not have automatically blocked off speciality training slots to all non-EEA doctors.²⁵¹

Disadvantages

216. The obvious disadvantage of the Department’s guidance is the continuing question over whether it is lawful. Ongoing legal action by BAPIO has already prevented the guidance from being implemented during the 2007 and 2008 recruitment rounds, causing more than 1,300 UK doctors to be “displaced” from the training system in 2007.²⁵² The most recent decision, by the Court of Appeal in November 2007, declared the guidance unlawful.

217. A final verdict on whether the guidance is lawful is expected from the House of Lords in May 2008. The Secretary of State declared that he was “quite confident” that the House of Lords would uphold the guidance, but he acknowledged that if it did not then alternative solutions would have to be sought.²⁵³

Changes to immigration legislation

218. One such alternative is to limit non-EEA applications through changes to the Immigration Rules enacted by the Home Office. As mentioned above, a partial restriction was introduced in February 2008 when the Home Office set out regulations preventing migrants achieving Tier 1 status (equivalent to HSMP status) in the future from applying

248 Ibid, p.15

249 Q 907

250 Q 783

251 MMC 59 FCO

252 Department of Health, *Recruitment to foundation and specialty training—Proposals for managing applications from medical graduates from outside the European Economic Area*. The Department does not state what proportion of “displaced” doctors have taken up non-training posts or what proportion have left the NHS altogether.

253 Q 913

for UK medical training posts.²⁵⁴ The new rules were not applied to HSMP doctors already in the UK, although this could in theory be done in the future.

Advantages

219. The principal advantage of addressing the status of non-EEA doctors through changes to the Immigration Rules is that such measures are not open to legal challenge. Thus Home Office regulations offer a more reliable alternative to the Department of Health's guidance and one whose impact is easier to predict. The Department pointed out in its February 2008 consultation that Immigration Rules changes would protect opportunities for UK graduates without disadvantaging existing HSMP doctors:

They will have prospective impact and will not disadvantage migrant doctors who are currently able to apply for post-graduate training places in direct competition with UK and EEA graduates. The changes will reduce the potential for the displacement of UK doctors in the long-term...²⁵⁵

220. The Secretary of State described the new regulations as “very helpful” and predicted that there would be 3,000 fewer applicants in 2009 as a result.²⁵⁶ He also pointed out that the Home Office rule changes had been cleared by the Cabinet and therefore had cross-governmental support.²⁵⁷

Disadvantages

221. In spite of this assertion, witnesses from other Government departments pointed out a number of disadvantages with attempting to limit non-EEA applications through Home Office regulations. The Home Office itself stated that preventing Tier 1 migrants from applying for medical training posts contradicted its own policy of attempting to attract young, well qualified and highly paid people to the UK:

This proposal is, of course, an exception in the policy behind HSMP and Tier 1—to attract the brightest and best by offering free access to the labour market.²⁵⁸

222. The FCO expressed a similar view, describing the changes as an “unwelcome precedent” which ran “counter to the essence of Tier 1” (the HSMP strand) of the new immigration system.²⁵⁹ The FCO pointed out that sudden or excessive restrictions on opportunities for non-EEA doctors would potentially damage relationships with countries such as India:

254 Home Office Press Release, *New points system begins*, 6 February 2008

255 Department of Health, *Recruitment to foundation and specialty training—Proposals for managing applications from medical graduates from outside the European Economic Area*, p.13

256 Q 894

257 Q 902

258 MMC 60 Home Office. The new Home Office points-based system takes account mainly of a candidate's qualifications and pay level. For example, 35 points are awarded for a Master's Degree and 50 for a PhD. 45 points are awarded for earning more than £40,000 per year, and 20 points for being aged under 28. 75 points are required to gain HSMP status. It is clear from these requirements that overseas doctors will generally be able to acquire HSMP status.

259 MMC 59 FCO

The implementation of measures to prevent access to specialist training by non-EEA doctors would not be welcomed by the Indian Government or medical bodies. As we have said above, in recent years this issue has been top of their agenda in discussions on migration and restrictions on access would be very likely to create difficulties for our wider bilateral relationship.²⁶⁰

223. Finally, the Home Office made clear that it had agreed to make restrictions on a “temporary” basis only, in order to address the “immediate difficulties” experienced by the Department of Health. Its submission emphasised the need for the Department to quickly put in place an alternative solution:

We know the Department of Health believes it urgently needs its own sustainable solutions to workforce planning problems and has acknowledged that a solution using immigration rules is only a stop gap.²⁶¹

Other policy options

Limiting non-EEA applications

224. The Committee asked Government witnesses what would happen if the House of Lords did not uphold the Department of Health’s guidance and whether contingency plans were in place. Amazingly, Home Office officials stated that no plans were in place and could make no suggestions for dealing with this eventuality.²⁶² Thankfully, the Department of Health was able to make some suggestions. The Secretary of State commented that if the Department’s guidance was not upheld by the House of Lords then a “fees system”, whereby non-EEA doctors were charged for postgraduate training, might be considered.²⁶³ However, the Department’s own consultation paper acknowledged a number of weaknesses with this proposal:

...such an arrangement is likely to require legislation and would take time to implement. It would be difficult to enforce recovery of fees levied after training if the doctor leaves the UK... this solution may not solve the problem of displacement unless fees could be set a level sufficient to deter most migrant doctors.²⁶⁴

225. Another alternative mentioned by the Secretary of State was to enforce the Department of Health’s guidance through primary legislation. He commented that this would be preferable to passing further Home Office legislation:

The other is to see whether we could pass into legislation from my Department something that would cover this rather than dealing with it through the Highly Skilled Migrant Programme. This is predicated on the fact that we lose the appeal [to

260 Ibid

261 MMC 60 Home Office

262 Q 778–Q 783

263 Q 907

264 Department of Health, *Recruitment to foundation and specialty training—Proposals for managing applications from medical graduates from outside the European Economic Area*, p.13

the House of Lords]. If we lose the appeal, how we can get that guidance into a much firmer setting.²⁶⁵

International development opportunities

226. Some witnesses argued, on a separate note, that some dedicated opportunities for non-EEA doctors should be retained, not to provide doctors for the NHS but rather in order for the UK to contribute to improving health systems in the developing world. Dame Carol Black commented that such programmes were supported by the Royal Colleges:

...the AMRC has recommended that the Health Departments create a limited number of training places for young doctors from developing countries, with the requirement that they return home at the end of their training. This would demonstrate commitment to an ethical approach to international recruitment.²⁶⁶

227. The Chief Medical Officer assured the Committee that programmes of this kind would not be affected by more general restrictions on opportunities for non-EEA applications.²⁶⁷ The Secretary of State commented that it might be possible to implement or extend such schemes in the future.²⁶⁸

Conclusions and recommendations

228. **The Committee supports the Government's long-standing policy of increasing the self-sufficiency of the UK for its medical workforce. The welcome expansion to the number of doctors trained in the UK, which began in 1999, means that the number of non-EEA doctors entering the UK training system needs to be carefully managed. There is a widespread consensus that some restrictions to opportunities for non-EEA doctors are required in order to protect opportunities for UK graduates and the considerable investment of UK taxpayers.**

229. **The Government's handling of this important and sensitive issue has been appalling. Despite beginning its pursuit of self-sufficiency in 1999, the Government made no real attempt to change the status of non-EEA doctors until 2006. In particular, we found the CMO's excuse (outlined in para. 210) weak and unconvincing. Its efforts since then, involving the Department of Health, the Home Office and the Treasury, have been poorly planned, badly communicated and inadequately co-ordinated. This lack of co-ordination was amply demonstrated by the failure of the Department of Health and the Home Office to arrange for their respective Ministers to give evidence to the Committee on the same day.**

230. **Worst of all, the Government's many initiatives failed to prevent open access to training places for doctors from across the globe in both 2007 and 2008. Hundreds of UK graduates have been unable to continue with their training as a result. Tens of**

265 Q 913

266 MMC 56A

267 Q 906

268 Q 905

thousands of non-EEA doctors, meanwhile, have suffered inconsistent and undignified treatment.

231. The Department of Health proposes to use its guidance to employers to protect opportunities for UK graduates in future. The legality of the guidance remains in question, however, and will not be finally established until May 2008. The Department has already twice failed to enforce its guidance and is running a grave risk by relying on a single legal decision as the basis of its medical workforce policy. The Department's guidance does, however, represent a good way to restrict non-EEA applications while allowing overseas doctors to train in hard-to-fill specialties. 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.

232. If the Department's guidance is not found to be lawful then the situation looks uncertain. Surprisingly, the Home Office made no suggestions for dealing with this eventuality. Recent Immigration Rules changes are limited in scope, contradict wider immigration policy and were acknowledged to be only a "stop gap" solution by the Home Office itself. Charging non-EEA doctors for postgraduate training would be impractical and the impact would be difficult to predict. 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.

233. The general move towards increased self-sufficiency should not prevent the NHS from offering a limited number of training opportunities to non-EEA doctors for international development purposes. We recommend that the Department of Health work with the 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.

7 Managing reform

Introduction

234. The events described in Chapter 3 and the evidence we received raised serious questions about the management both of the introduction of the new specialty training schemes in 2007, and of the wider MMC programme. The Tooke Review criticised the poor performance of the Department of Health across several areas of programme management:

The Inquiry has found evidence of DH deficiencies in policy making with ambiguous accountability structures for policy development, and very weak governance and risk management processes.²⁶⁹

Sir John Tooke also criticised “deficient project management” by the Department, describing this and other failings as “the structural fault where much of the blame lies”.²⁷⁰

235. In this chapter we therefore examine the management of the MMC reforms and make recommendations for improving performance in future. We look in particular at:

- The policy development process whereby MMC’s principles were transformed into specific policies and plans;
- Governance arrangements and accountability structures for the introduction of the new programmes;
- The project management of the reforms, including the timescales for introducing changes; and
- The calibre of leadership demonstrated by both the Department of Health and the medical profession during the implementation of reform.

236. This chapter focuses mainly on the role of the Department of Health in managing the MMC reforms. We consider the role of the other organisations involved with postgraduate medical training in more detail in Chapter 8.

Policy development

237. We saw in Chapter 2 that MMC was developed in a complex policy environment. There were a range of influences on the programme: some, such as *Unfinished Business* and the increasing number of UK medical graduates, related directly to the needs of junior doctors; while others, such as NHS deficits or the European Working Time Directive, had broader origins and significance. Inevitably, this created a number of different pressures as the aspirations of the reform programme were made into specific plans for implementation. This section focuses on the extent to which the policy development

²⁶⁹ *Aspiring to Excellence*, p.20

²⁷⁰ Q 161

process adhered to the programme's original aspirations, particularly in light of the many other influences on MMC.

Clarity of the overall aims of MMC

238. The guiding principles for the reform of training were clearly expressed at the outset. The so-called “seven pillars” of MMC were set out in 2004: the new training system should be “trainee-centred; competency-assessed; service-based; quality-assured; flexible; coached; and structured and streamlined.” Witnesses strongly questioned, however, whether the aim of the MMC programme was actually to implement the seven pillars. Some suggested that other motivations, such as the need to minimise expenditure, were more influential than the seven pillars in shaping the reform programme.

239. The Chief Medical Officer stated that the over-riding aim of MMC was to improve the quality of the training system by realising the aspirations embodied by the seven pillars. He argued that this aim was clear to all those involved:

I do not think there was any confusion about the overall aims of the project. Indeed, I think those were absolutely clear...²⁷¹

240. Sadly, few other witnesses agreed. RemedyUK commented that the aims of the reform programme were “poorly defined, changed over time and were sometimes conflicting”.²⁷² The Association of Surgeons agreed, arguing that the initial aims of MMC, set out in the “seven pillars”, became confused with and contradicted the requirements of the European Working Time Directive:

...the introduction of MMC at the same time as EWTD was a disaster, due to conflicting priorities of education, training and service delivery using ideas and working practices that had not been thought-through or road-tested.²⁷³

241. The Association of Surgeons also argued that the emergence of an overall NHS deficit in 2004/05, which worsened in 2005/06, caused MMC's aims to be further changed and complicated by the need to save money.²⁷⁴ Alan Crockard, National Director for MMC until 2007, made a strikingly similar point, arguing that one of the programme's leaders was primarily concerned with financial considerations:

CMO and Director of Workforce (2004–2006) saw the project from different perspectives. The latter, having been part of the Consultants contract and GP contract negotiations was clearly concerned about the resource implications of MMC.²⁷⁵

271 Q 6

272 Ev 140

273 Ev 95

274 Ev 94

275 Ev 129

242. This lack of agreement between the leaders of the reform programme itself regarding the overall aims of the MMC programme was also among the findings of the Tooke Inquiry. *Aspiring to Excellence* concluded that:

...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.²⁷⁶

Realising the principles in practice

243. Witnesses were similarly sceptical about the extent to which the specific reforms introduced by MMC, and particularly the changes to specialty training, were consistent with the original seven pillars. The Royal College of Psychiatrists argued that two of the pillars, increasing flexibility and tailoring programmes to individuals “have singularly not been met”.²⁷⁷ RemedyUK agreed that flexibility was “largely lost in implementation”.²⁷⁸ The lack of flexibility in the new training arrangement, largely as a result of the introduction of run-through training in all specialties, was also noted by Fidelio:

...we have nothing against some of the motherhood and apple pie of the MMC seven pillars. But with typical dishonesty, we note that at some stage ‘flexibility’ disappeared from these trumpeted pillars...²⁷⁹

244. The BMA went further still, arguing that only two of the seven pillars had actually been adhered to during implementation:

The speed of the introduction of MMC has seen the majority of the principles ignored...it is utterly unacceptable that only two of the seven pillars remain standing. These are that training is service based and quality assured...Through expediency, the other five have fallen by the wayside. Most concerning is the loss of the pillars stating that training should be trainee centred and flexible.²⁸⁰

245. The Department of Health presented a different view, arguing that many of the seven pillars had already been realised through the new programmes:

The approval by PMETB of clear, approved curricula has meant that the underlying principles of high-quality, well trained doctors, structured programmes, and consistent national standards, have been met...there are also minimum times to complete training, skilled trainers, a competency basis and quality assurance of both educational processes and outcomes.²⁸¹

276 *Aspiring to Excellence*, p.40

277 See Ev 164. Some witnesses also pointed out that some of the seven pillars could be interpreted as mutually exclusive, for example the ambition for training to be both “structured and streamlined” and “flexible”.

278 Ev 141

279 Ev 189

280 Ev 134

281 Ev 9

246. The Department went on to acknowledge, however, that the goal of increasing flexibility had not been achieved, particularly as a result of the introduction of run-through training. In a section curiously entitled “Principles still to be implemented”, the Department stated that:

We acknowledge that, in the implementation of MMC, this flexibility for the trainees has not been fully realised. This has come about as the principle of seamless specialist training has been implemented in run-through training programmes that do not currently provide the level of flexibility originally envisaged.²⁸²

The development of run-through training

247. It is clear from this that the decision to introduce run-through training in all Specialty areas contradicted one of MMC’s key principles, namely the need for increased flexibility. This decision provides a compelling example of the weakness and confusion which characterised the MMC policy development process. The specific problems caused by run-through training are described in detail in Chapter 5; what is of particular concern here is how the policy development process allowed for the introduction of a measure which so clearly contradicted the established principles of the reform programme.

248. As we observed in Chapter 2, 2002’s *Unfinished Business* had envisaged that Foundation training be followed by two separate specialist training programmes, “basic” and “higher” training.²⁸³ The idea of a “single training grade” was tentatively suggested, but it was proposed that this possibility “should be explored specialty by specialty”. Two years later, however, *MMC: The next steps* set out plans for “a seamless training process” delivered through “a single run-through approach” in all Specialty areas.

249. The Tooke Inquiry was unable to establish how and by whom the critical decision to implement run-through training was taken. Sir John Tooke stated that:

...“run-through” was one of the fundamental mistakes in this process. We have talked about the principles in *Unfinished Business* and that morphed into something that involved run-through training. The process by which that decision was made is unclear to the panel...²⁸⁴

250. The Department of Health’s memorandum shed little light on the issue, stating only that “in implementation, inflexibility has crept in” to the new training system. The Chief Medical Officer provided more information, pointing out that plans for run-through training were discussed with professional groups prior to the publication of *MMC: The next steps*:

The next major publication...was called *Next Steps*...It was at that point that the concept of run-through training was majored on and developed further. There had

282 Ev 10

283 *Unfinished Business*, pp.5–6

284 Q 186

been a lot of discussion with professional bodies and others which led to that point.²⁸⁵

251. BMA representatives acknowledged that they had in principle supported the introduction of a run-through grade. However, Dr Jo Hilborne went on to point out that several details of the run-through system introduced by MMC were not in keeping with the BMA's recommendations. She pointed out that "robust careers advice" and opportunities for doctors to switch from one specialty to another were both absent from the MMC run-through system, creating a particularly inflexible system.²⁸⁶

252. Bernard Ribeiro, President of the Royal College of Surgeons argued that the plans set out in *MMC: The next steps*, including the blanket introduction of the run-through grade, had not been subject to adequate consultation with the profession:

...we supported the initial principles of MMC in *Unfinished Business* but not what happened subsequently; it was imposed.

253. It is apparent, therefore, that the "fundamental mistake" of establishing a comprehensive run-through training grade resulted from a decision on which significant parts of the medical profession were not adequately consulted. Some parts of the profession, notably the BMA, agreed in principle with run-through training, but were unable to influence the critical details of implementation.

Improving policy development

254. The Tooke Inquiry made clear suggestions for improving policy development, to strengthen both the MMC programme and future Department of Health initiatives. *Aspiring to Excellence* emphasised that the principles behind the reform of medical training, and in particular the importance of flexibility, should be re-established:

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.²⁸⁷

255. The Tooke Review also called for the Department to consult more closely with the medical profession and other interested parties during the policy development process, and to listen and take account of specific concerns:

DH should formally consult with the medical profession and the NHS on all significant shifts in government policy which affect postgraduate medical education... and ensure that concerns are properly considered by those responsible for policy and its implementation.²⁸⁸

285 Q 10

286 Q 341

287 *Aspiring to Excellence*, p.66

288 Ibid

Programme governance

Over-complex structures

256. Problems with the policy development process for MMC stemmed in part from the over-complex governance structures for the programme. The large number of bodies involved and complex lines of accountability between them were cited by the Secretary of State as one of the most important overall causes of the project’s failure:

...you had the policy being set by something called the UK Strategy Group. You had the criteria being set by the Specialist Training Action Group. Implementation was the responsibility of the MMC Programme Delivery Board. The Strategic Health Authorities through the Deaneries were responsible for implementation... so it was very disparate and it was... a difficulty of knowing who had the lines of accountability with all of that group trying to work together.²⁸⁹

257. The sheer complexity of the management and governance structures for MMC is well demonstrated by this diagram, produced in the Tooke Review:

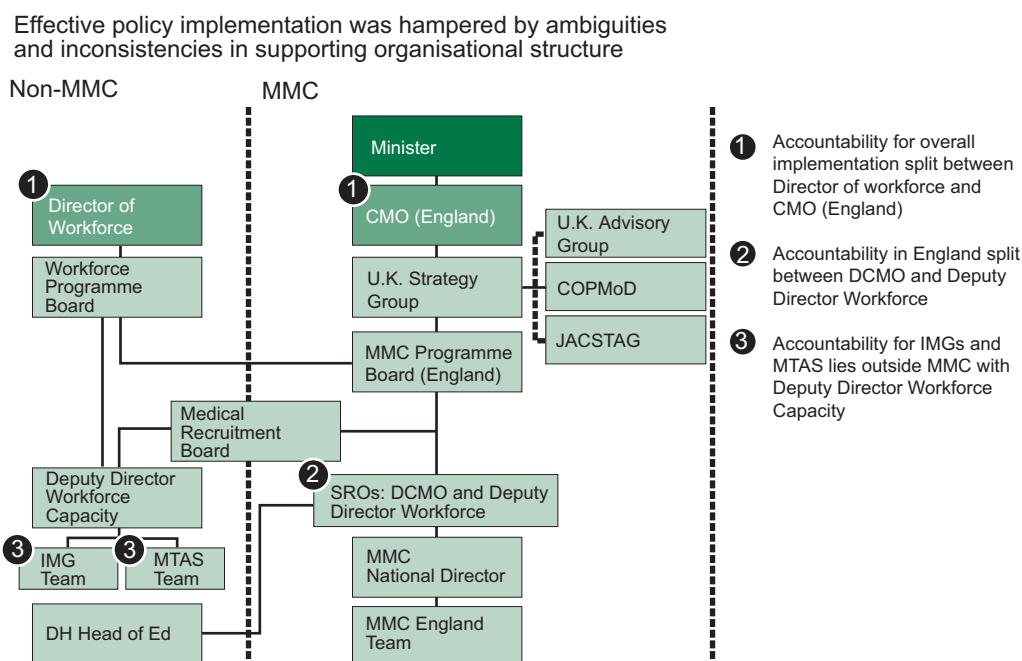


Figure 6: Overall governance structure for MMC

Source: *Aspiring to Excellence*

258. *Aspiring to Excellence* particularly emphasised the problems caused by dividing responsibility between two different directorates of the Department of Health: the Workforce directorate and that of the Chief Medical Officer.²⁹⁰ Two key elements of the planning for 2007, the development of the national recruitment system and the issue of resolving the status of non-EEA doctors, were the responsibility of the Workforce

289 Q 842

290 *Aspiring to Excellence*, p.45

directorate. Professor Alan Crockard described how the MMC team, reporting to the Chief Medical Officer, was unable to influence these crucial areas of the programme:

The MMC team itself had no authority but could persuade and influence. On many issues e.g. IMG and status of Trust Grades, MMC was given no clear guidance and no means of mitigating serious project risks.²⁹¹

259. The Chief Medical Officer acknowledged that the split accountability structure had caused problems, but stated subsequently that he had not resigned in the wake of the 2007 crisis precisely because he had not been responsible for key areas where implementation failed.²⁹² Thus Department of Health witnesses used the complexity of the MMC governance structures both to explain the failings of 2007 and, paradoxically, to absolve individuals from responsibility for them.

Escalation of concerns

260. Witnesses also argued that the MMC programme was not well understood by Ministers and other leaders at the Department of Health, and that concerns about the progress of the project were not escalated appropriately. Professor Alan Crockard stated that “the Department of Health management board had no concept of the implications of MMC”.²⁹³ He went on to suggest that the problems experienced in late 2006 were not made known to the leaders of the Department:

I am also uncertain how aware politicians and senior Department of Health officials were of warnings such as the RED status awarded to the MTAS project by the Gateway review team...in August 2006. I doubt they were also informed of the missed “drop dead” dates in December 2006.²⁹⁴

261. As we saw in Chapter 2, Professor Crockard told us he approached a number of other agencies, including the National Audit Office, when his concerns about the project were ignored by the Department of Health in late 2006. Representatives of the BMA described a similar experience when their concerns about the project, set out in the 2006 “Call for Delay”, were “ignored”.²⁹⁵ RemedyUK suggested that the Department continued to disregard concerns expressed by the profession:

...by and large the manner in which MMC was conducted was very much top down and it did not listen to anyone. If it adopts the same approach we are lost. I see no evidence that it has changed its approach, so I am very concerned about it...²⁹⁶

291 Ev 128

292 Q 147

293 Ev 129

294 Ev 127

295 Q 389

296 Q 238

Improving governance

262. Recommendations for improving the governance of the MMC programme were set out in the Tooke Review which called for “clearer roles and responsibilities for a single Senior Responsible Officer” and “clear roles and accountability for senior DH members...”²⁹⁷ Professor Alan Crockard recommended that there should never be more than one Senior Responsible Owner for future programmes.²⁹⁸ Dr Ian Wilson of the BMA echoed this suggestion, calling for a single leadership role within the Department of Health:

...Much clearer governance [is needed] involving a senior clinician within the Department and that this should be about quality and standards and not about workforce planning.²⁹⁹

263. The Department of Health pointed out that changes of this kind had already been made, stating that a single leadership role for MMC had been established in March 2007:

...In March 2007, the scope of the project was reviewed and a new, unambiguous, Senior Responsible Owner (SRO) was established...In early May, an interim appointment was made to a new post of Chief Operating Officer to provide a full time, single line of accountability...³⁰⁰

264. The Department set out its “new, simplified, governance structure” in its response to the Tooke Review in February 2008:

297 *Aspiring to Excellence*, p.67

298 Ev 129

299 Q 421

300 See Ev 15. As we saw in Chapter 3, however, both the SRO and the Chief Operating Officer for MMC had been replaced by the end of 2007

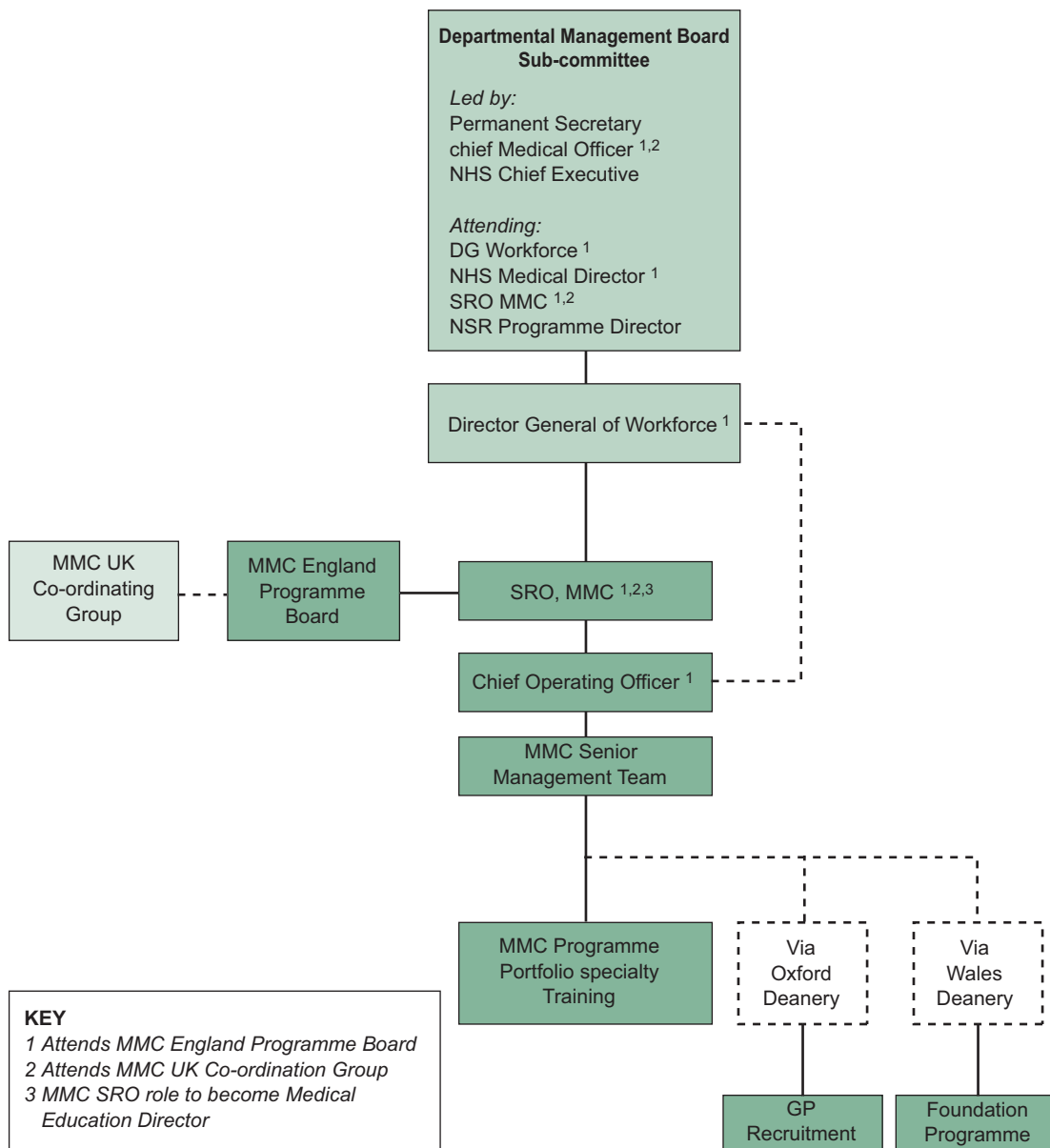


Figure 7: New governance and reporting structure at the Department of Health for MMC

Source: Response to the independent Tooke inquiry into MMC

265. The Tooke Review had recommended that the four UK Chief Medical Officers be the Senior Responsible Owners for the MMC programme in their respective administration. As shown in the diagram above, the Department of Health rejected this recommendation in England, creating a separate SRO position, accountable to the Director General of Workforce. Thus the responsibility of the Chief Medical Officer for England for MMC appears to have been reduced in the wake of the 2007 crisis.

266. The Department also emphasised other improvements to its governance systems. It stated that additional staff and better performance management arrangements had been introduced to improve the running of the project itself. In addition, the Department emphasised that more than half of the members of the new Programme Board were from

the medical profession, citing this as evidence of a “deeper level of clinical engagement” within the new governance structure.³⁰¹

267. Despite this assurance, Dr Ian Wilson of the BMA, a current member of the Programme Board, expressed concerns about the level of engagement. He warned that there was a risk that officials would once again begin to overlook the concerns of the medical profession, one of the reasons for the crisis of 2007. Dr Wilson stated that:

I think there are many members of the current 2008 programme board, the clinical side in particular, that have grave concerns that the governance of 2008...is in danger of slipping back into some of the territory that 2007 slipped into...³⁰²

Project management

268. The implementation of MMC was further hampered by basic failures of project management. The Chief Medical Officer acknowledged that such failures were at the heart of the problems experienced in 2007:

Dr Naysmith: So it was project management really that was at fault?

Sir Liam Donaldson: Yes, I think that is a fair summary.³⁰³

In this section we examine the main problems with project management and how they should be addressed.

Timescales for change

General timescale

269. A consistent criticism of project management was the sheer lack of time to plan and implement the 2007 changes, and particularly to put the new recruitment system in place. Professor Sarah Thomas, Postgraduate Dean for South Yorkshire and South Humber, commented that:

The design of the IT system did not start until half-way through September 2006... It left very little time to get it all finished...³⁰⁴

270. Work Psychology Partnership, the company contracted to design the application forms, pointed out that there was a similarly short timescale for completing their work, which was fundamental to the 2007 recruitment system. This meant that the short-listing system could not be piloted and the application form had to be adapted from previous work rather than being produced from scratch:

301 See Ev 15–16

302 Q 420

303 Q 59

304 Q 567

The time scale for delivery was extremely tight and we expressed our concerns at the outset (June 2006)...Given the time scale (approximately 12–16 weeks) we had no option but to use existing application form materials.³⁰⁵

271. The Tooke Review compared the timescale for implementing the new Foundation programme in 2005 with that for the new Specialty training arrangements in 2007. It found that the timescale for the 2007 changes was significantly more contracted, despite the increased complexity of the changes being delivered. The compression of planning and decision-making for 2007 into an inappropriately short space of time is well demonstrated in the diagram below:

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

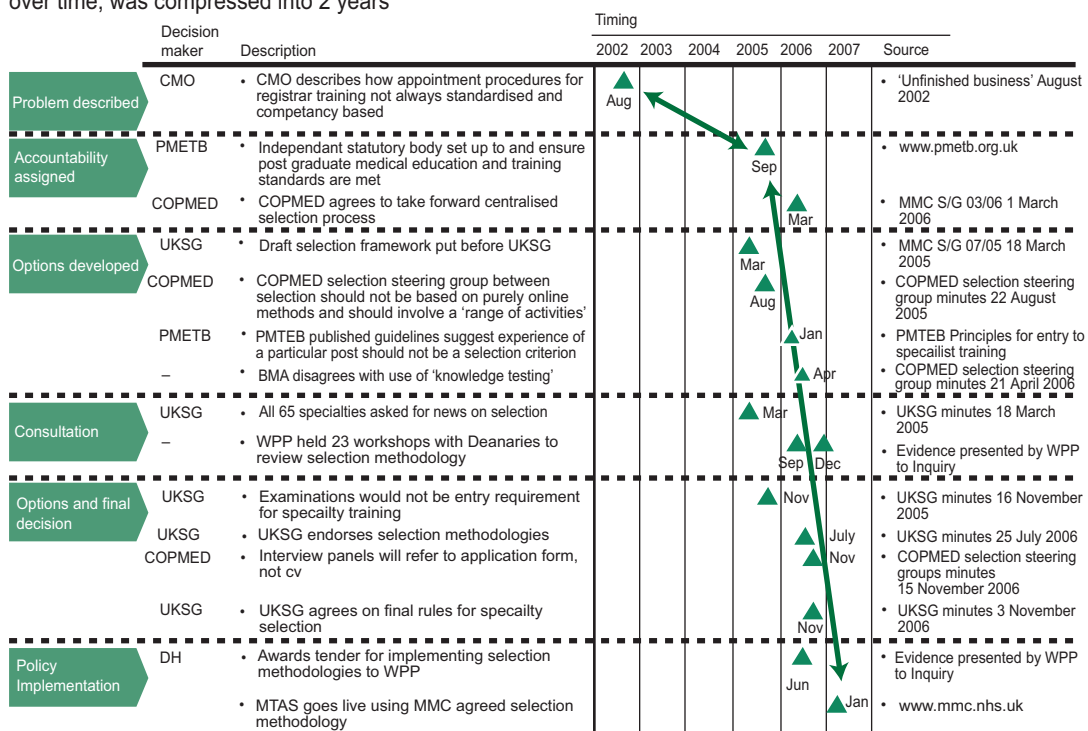


Figure 8: Decision-making process for the 2007 reforms
Source: *Aspiring to Excellence*

272. The Department of Health acknowledged that the “very ambitious timescale” for introducing the 2007 reforms had left “insufficient time for piloting and full testing” of the new arrangements.³⁰⁶ The Department even accepted that it should have delayed the implementation of the new recruitment system for a year, in line with the “Call for Delay” issued by the BMA:

It would have been more prudent to plan for implementation of national specialty recruitment for 2008 rather than for 2007 recruitment.³⁰⁷

305 MMC 52 WPP

306 Ev 1

307 Ev 16

The “big bang”

273. Witnesses also criticised the decision to introduce all of the new Specialty training programmes and the new recruitment system simultaneously in 2007. This so-called “big bang” approach to change was described as “neither necessary nor appropriate” by the Royal College of Surgeons.³⁰⁸ The British Association of Orthopaedic Trainees argued that “a staged, gradual introduction, rather than the ‘big bang’” should have taken place.³⁰⁹ The Royal College of Psychiatrists pointed out that the “big bang” approach had been adopted “against the advice of many people”.³¹⁰

274. The Department accepted that the “big bang” approach to introducing the changes had made matters worse in 2007. It stated that:

This year’s problems in recruitment were exposed because we changed the training structure, the selection procedure and introduced a national recruitment process all in the same year...³¹¹

Risk management

275. The Tooke Inquiry was also highly critical of the quality of risk management during the implementation of the MMC reforms. *Aspiring to Excellence* commented on “woefully inadequate risk escalation” procedures within the Department of Health. It also pointed out that two key elements of the project, the national recruitment system and the need to resolve the status of non-EEA doctors, were given “red” risk ratings in May 2006 and July 2006 respectively. Despite this, the Tooke Inquiry found “little evidence of contingency planning or escalation” to mitigate these serious risks, which went on to have such disastrous consequences in 2007.³¹²

276. The Royal College of Physicians of Edinburgh also criticised risk management processes, and particularly the absence of a “plan B” in the event of problems with the new systems:

There was no obvious risk assessment or recovery plan for when the system failed... The apparent lack of risk assessment and contingency planning is inexcusable.³¹³

277. Methods Consulting, the company responsible for the national IT system, argued that individual risks to the project were anticipated and monitored. However, Methods stated that the negative consequences of problems with the new systems were not well understood. Mark Johnston, CEO of Methods, acknowledged that the scale of the adverse reaction to the introduction of the new recruitment system in 2007 was not anticipated by suppliers:

308 Ev 114

309 Ev 138

310 Ev 165

311 Ev 1

312 *Aspiring to Excellence*, p.52

313 See Ev 152 and Ev 153

I think in hindsight the environment in which this project was being undertaken, which was not necessarily imparted to ourselves to start with, meant that there was undoubtedly a risk that there would be an adverse reaction, regardless of what happened on the system, to what the system was trying to achieve. That was a much higher risk than most projects we work on.³¹⁴

278. Hugh Taylor, Permanent Secretary at the Department of Health, made a similar point. He stated that the Department's senior leaders were made aware of individual risks to the project, but did not have an overall picture of the risks associated with implementation in 2007. He argued that this made it more difficult to make decisions about the future of the programme and to decide, for example, whether to delay implementation:

We were, I think, at senior levels in the department monitoring a number of the key risks associated with it...What, I am afraid, collectively we and others across the system failed to do was to look at the risk right across the system as a whole and draw what might in retrospect have been the right conclusions.³¹⁵

External communication

279. Another element of project management which went badly wrong was communication with applicants themselves, both prior to the introduction of the new systems and during the crisis of 2007. Officials acknowledged, for example, that the intention that only 50% of posts were to be filled in Round 1 of recruitment in 2007 was not made sufficiently clear to candidates:

Professor Marshall: It was not adequately communicated to the applicants, and I think if it had been---

Sandra Gidley: Was it communicated at all?

Professor Marshall: I do not know the answer to that. I do not think it was.³¹⁶

280. It is clear from the documentation provided in the final report of the Douglas Review that messages to candidates came from a number of different sources during the 2007 crisis. The Review Group published several statements to candidates in March and April 2007, announcing significant changes to the recruitment system on a weekly basis. Statements later in April and during May concerning the future of the IT system, however, were made by the Secretary of State; from June onwards, most communication with candidates was undertaken by the MMC team.

281. Dr Jo Hilborne of the BMA emphasised the poor quality of communication with candidates and argued that this stemmed in part from the confused governance structures for MMC. She made clear, however, that responsibility for communication fell ultimately to the Department of Health:

314 Q 462

315 Q 852

316 Q 99

The lines of communication were so vague and it was so difficult to know where responsibility rested that I cannot tell you who should have been communicating, except to say that this is a Department of Health initiative, absolutely led and implemented by them, and therefore they as a department should take responsibility for telling doctors what is happening.³¹⁷

Improving project management

282. A number of suggestion for improving project management were set out in the Tooke Review, including:

- Improved risk management, specifically through “faster escalation and resolution of ‘red risks’”;
- Better documentation of decision-making and more clarity about key policy choices; and
- Simpler governance structures and a single line of accountability.³¹⁸

283. The Department of Health acknowledged the need to substantially improve project management. Officials pointed out that improving communication with applicants had been one of the immediate aims in response to the 2007 crisis.³¹⁹ The Department also agreed to make changes to improve risk management and other project assurance systems:

Assurance of the programme (management, finance, risk, IT/technical) should be undertaken through the identification at programme initiation of appropriate quality and/or review processes and deadlines.³²⁰

284. As we have seen, officials acknowledged that the decision to press ahead with the implementation of reforms in 2007 represented a serious error. The Department stated that it would avoid similar mistakes in future by establishing clear systems for determining whether projects should go ahead:

The business case for any future programme should clearly identify the tolerances for the programme, including the circumstances in which the programme should be stopped or deferred.³²¹

285. The Department of Health also pledged to pilot future changes more thoroughly and to avoid a “big bang” approach to reform:

Future programmes should carefully consider whether the approach being undertaken amounts to a “big bang” introduction of new systems or processes, and if so, should consider the use of pilots...³²²

317 Q 358

318 *Aspiring to Excellence*, p.67

319 Q 97

320 Ev 17

321 Ibid

Box 3: A contrasting picture—the introduction of the Foundation Programme

The programme management difficulties cited in this chapter relate mainly to the introduction of the specialty training reforms in 2007. Witnesses frequently commented that the arrangements for the implementation of the Foundation programme from 2005 were considerably more robust. The Tooke Review and others emphasised that:

- The timescale for planning the Foundation programme reforms was much more realistic than that for specialty training, with key decisions taken at an early stage.³²³
- The Foundation programme was extensively piloted, while the specialty training reforms were introduced without any assessment of their likely impact.³²⁴
- Funding was available to support the new Foundation programme but not the new specialty training schemes, in particular because of the spread of deficits across the NHS in 2005/06.³²⁵
- There was a close match between the number of posts and the number of applicants when the Foundation programme was introduced in 2005; as we saw in Chapter 3, this was not the case when specialty training was reformed in 2007.³²⁶

We discuss the future of the Foundation programme in more detail in Chapter 5.

Leadership

286. Inevitably, the crisis of 2007 and the ineptitude of the management of the MMC reforms caused many to question the leadership shown by both the Department of Health and the medical profession. Although the heads of the BMA and of the MMC project both resigned during the 2007 crisis, other senior leaders at the Department of Health and the Royal Colleges remained in post. In this section we look at the quality of leadership and how to improve it.

The Department of Health

287. Leadership at the Department was widely criticised during the inquiry. The Tooke Review commented that the split accountability structure for the MMC programme meant there was “an overall lack of leadership” of the programme.³²⁷ BMA representatives agreed, arguing that the absence of an overall leader for the project was the responsibility of the Chief Medical Officer:

You have heard already from Sir Liam Donaldson that there was no person in overall charge. I take that to be a significant failure of his because I believe that as the Chief

322 Ibid

323 *Aspiring to Excellence*, p.49

324 Ev 122

325 Ibid

326 See Chapter 2

327 *Aspiring to Excellence*, p.147

Medical Officer it is his job to make sure that there is somebody in charge of a process as important as this...³²⁸

288. Mr Matthew Jameson Evans of RemedyUK agreed, arguing that ultimate responsibility for the failings lay with the Chief Medical Officer:

There have been three votes of no confidence in Sir Liam Donaldson by the BMA. As a group we have tended to avoid calling for people's heads, but we would have loved to see the assumption of responsibility at the highest levels.³²⁹

289. Dame Carol Black, Chair of the Academy of Medical Royal Colleges, was asked whether she and other leaders of the profession continued to support the current Chief Medical Officer. She did not answer directly, stating only that the Royal Colleges "continued to support the principles of MMC". She did not identify what these principles were, or whether they continued to correspond to MMC's original "seven pillars".³³⁰

290. The Chief Medical Officer defended his position, setting out a number of reasons for not resigning in the wake of the 2007 crisis:

The principles and the policy were commended in the Tooke Report and by others, so I do not think the question of criticism of the policy arises. As I indicated to you, accountability did not rest only with me, it was spread quite widely...Policy in relation to the two factors that made the biggest difference, I think, in the crisis were on international medical graduates and on the design of the application form, and those were not matters where I had overall or sole responsibility.³³¹

291. Sir Liam Donaldson also argued that having a single person in overall charge of the MMC programme would have brought its own disadvantages:

If one single person had been in overall charge, taking all the decisions, that would have brought its own problems of maybe insufficient participation, different points of view, not having the opportunity to be expressed...³³²

292. The Secretary of State, meanwhile, expressed full confidence in the Chief Medical Officer, arguing that he had "done a terrific job over ten years".³³³ As mentioned above, the Chief Medical Officer appears nevertheless to have less direct involvement with MMC following recent changes to the programme's governance structure.

328 Q 358

329 Q 239

330 Q 532

331 Q 147

332 Q 149

333 Q 864

The medical profession

293. The leadership of the medical profession, and particularly the failure of the profession to speak with a coherent voice during the planning and implementation of MMC, was also widely criticised. The Tooke Review stated that:

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.³³⁴

294. Dr Moira Livingston from NHS Northeast agreed that the medical profession had struggled to offer a coherent view during the implementation of MMC, in spite of the large number of bodies with leadership responsibilities:

We have royal colleges, we have an academy, we have specialist societies, we have the GMC, we now have the PMETB, and I think that, despite august bodies doing an extremely good job and working hard and delivering what is required of them individually, we cannot seem to get a consistent consensus view.³³⁵

295. Dame Carol Black, chair of the Academy of Medical Royal Colleges, accepted that the individual Royal Colleges had failed to act in a co-ordinated fashion:

Every college did its very best with MMC to meet its individual needs...they did not act together in unity as an academy...³³⁶

296. She also acknowledged that the AMRC itself had been unsuccessful in helping the different interest groups to work together:

...although since 1976 there has been an Academy of Medical Royal Colleges, it was in a rather rudimentary form to do the things that you would require it to do.³³⁷

Improving leadership

297. The Tooke Inquiry made a number of suggestions for improving leadership at the Department of Health, including:

- The Chief Medical Officer to be given overall responsibility within the Department for all issues relating to medical education;³³⁸
- The creation of a new organisation, NHS Medical Education England, to lead future reforms, something which we consider in more detail in Chapter 8;³³⁹ and

334 *Aspiring to Excellence*, p.12

335 Q 721

336 Q 497

337 Q 526

338 *Aspiring to Excellence*, p.67

339 *Aspiring to Excellence*, p.68

- The Chief Medical Officer to act as the main point of liaison between the Department of Health and the new national body.³⁴⁰

298. In addition, a number of witnesses suggested reforming or replacing the AMRC to improve medical leadership and to allow the profession to act more coherently. Fidelio called for “an over-arching but representative College of Medicine” to be set up to co-ordinate the work and communicate the views of the Royal Colleges. Sir John Tooke also emphasised the need for the profession to “find a way of speaking coherently” in order to influence future policy development.³⁴¹ *Aspiring to Excellence* recommended that:

The medical profession should have an organisation/mechanism that enables coherent advice to be offered on matters affecting the entire profession.³⁴²

299. Dame Carol Black, Chair of the AMRC, stated that improvements to the Academy had been made. She did not make clear what these were, however, stating only that:

...we are now putting in place a more effective mechanism and we have better infrastructure.³⁴³

Conclusions and recommendations

300. **The management of the introduction of the MMC reforms by the Department of Health was inept. Key policy decisions and the processes for making and documenting them were ineffective and the medical profession, while frequently consulted, rarely influenced critical decisions. The governance systems for the programme were far too complicated, roles and responsibilities were ill-defined and lines of accountability were irrational and blurred. The arbitrary division of responsibilities between the Chief Medical Officer and the Workforce directorate was a fatal fault line within the management of the programme.**

301. **Project management for the introduction of changes to specialty training was equally poor. Much of the key planning for the 2007 changes took place in a mad scramble at the end of 2006. The “big bang” approach to the reforms and the failure to pilot any of the new arrangements proved particularly serious errors. Individual risks to the project were assessed, but problems were not made known to senior officials and there was no risk management of the project as a whole. As a result, the Department did not recognise the deficiencies within the programme and could not prevent implementation from going ahead prematurely. Project management decisions took little account of the needs and concerns of applicants themselves and communication with junior doctors was appalling.**

302. **The leadership shown by the Department of Health during this period was totally inadequate. Despite being the architect of the reforms, the Chief Medical Officer chose not to take on a clear leadership role and thus did not accept overall responsibility for**

340 *Aspiring to Excellence*, p.70

341 Q 172

342 *Aspiring to Excellence*, p.69

343 Q 526

the 2007 crisis. The confidence of the medical profession in the current CMO has been seriously damaged by MMC. Serious criticisms of the CMO have arisen in part because of the ambiguity of the role. We recommend that the job description be reviewed to define the role more accurately and then publicised to facilitate wider understanding of the CMO's duties and responsibilities.

303. 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.

304. 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 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;
- All future policy development decisions should be approved by the MMC Programme Board;
- A document reviewing the principles behind the MMC reforms should be agreed by the Programme Board and published by August 2008;
- Meetings and decisions of the Programme Board must be properly minuted and attendance at the Programme Board should be consistent;
- All future changes should be piloted and evaluated;
- A “big bang” approach to reform should be avoided wherever possible in future;
- Communication with junior doctors should be improved and a single source of authoritative information established; and
- 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 given his distant relationship with MMC.

305. In particular, these changes should help to ensure that the new Programme Board represents a genuine partnership between the Department of Health, the NHS and the medical profession. Such an approach is vital if the new Board is to avoid the weaknesses and pitfalls which affected the previous UK Strategy Group and the Douglas Review group.

306. 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.
- 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.
- 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.
- 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.
- Ministers and officials should set more realistic timescales for introducing major changes, and should be prepared to delay implementation if necessary.

307. The leaders of the medical profession itself were also ineffective, divided by factional interests and unable to speak with a coherent voice. The weak and tokenistic nature of the Academy of Medical Royal Colleges was exposed by the MMC crisis. We therefore recommend that the Royal Colleges review the role of the Academy of Medical Royal Colleges and consider replacing it with an executive body which has the authority to make decisions on behalf of all the Colleges.

8 Organisational responsibilities

Introduction

308. A wide range of organisations share responsibility for the design, regulation and delivery of postgraduate medical training. Although led by the Department of Health, the development and implementation of MMC was undertaken by, and had implications for, many other bodies, including Postgraduate Deaneries, PMETB, Strategic Health Authorities, employers, and numerous medical groups. Many of these organisations were heavily criticised in the wake of the 2007 crisis and the wider shortcomings of the MMC programme. The Secretary of State himself stated:

When you look back at how this was all put together, you had four UK departments of health, you had all the educational bodies, you had the bodies that set standards, you had the regulatory organisations, and all of that put together led to a classic case, I think, of systems failure.³⁴⁴

309. We looked in detail in Chapter 7 at the management and leadership of the MMC programme, focussing particularly on the role of the Department of Health and the medical profession. In this chapter we look more widely at the performance of, and distribution of responsibilities between, the main organisations involved with medical training. We examine in turn:

- Postgraduate Deaneries;
- Strategic Health Authorities
- Employers and other training providers;
- PMETB;
- The Royal Colleges and Specialist Societies; and
- The Department of Health.

310. The Tooke Review recommended significant changes to organisational responsibilities for medical education, including the creation of a new over-arching body, NHS Medical Education England (NHS: MEE), to oversee postgraduate training. We examine the case for establishing NHS: MEE at the end of the chapter.

Commissioners and providers of training

Postgraduate Deaneries

311. As the regional organisers and overseers of training programmes, the 15 Postgraduate Deaneries in England have a critical role to play in the day-to-day provision of medical training. The Deaneries were closely involved with the design and implementation of

MMC and MTAS, particularly through the work of the Conference of Postgraduate Medical Deans (COPMeD). The Department of Health explained that COPMeD had specific responsibility for some elements of the national recruitment process:

In August 2005, the Conference of Postgraduate Medical Deans (COPMeD) established a UK Recruitment and Selection Steering Group to develop person specifications, selection criteria and the application form for the specialty selection and recruitment process.³⁴⁵

312. Individual Deaneries also had a key role to play, particularly in the implementation of the new recruitment processes. Following a 2004 review of their role, Postgraduate Deans were made accountable to local SHAs for the delivery of training.³⁴⁶ Some Deaneries were also made coterminous with SHAs following the re-organisation of the NHS in 2006. As a result, many Deaneries were in a state of flux during the planning of the MMC reforms.

313. In spite of this, Deaneries themselves asserted that they were closely involved with the development of MMC. COPMeD stated that “Postgraduate deans and GP directors were engaged in all stages of planning this reform.”³⁴⁷ In this section we look first at the role of COPMeD, and then at that of individual Deaneries.

Criticism of COPMeD

314. COPMeD played a substantial role in the design of MMC and was represented on all of the key groups and Committees which oversaw the programme.³⁴⁸ COPMeD was also responsible for the design of some elements of the 2007 recruitment process through the COPMeD Recruitment and Selection Steering Group. It is unsurprising, in light of the problems experienced in 2007, that witnesses were often critical of COPMeD’s performance. Some argued that COPMeD had failed to provide proper leadership or to take charge of the MMC programme.³⁴⁹ Others blamed COPMeD for the major flaws in the national recruitment process. RemedyUK argued that COPMeD could and should have prevented the MTAS system from being introduced in 2007:

COPMeD were given operational responsibility for MTAS. As 2007 approached it became apparent that MTAS may not be ready in time for the launch; the 331 Gateway Review gave it a red status. It is unclear why CoPMeD did not call for a delay...³⁵⁰

315. Even the Department of Health was implicitly critical of COPMeD’s contribution to the design of the new recruitment process, stating that:

345 Ev 6

346 Ev 8

347 MMC 57 COPMeD

348 *Aspiring to Excellence*, p.53

349 Ev 99

350 Ev 147

Non-Departmental organisations, such as the Conference of Post Graduate Medical Deans of the UK, were responsible for particular parts of the recruitment to specialty training, and these projects lacked a formal project management approach.³⁵¹

Defence of COPMeD

316. The Postgraduate Deans defended the performance of COPMeD. The English Deans group, all members of COPMeD, argued that COPMeD's specific responsibilities were poorly defined and that its views were sidelined:

...there was lack of clarity about what was to be undertaken by the project team and what was expected of Deans. Although COPMeD established a group to lead the implementation of MMC our input seemed to be undervalued.³⁵²

317. Professor David Sowden, a member of COPMeD and now SRO for MMC at the Department of Health, acknowledged the failure of the 2007 recruitment process. He argued, however, that ultimate responsibility for this lay with the Department of Health rather than COPMeD:

the MTAS process and other aspects of MMC were exceptionally poor. The point is that that was not in the gift or control of COPMeD to any great extent. We and many other parties, including the [Royal] Colleges, were involved in some of the decisions reached, but the process of project management should have rested with the department and it was there where many of the deficiencies became manifest...³⁵³

Future extent of COPMeD's remit

318. Witnesses also pointed out that COPMeD was not an executive body and could not hold its members directly to account, particularly after individual Deaneries were made accountable to SHAs in 2004. Many saw this as a fundamental weakness of COPMeD, similar to that affecting the Academy of Medical Royal Colleges.³⁵⁴ The National Association of Clinical Tutors commented that:

COPMED is a conference of Deans with no clear structure or identity and were not able to take the lead in owning this education agenda.³⁵⁵

319. COPMeD itself acknowledged this difficulty, commenting that "COPMeD is not an executive body, but it facilitates the deans taking corporate action."³⁵⁶ Given the problems experienced in 2007 and the formal limitations of COPMeD's remit, there was a clear case for reducing COPMeD's future role in the project management of detailed reforms.

351 Ev 16

352 Ev 90

353 Q 563

354 See Chapter 6

355 Ev 99

356 MMC 57 COPMeD

Performance of individual Deaneries

320. In spite of the difficult context in which their work took place, the performance of local Deaneries in implementing the changes to training schemes and recruitment systems was often praised. Witnesses recognised that Deaneries responded well to the chaotic nature of the 2007 recruitment process, particularly after major changes to the selection system were announced at a very late stage. RemedyUK strongly criticised the MTAS process but praised the response of Deaneries to the need to arrange thousands of additional interviews in April and May 2007:

The Deanery HR staff were presented with a Herculean task, which was almost impossible to achieve given the resources made available to them, and they largely coped very well.³⁵⁷

321. The scale of the additional work created in 2007 was emphasised by the London Deanery, which stated that its staff had worked a total of 7,500 hours of overtime in 2007. NHS Employers made a similar point:

...deaneries and employers pulled out all the stops, with many people working excessive hours to make sure the recruitment process was completed.³⁵⁸

Future role and accountability of individual Deaneries

322. Although Deaneries appear to have coped relatively well with the crisis of 2007, some witnesses nonetheless raised concerns about their future role, questioning in particular whether it was appropriate for Deaneries to remain accountable to SHAs. The Royal College of Physicians called for Deaneries to be directly accountable to the Department of Health. It also pointed out that Deaneries were not seen to have the same level of independence as Royal Colleges:

The relationship between the Deaneries and the NHS trust is very different from the relationship to the colleges and trust. Trainees perceive the Deaneries as less impartial and more focused on maintaining service needs of the trusts than the individual training needs of junior doctors.³⁵⁹

323. The Postgraduate Deans defended the current arrangements, citing improved working relationships between Deaneries and SHAs. Professor Elisabeth Paice, Dean Director for the London Deanery, emphasised the advantages of making Deaneries coterminous with SHAs:

The experience of London Deanery working with five SHAs and working with one, NHS London, has been a revelation. It has been infinitely better to work to the same agenda and with the same span, concept and goals. I would not wish to turn back that clock.³⁶⁰

357 Ev 147

358 Ev 174

359 Ev 160

360 Q 616

324. Despite these assurances, the Tooke Review called for a further review of the role of Deaneries, expressing concerns about the effect of Deaneries' accountability to SHAs on the strength of their relationships with the Royal Colleges and Universities.³⁶¹

Strategic Health Authorities

325. Strategic Health Authorities (SHAs) hold the budgets for postgraduate medical training and have formal responsibility for commissioning training places, working closely with Postgraduate Deaneries. The recent performance of SHAs and their commitment to education and training have, however, been widely questioned, while the involvement of SHAs with MMC itself was affected by the 2006 re-organisation of the NHS, which reduced the number of SHAs from 28 to 10. In this section we look at past and future SHA involvement with medical training and with MMC.

Lack of SHA input into MMC

326. In general, witnesses agreed that SHAs had had little involvement with the development of MMC, despite their important role as commissioners of postgraduate medical training. COGPED stated that SHAs had shown a general unwillingness to engage with national programmes such as MMC, a point also made by the Royal College of GPs.³⁶² Anne Rainsberry, Director of Workforce for NHS London, acknowledged this during the Committee's *Workforce Planning* inquiry. She argued that SHAs had been excluded from the planning of MMC:

...it was a very centrally driven initiative where effectively the department...would say to the Strategic Health Authority, "These are the specialties that are expansion, there are a few that are in reduction, this is the national curriculum and, therefore, please sign here."³⁶³

327. NHS Employers pointed out that SHAs had been distracted by the 2006 re-organisation, but should nonetheless have done more to take charge of the MMC programme:

SHAs were in the throes of reconfiguration for much of this period and may have been unable to take full account of the significance of the impact of changes to medical training. With the benefit of hindsight it would have been important to have ensured they took a leadership role early on...³⁶⁴

Management of training budgets

328. SHAs were also accused of failing to prioritise medical education in their management of the Multi-Professional Education and Training (MPET) Levy which funds the majority of NHS training activities. A number of witnesses accused SHAs of cutting medical

³⁶¹ *Aspiring to Excellence*, p.93

³⁶² See Ev 132 and Ev 187 respectively

³⁶³ Health Committee, *Workforce Planning*, Fourth Report of Session 2006–07, HC 171–II, Q 736

³⁶⁴ Ev 174

training budgets in the 2005–06 and 2006–07 financial years in response to local health service deficits.³⁶⁵ The Royal College of Surgeons suggested that this practice had impeded the development of MMC:

Strategic Health Authorities were responsible for raiding training budgets during 2006 in order to bring the NHS into financial balance. This shortfall clearly made an impact on decisions made by the Deans.³⁶⁶

329. SHAs defended their position, arguing that cuts had not had a major impact on medical education. Anne Rainsberry acknowledged that NHS London had made some reductions to the medical training infrastructure in 2006–07, for example by reducing study leave allocations, but pointed out that such funding had now been restored.³⁶⁷ She also stressed that the number of medical training places had increased with the introduction of the MMC reforms in 2007.³⁶⁸ Dr Moira Livingston, Director of Workforce at NHS Northeast, also emphasised her organisation’s continuing investment in postgraduate medical training:

...in the north-east there were, in fact, no budget cuts to the deanery. We receive a deanery investment plan every year and we met the requirements of the deanery...since 2005, 2006... there has been an increase in training numbers, overall 58%, and if we look at the specialty training, training numbers, they went up by 71%, with general practice being less, at 22%. So that commitment to training, in terms of the number of trainees in the system, I think, is evident.³⁶⁹

Increasing SHA engagement with education

330. Despite these reassurances, a number of witnesses called for changes to increase the involvement of SHAs in medical education and improve their commissioning performance. The Tooke Review called for SHAs to improve partnerships with local education providers and to take a closer interest in medical training issues:

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.³⁷⁰

331. Professor Sir Nick Wright expressed a similar view, and was specifically critical of the decision not to require SHAs to have a higher education representative at board level. He asserted that only three of the ten SHA boards have a member from a higher education background, commenting that:

³⁶⁵ See, for example, Ev 96

³⁶⁶ Ev 116

³⁶⁷ Qq 698–700

³⁶⁸ Q 697

³⁶⁹ Q 695

³⁷⁰ Ev 141

It has always been the tradition in this country. The Strategic Health Authorities, the teaching hospital Trusts always had a non-executive director who is an academic. That has been lost.³⁷¹

332. Some argued, however, that improvements had already been made. The English Deans and the London Deanery both described improved working relationships between SHAs and Deaneries,³⁷² while representatives from NHS London and NHS Northeast pointed out that their organisations had representatives of the education sector at board level.³⁷³ And the English Deans commented on a general improvement in SHA engagement since the 2006 reorganisation:

The new SHAs are demonstrating a far greater engagement with the medical education agenda than their predecessor organisations...³⁷⁴

Oversight and performance management of SHAs

333. Witnesses also called for tougher performance management by the Department of Health to ensure that SHAs were held to account for the use of education and training funding. Service Level Agreements between SHAs and the Department were introduced in 2007/08, with the aim of improving the oversight of education spending. The Tooke Review, however, expressed doubts about the effectiveness of these arrangements and called for the system to be reviewed:

A formal review of the compliance with Service Level Agreements between DH and the SHAs relating to commissioning training and the functionality of the arrangement should be undertaken in 2008/9.³⁷⁵

334. SHA representatives agreed that improving oversight was an important goal, but argued that the introduction of Service Level Agreements had proved effective. Dr Moira Livingston described the benefits from the new arrangements:

...within SHAs we are all required, through a service-level agreement with the Department of Health, to have a learning development agreement and that has provided us with a tremendous lever. In the north-east we have all bar one trust as a foundation trust in terms of acute secondary care providers, and having a lever such as that allows to us to go in and discuss funding, directing the funding and driving up the quality of training.³⁷⁶

335. The Department of Health also defended the new performance management regime, stating that SHAs had generally performed well against the new Service Level Agreements:

371 Q 651

372 See Ev 76 and Q 616 respectively

373 Q 708

374 Ev 74

375 *Aspiring to Excellence*, p.144

376 Q 720

In 2007/08, a range of Key Performance Indicators (KPIs) for the MPET allocation were agreed with SHAs. Performance against these indicators was first assessed in summer 2007. A further review is under way. There is good evidence about the effectiveness of the arrangements for 2008. Most SHAs have achieved most of their KPIs or are on track to do so by 31 March...³⁷⁷

Employers and training providers

336. The many hospitals, GP practices and other care providers that employ doctors during their training are central to the medical education system. Employers provide the bulk of training which doctors receive and in turn rely on training doctors to provide a large proportion of patient care. In this section we look at the role of employers, and their representative organisation NHS Employers, in the MMC programme.

The role of employers to date

337. Witnesses consistently argued that employing organisations had had too little involvement with the design and implementation of MMC. Sir Jonathan Michael pointed out the critical role of employers and argued that they had not been sufficiently engaged with the reform programme:

...the role of employers and their engagement has been sub-optimal. Clearly, employers have accountabilities as employers and therefore they need to be engaged not only in employment issues but they have a responsibility to their employees to make sure they are properly trained...They also have a responsibility in terms of engagement in workforce planning because the needs of individual employers must be part of the overall picture.³⁷⁸

338. Sian Thomas, Deputy Director of NHS Employers, confirmed that employing organisations had not been closely involved with the development of the MMC reforms:

Before February 2007 we had a very peripheral role. We were probably regarded as a peripheral stakeholder in the process and, therefore, our influence was limited. We had no role on governance and had very limited engagement in implementation and design. In fact, I would say a great majority of the design decisions were made without employer input.³⁷⁹

339. This view was supported by the Tooke Review's analysis of the MMC governance system. *Aspiring to Excellence* demonstrated that NHS Employers was not represented on any of the key decision-making bodies during the development of MMC. The Association of UK University Hospitals was represented on the MMC Advisory Board, but there was no other formal involvement for employers prior to 2007.

340. Sian Thomas did point out, however, that the role of employers, and of NHS Employers itself, had considerably increased in response to the 2007 crisis:

377 Department of Health, *The Secretary of State for Health's Response to Aspiring for Excellence*, p.39

378 Q 156

379 Q 710

...at the beginning of March we realised there were grave problems, and that was when our active and full participation began through membership of the review group, and I would have to say since that date we are more engaged.³⁸⁰

Employers' future role

341. In general, witnesses argued that employers should continue to have a more active role in the management and reform of postgraduate medical training. The NHS Workforce Review Team, NHS Employers and the Tooke Review all expressed this view.³⁸¹ More specifically, Sian Thomas argued that employers should be involved in debates about the future role of consultants and other medical staff:

...to determine what we want doctors to do in the future: what is their role in the healthcare team and what will the career structure look like? Employers will determine that, and they may actually not all determine the same thing and may want to do different things, which is obviously, in an autonomous employer situation, what they are entirely able to do.³⁸²

342. She also argued that employers should be more closely involved in the future design of recruitment process:

...more employer views need to be taken into account in the design especially of the recruitment processes, because at the end of the day these are our employees who we will be employing for 30, 40 years and the end product of this process is important to employers on the ground.³⁸³

343. The arrangements for the new MMC Programme Board do appear to give employers a more prominent role. As well as a representative from NHS Employers, the new Board includes the heads of two major acute hospitals.³⁸⁴

Conclusions and recommendations

344. There are a number of organisations involved in the design and delivery of medical training at local and national level. Although led by the Department of Health, the MMC programme placed an onus on all of these groups to work coherently and constructively. The causes of and responses to the crisis of 2007 provide clear evidence of widespread failure to co-ordinate thought and action. The Secretary of State attributed the breakdown of the MMC programme to a “systems failure”. We agree.

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

380 Ibid

381 See Ev 66, Q 710 and *Aspiring to Excellence*, p.143 respectively

382 Q 757

383 Q 710

384 Department of Health, *The Secretary of State for Health's Response to Aspiring for Excellence*, p.59

- 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.
- 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.
- 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.
- 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.
- 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 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.
- 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.

Regulation and inspection

PMETB

346. The Postgraduate Medical Education and Training Board (PMETB) was established in 2003 as part of the wider reform of the regulation of the medical profession which followed the Shipman Inquiry.³⁸⁵ The Board's main role was to provide regulation and quality assurance for postgraduate training. Although its creation was not connected with MMC, PMETB was immediately charged with overseeing the reform of the 59 specialty training curricula in support of the MMC programme. The Board also took over responsibility for directly inspecting training providers, a task previously carried out by the Royal Colleges. The role of PMETB has been widely debated in the wake of the 2007 crisis.

385 For more details, see *Aspiring to Excellence*, pp.31–33

Criticism of PMETB

347. A number of witnesses, particularly from within the medical profession, were critical of PMETB's performance to date. The Yorkshire Deanery argued that PMETB had contributed to the rigidity of the MMC training structure by taking a "harsh line" on whether to recognise experience gained outside the UK training system.³⁸⁶ The Royal College of Surgeons also criticised the "rigidity" of PMETB's approach to developing the new curricula to support MMC.³⁸⁷

348. Other witnesses criticised the role of PMETB in inspecting training programmes. The Royal College of Psychiatrists argued that the quality of inspection had declined since PMETB took over this responsibility.³⁸⁸ Fidelio went further, describing the transfer of this responsibility to PMETB as "a direct attack upon the medical profession, and in particular its Royal Colleges."³⁸⁹ The Royal College of Physicians called for PMETB to scale back its inspection activities, proposing "maximum delegation" of responsibility to the Royal Colleges.³⁹⁰

349. Finally, witnesses argued that PMETB had failed to accept responsibility for problems with curriculum development and the wider MMC reforms. The Royal College of Surgeons expressed disappointment at PMETB's unwillingness to accept criticism of its role,³⁹¹ while the Royal College of Psychiatrists accused PMETB of avoiding its operational responsibilities:

High-sounding strategic statements are followed, if at all, by evasion of the reality of daily operation.³⁹²

Defence of PMETB

350. PMETB defended its own performance, pointing out that it had completed the revision of all 59 specialty training curricula in time for the introduction of the 2007 reforms as well as creating the new CESR route to specialty registration.³⁹³ The Board argued that its work had attracted unfair criticism because its role was confused with that of the MMC programme:

There has been a good deal of confusion about the respective roles of PMETB and MMC, not least because they were established at much the same time. However, PMETB and MMC are quite different...PMETB played no part in the design or

386 Ev 71

387 Ev 116

388 Ev 167

389 Ev 191

390 Ev 161

391 Ev 116

392 Ev 167

393 See Chapter 4

implementation of the MMC career structure beyond offering guidance on how the proposed model would relate to our standards and principles.³⁹⁴

351. The Secretary of State also defended PMETB's achievements in his response to the Tooke Review. He commented that:

I am very conscious of the progress PMETB has made and the significant contribution they have made to postgraduate medical education. They have put in place a much-needed and valued programme of work. Their work on the quality framework and their toolkit in particular are excellent achievements.³⁹⁵

The case for streamlining regulation

352. The Tooke Review offered a balanced assessment of PMETB's progress to date, acknowledging that it had made some achievements after a "slow start". *Aspiring to Excellence* recommended, however, that PMETB be absorbed by the General Medical Council (GMC) to create an integrated regulatory body:

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.³⁹⁶

353. Witnesses generally expressed support for this proposal. The Royal College of Physicians and Royal College of Surgeons both agreed that PMETB should be assimilated by the GMC.³⁹⁷ Professor Sir Nick Wright pointed out that such an arrangement would make the regulation of postgraduate training more independent and expressed support for the GMC:

Moving this to the General Medical Council would show that there is independence in regulation outwith the secretary of state's purview... I have every confidence the GMC could produce the goods.³⁹⁸

354. The Chief Medical Officer also expressed supported for the idea of streamlining the two regulators:

When we had the response to consultation on medical regulation, it was clear that some very strong arguments were mounted for merging the PMETB into the GMC, and that became my position and I would agree with Sir John Tooke that that would be a good thing to do.³⁹⁹

394 Ev 104

395 Department of Health, *The Secretary of State for Health's Response to Aspiring for Excellence*, p.43

396 *Aspiring to Excellence*, p.116

397 See Ev 167 and Ev 116 respectively

398 Qq 641, 643

399 Q 144

PMETB's and the Government's response

355. The only opposition to the idea of a merger came from PMETB itself, which argued that the responsibilities of the regulators should not be changed until a planned review had been carried out in 2011.⁴⁰⁰ Professor Peter Rubin, PMETB's Chair, argued that reorganising PMETB and the GMC would disrupt the implementation of other changes to medical training:

If some or all of Professor Tooke's recommendations or recommendations that you make are implemented to postgraduate medical education, then an effective regulator will be very important, and so that would be the worst time to shut down the regulator that deals with postgraduate medical education...⁴⁰¹

356. In spite of this, the Secretary of State agreed in his response to the Tooke Review that PMETB and the GMC should be merged. He did not, however, agree to make the change "as quickly as possible", as *Aspiring to Excellence* had recommended. Instead, the response stated that the merger would not take place for at least two years:

I have accepted the Inquiry's recommendation to merge PMETB with the GMC... The legislative process means that this will not be before 2010. We will publish a timetable for doing so once a plan has been worked through.⁴⁰²

Royal Colleges and Specialist Associations

357. The numerous Royal Colleges and Specialist Associations play an important role in the medical training system, setting standards and assuring the quality of training across their individual disciplines. Significant elements of the Royal Colleges' role in MMC are considered in Chapter 7 where we make recommendations about the leadership of the medical profession and the role of the AMRC. In addition, witnesses made a number of suggestions for adjusting and improving the Royal Colleges' contribution to MMC and the wider medical training system:

- Several Royal Colleges suggested that they should take back responsibility for directly inspecting training providers from PMETB,⁴⁰³ although Deaneries felt that the inspection process had improved under PMETB.⁴⁰⁴
- The Association of Surgeons pointed out the specific value of Specialist Associations and argued that they should be given a bigger role in decision-making in future.⁴⁰⁵
- Other witnesses called for the Royal Colleges to be more prepared to challenge the direction of reform. Fidelio described the response of the Royal Colleges to the

400 MMC 27A

401 Q 637

402 Department of Health, *The Secretary of State for Health's Response to Aspiring for Excellence*, p.43

403 See, for example, Ev 160 where the Royal College of Physicians described PMETB's inspection processes as "not rigorous enough".

404 *Aspiring to Excellence*, p.60

405 Ev 94

2007 crisis as “very disappointing” and called on the leaders of the Colleges to “stiffen the spines” when dealing with the Department of Health.⁴⁰⁶

Conclusions and recommendations

358. 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.
- 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.

The Department of Health

359. The Department of Health played a fundamental role as the instigator and leader of the MMC reform programme. We discussed many aspects of the Department’s performance, including leadership, policy development and project management, in Chapter 7, making a number of recommendations for future improvements. We look briefly here at other elements of the Department’s role.

Attitude and working relationships

360. Witnesses were critical of the overall attitude of the Department of Health towards the MMC programme and the medical profession, calling for it to be more constructive and approachable in future. We saw in Chapters 2 and 3 that the Department ignored warnings from the medical profession about potential problems with the 2007 reforms, and that it did not heed the BMA’s “Call for Delay” in 2006. Professor Stephen O’Rahilly of Fidelio was highly critical of the Department’s general approach to dealing with the profession:

To date, there has been a rather lethal brew of high-handedness and incompetence and one hopes that will be fixed. I fear there is a fundamental distaste for the medical profession in the centre of the Department of Health...⁴⁰⁷

361. RemedyUK expressed a similar view, stating that the Department “did not listen to anyone” during the development of MMC.⁴⁰⁸ Dr Ian Wilson of the BMA also condemned the Department’s attitude to the profession in recent years, but pointed out that things had improved in the wake of the 2007 crisis:

406 Qq 201–2

407 Q 238

408 Ibid

I will use the words fickle and contemptuous...That is the way that the Department of Health has responded to the medical profession over a number of years of late, but we have been working increasingly well with them more recently and have much better communications with them than we ever did, so it would not be fair to describe them in that way now.⁴⁰⁹

362. The Chief Medical Officer defended the Department's approach, pointing out that the medical profession was heavily involved with the MMC programme. He argued that it was not possible for the Department to satisfy the demands of all the different groups within the profession:

In any programme of implementation there will be many, many different views expressed. It is very easy with hindsight to pick out one and say. "That was the shining torch we should have followed," but at the time many, many different voices were involved...⁴¹⁰

Extent of remit for medical training

363. Questions were also raised about the extent of the Department's involvement with the detailed implementation of MMC. The Department established a highly complex governance structure for MMC and was involved in a number of different elements of the programme.⁴¹¹ The overall direction for MMC was set by the Department's UK Strategy Group which reported directly to the Chief Medical Officer. Operational matters were dealt with by MMC's Programme Delivery Board, which reported jointly to the CMO and the Director of Workforce. Meanwhile elements of the detailed design of the reforms, including the 2007 recruitment process, were undertaken by the Department's Workforce Directorate.⁴¹²

364. The Tooke Review raised concerns about whether the Department should have involved itself in the detailed implementation of MMC. Sir John Tooke told the Committee that while the Department should have responsible for defining policy, it should not take on responsibility for implementation as well:

...the department in conjunction with professional stakeholders has the key role in determining policy...but at least for the panel there is an open question as to whether the Department of Health has the resources and professional skills to implement something of this nature. My personal view is that for something like this it is probably better conducted by an accountable arm's length body...⁴¹³

365. Sir John Tooke went on to argue that the Department should reduce its involvement in the implementation of major programmes such as MMC, calling for "policy and implementation separation" at a national level. Fidelio made a similar point, arguing that the Department's overall involvement with MMC should be reduced:

409 Q 404

410 Q 56

411 See Chapter 6

412 *Aspiring to Excellence*, p.53

413 Q 162

If no one at the Department of Health accepts responsibility for this year's disaster, no future modification is safe in their hands.⁴¹⁴

366. Many witnesses supported the Tooke Review's recommendation that elements of the Department's role in MMC should be taken over by a new national body. We consider this debate in more detail below.

Conclusions and recommendations

367. **Significant reform of the Department of Health's relationship with the medical training system is required. The Department became too involved in detailed implementation of MMC, and particularly of the MTAS recruitment system, losing sight in the process of the programme's strategic aims. Despite consulting frequently with medical groups, the Department also failed to adequately reflect the wishes of the profession in its plans, leading to a breakdown in this key relationship. We therefore recommend that the Department:**

- **Establish a clear distinction between its policy-making activities and its support for the detailed implementation of policy;**
- **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;**
- **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; and**
- **Reduce its direct involvement with policy implementation, ceding control to Postgraduate Deaneries, Royal Colleges and employers.**

NHS: Medical Education England

368. As outlined in Chapter 4, the Tooke Inquiry recommended the creation of a new national body, NHS: MEE, to oversee medical education and training. *Aspiring to Excellence* proposed that the new organisation take over responsibility for defining the principles for postgraduate training from the Department of Health. It also recommended that NHS: MEE be made responsible for a ring-fenced budget for medical education, removing this responsibility from SHAs. In addition, NHS: MEE would take over from the MMC Programme Board as the main forum for interaction between the Department of Health and the medical profession.⁴¹⁵

369. The decision about whether to set up a new national body therefore has significant implications for the future both of the other organisations involved in postgraduate training and of the training system itself. In this section, we consider the arguments for and against the creation of NHS: MEE.

414 Ev 189

415 *Aspiring to Excellence*, p.7

Arguments in support of NHS: MEE

370. Sir John Tooke set out the case for establishing a new body to oversee medical training in a letter to the Committee in February 2008. He argued that neither the Department of Health nor SHAs were capable of overseeing the reform of medical training, creating the need for a new and dedicated organisation to do this:

Our belief that such a body is necessary stems from a fundamental lack of confidence by the medical profession in the Department of Health's ability to manage the implementation of changes in PGMET, and the clear need to separate policy from implementation. Devolution of *complete* responsibility to SHA level engenders even less confidence, given the current lack of workforce planning and commissioning capacity, the lack of labour market intelligence and the very recent history of education and training budgets being raided to meet service pressures.⁴¹⁶

371. Several witnesses, particularly from within the medical profession, expressed strong support for the creation of NHS: MEE. Professor Peter Rubin stated that:

...the establishment of NHS: MEE, with a ring-fenced budget for medical education... would by itself go a long way to ensure that we do not have a repeat in the future of the MTAS/MMC problems. That is a view that is shared not just by the regulators but by the Academy of Medical Sciences, by the Medical Schools Council, by the Academy of the Royal Colleges.⁴¹⁷

372. A similar view was expressed by Professor Neil Douglas, vice-chair of the AMRC and a member of the MMC Programme Board. He drew attention to the effectiveness of NHS Education Scotland, a body with responsibility for overseeing education for all staff groups within the Scottish NHS. He argued that the recommendation to create NHS: MEE was central to the changes proposed by the Tooke Review:

...recommendation 47 is the key one in the new version of Tooke. I work very closely with NHS Education Scotland in Edinburgh. They are an extremely effective organisation, controlling of the funds is critical to properly planning the training for the juniors. If anything gets enacted, it has to be recommendation 47.⁴¹⁸

373. Others witnesses emphasised the risks involved with devolving responsibility for medical education directly to SHAs, one of the perceived alternatives to creating NHS: MEE. Dr Bill Reith argued that SHAs would struggle to prioritise medical education, given the scale of their other responsibilities:

There are so many things for SHAs to be doing that, frankly, it seems that for some education does not have the priority that it merits, so we certainly support an independent special health authority of some kind.⁴¹⁹

416 MMC 61—Tooke Review Panel

417 Q 651

418 Q 652

419 Q 540

Arguments against NHS: MEE

374. Other witnesses, however, raised concerns about the prospect of setting up NHS: MEE and argued that a new organisation was not desirable or necessary. Representatives from SHAs, Deaneries and employers consistently expressed this view. Professor Elisabeth Paice of the London Deanery argued that creating an organisation dedicated specifically to medical education would make it more difficult to integrate planning and would isolate decisions about the medical workforce from their wider context:

I would hate to see medical isolationism as the outcome of this and a step backwards from the integration of service strategy and financial planning, using medical education, if you like, as an enabler for service change and reform.⁴²⁰

375. Anne Rainsberry, Director of Workforce at NHS London, agreed, pointing out that NHS: MEE would prevent SHAs from integrating service planning with workforce and education planning:

I think that it fractures the relationship between service and education...strategic health authorities are the only part in the system where the balancing of service, long-term strategic planning and education align, and I think, by taking medical education off-line in that way, it would fracture that relationship...⁴²¹

376. NHS Employers expressed a number of concerns about the proposal, arguing that creating a national body would contradict the policy of devolving decision-making within the NHS. NHS Employers also opposed the ring-fencing of education budgets and pointed out that the creation of NHS: MEE would make implementation of other changes called for by the Tooke Review more difficult:

...the proposal does not seem to support the desirable intention, set out clearly in the Tooke Report, of getting those involved in the policy and commissioning of education for doctors closer both to undergraduate medical schools and to the service.⁴²²

377. Anne Rainsberry pointed out that the success of NHS Education Scotland was not directly relevant to the debate about NHS: MEE, largely because of the smaller scale of the Scottish health service:

It does work well in Scotland, I would agree with that, but the number of their trainees is similar to one of our medium-size deaneries...⁴²³

378. Witnesses also pointed out that the remit of NHS Education Scotland covers all staff groups, rather than just medicine. NHS Employers argued that if a new organisation were created then it should be responsible for overseeing all training and education, describing the idea of a separate organisation for medical education as “not helpful”. In a subsequent

420 Q 607

421 Q 718

422 MMC 45A—NHS Employers

423 Q 722

letter to the Committee, Sir John Tooke acknowledged that an organisation dedicated specifically to medical education was not necessarily required:

Whereas the Final Report proposed the creation of NHS:MEE (reflecting the fact that our remit was medicine) the Panel supports the concept of NHS Education England, embracing the needs of the various professional clusters.⁴²⁴

The Department of Health's position

379. The Secretary of State was guarded when questioned about NHS: MEE and did not state whether the Tooke Review's recommendation would be accepted. He acknowledged the differences in opinion regarding the proposed national body, but particularly emphasised the opposition of some interested parties:

This thought of putting one organisation in charge of that has got its advocates and its detractors. Since Tooke's Report was published I have had many people saying to me that they do not agree with that recommendation. The deaneries have put on record their concerns about that recommendation. Given that is the case, we need to consider it and we need to consult...⁴²⁵

380. The Department's formal response to the Tooke Review was similarly cautious, deferring the decision about whether to set up NHS: MEE until the publication of the NHS Next Stage Review:

The Workforce Planning, Education and Training (WPET) work, which is part of the NSR, is addressing many of the substantial issues raised by this Inquiry recommendation... The proposal for an NHS:MEE needs to be considered alongside this work. The NSR is due to report by the end of June.⁴²⁶

Conclusions and recommendations

381. The Tooke Review's proposal to create a new arms-length body, NHS: MEE, to oversee medical training was strongly supported by the medical profession, but opposed by other key groups including Deaneries, SHAs and employers. NHS: MEE offers a number of potential benefits. First, a new body would provide a dedicated forum for improving medical training, free from external pressures and influences. Secondly, NHS: MEE would be able to work specifically on implementing many of the Tooke Review's other proposals. Thirdly, a ring-fenced budget would ensure that funding for medical training could not be used for other purposes. And finally, neither the Department of Health nor Strategic Health Authorities have proved themselves capable of leading the reform of the medical education system, as witnessed by the debacle of 2007.

382. The creation of NHS: MEE would also have a number of potential risks and disadvantages, however. Chief among these is that a body dedicated to medical

424 MMC 61—Tooke Review Panel

425 Q 886

426 Department of Health, *The Secretary of State for Health's Response to Aspiring for Excellence*, pp.54–55

education alone would cause medical workforce planning to become further isolated from wider health service planning. In addition, there are already numerous organisations involved with medical training, and it seems unlikely that creating another one would improve the coherence of the reform programme. Equally, if the Department is serious about devolving more responsibility to local organisations, then creating another national body would run counter to this ambition, as well as contradicting the Department's recent efforts to reduce the number of arm's-length bodies. Establishing a new organisation would be expensive and time-consuming and would potentially disrupt the implementation of future change. Finally, the theoretical independence of arm's-length bodies has often proved illusory in practice, at times allowing responsible Departments to abrogate responsibility for key issues without relinquishing ultimate control of policy.

383. In view of the scale of the 2007 crisis and the "systems failure" identified by the Secretary of State, there is a clear need for strong central co-ordination of future changes to medical training. The NHS: MEE as envisaged by the Tooke Review would be, however, a step too far. The MMC Programme Board already brings together the medical profession, the Department of Health and the NHS and can therefore assume this co-ordinating role, provided that it is swiftly strengthened and reconstituted as we propose. We therefore 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.

Conclusions and recommendations

The gathering storm: 2003–2007

1. The initial implementation of the Modernising Medical Careers (MMC) programme went relatively smoothly through the introduction of the new Foundation programme in 2005. As the Department prepared for the subsequent reform of Specialty Training, however, a number of warning signs indicated that all was not well. Concerns were raised both within and outside the Department about the inflexibility of the new training system, the inadequacy of the new national recruitment system, and a possible shortage of training posts. In spite of these issues, and heedless of the warnings of the Royal Colleges and of an official “Call for Delay” by the BMA, the Department pressed ahead with its plans for wider reform in 2007. We recommend that the Department ensures that it heeds such warnings in future. (Paragraph 39)

The 2007 crisis

2. The introduction of the new Specialty Training arrangements in 2007 was disastrous. The failure to restrict overseas applicants and the manifest weakness of the national recruitment system made the collapse of confidence in the selection process inevitable. The design of the initial application forms was particularly inappropriate, failing to recognise doctors’ key achievements and giving undue weight to “white space” questions. The short-listing process, critical to the futures of so many, therefore descended into little more than a creative writing exercise. Candidates and assessors alike were justifiably outraged by the sheer inadequacy of MTAS. (Paragraph 76)
3. The period between February and August 2007 was characterised by unrelenting chaos and severe anxiety for thousands of junior doctors. The repeated changes to the recruitment system, a High Court challenge and the failure to protect the privacy of candidates’ personal information ensured that the process was miserable for all the applicants involved. The Review Group, faced with an impossible situation, was unable to restore confidence in the recruitment system. The wave of resignations by senior medical leaders and series of emergency Ministerial statements which followed were both acutely embarrassing for the Government. The reputations of both the Department of Health and the leaders of the profession were severely diminished by the events of 2007. (Paragraph 77)

Fall-out: 2007–2008

4. The independent Tooke Inquiry produced a perceptive and comprehensive analysis of the problems which affected the MMC programme and the causes of the 2007 crisis. The Secretary of State was right to quickly accept many of the Inquiry’s recommendations for change and improvement. Decisions on the Inquiry’s most significant and far-reaching proposals, however, were deferred. We recommend that the Department publish an updated response to the Tooke Inquiry, setting out its

final decisions on all 47 recommendations, immediately after the Darzi review has been published. (Paragraph 104)

The medical workforce

The Foundation Programme

5. The implementation of the new two-year Foundation programme did not suffer from the errors which marked that of specialty training. We heard evidence of significant benefits from the new schemes as well as a number of continuing problems. It is too early to judge whether the new Foundation programme has proved an overall success and we therefore recommend that the current two-year scheme is retained while a full evaluation of its impact is carried out in due course. (Paragraph 122)
6. We note the Tooke Inquiry's concern that the current arrangements for the Foundation programme are not legally sound. We recommend that the Department address this question as a matter of urgency and, if necessary, consider introducing legislation to safeguard the legality of the current two-year programme. Only if no lawful alternative can be found should the Tooke Review's recommendation to split the Foundation programme be accepted. (Paragraph 123)

Specialty training

7. It is clear that the creation of run-through posts across all specialties in 2007 was a serious error. The rigidity of many 2007 run-through schemes contradicted MMC's principles of increasing flexibility and providing a broad-based beginning to specialty training. Run-through training was especially unsuited to the needs of a number of large specialties, include general medicine and surgery. Such specialties have already un-coupled their run-through programmes for 2008 and we support this development. (Paragraph 136)
8. We do not agree, however, with the Tooke Review's recommendation that un-coupling should take place across the board. It is clear that the run-through model has advantages for some specialty areas and may help to attract doctors to traditional shortage specialties. It is also evident that flexibility can be built into run-through schemes, as the case of Paediatrics has demonstrated. Most persuasively, it was the imposition of a "one size fits all" structure which caused such problems in 2007. Forcing all specialties to un-couple would risk repeating this mistake. We therefore 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. We further recommend that specialties be permitted to offer a mixture of run-through and un-coupled training posts where this best meets their needs. (Paragraph 137)

Academic medicine

9. Academic medicine is a vital part of the training system which appeared to be badly neglected and damaged by the MMC reforms. Research opportunities should be

accessible to all doctors in training, while dedicated academic training posts must be made more attractive. To this end, 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. We further recommend that the number of centrally funded academic training posts be increased and that the academic training system run parallel to that for mainstream clinical training. (Paragraph 143)

Recruitment and selection

10. The crisis of 2007 was caused in large part by the failure of the recruitment system for specialty training. In response, the Department has handed control of recruitment back to the Postgraduate Deaneries who largely reverted to traditional selection processes in 2008. We support this move and recommend that the Department devolve all responsibility for recruitment to Deaneries as soon as possible, including allowing them to set their own timetables. Deaneries should in turn do more to involve local employers and individual consultants in the design and implementation of selection systems. (Paragraph 154)
11. The delegation of responsibility for recruitment to regional and local organisations should not prevent Deaneries from organising national selection processes when this approach best meets the needs of particular specialties. Nor should it stop Deaneries from using centralised infrastructure, including IT software, where they consider it necessary to improve recruitment and when adequate piloting has taken place. (Paragraph 155)
12. The imposition of a single start date for all training programmes in 2007 was a serious error which reduced the flexibility of the recruitment system and had the potential to compromise patient safety. We recognise that a staged approach to recruitment has been introduced in 2008 and we support this move. We recommend that a staged recruitment process, with at least three substantial recruitment rounds per year, be established in the future. (Paragraph 156)
13. The serious problems experienced in 2007 should not prevent Deaneries from exploring future changes to selection methods. It is vital, however, that such changes are carefully tested and evaluated prior to implementation. We note that the MMC Programme Board has established a pilot programme for new selection methods and we support this approach. In particular, a recognised national test or exam, also referred to as a national "metric", has the potential to increase the objectivity of short-listing and to make recruitment more efficient. We recommend that the Programme Board consider the case for introducing a national "metric" as a matter of priority. (Paragraph 157)

Staff Grade and Associate Specialist posts

14. Reforming the Staff Grade and Associate Specialist (SAS) grades was one of the original aspirations of the MMC programme. To this end, the establishment of a new way of achieving specialist registration, the CESR route, is a welcome development. Wider progress, however, has been limited and access to training and CPD remains

patchy. In particular, the failure to implement a “credentialing” system has prevented training and experience gained by SAS doctors from being formally recognised, meaning that SAS posts continue to be regarded as inferior to traditional training posts. The introduction of a new contract for SAS doctors has also been delayed, further hampering progress. We recommend that the introduction of this new contract be given a high priority by the Department. (Paragraph 171)

15. The failure to substantially reform the SAS grade is highly disappointing, in particular because SAS posts have the potential to provide an attractive alternative to the formal training system. This potential must be realised in the future. Such a development would not only belatedly improve prospects for SAS doctors themselves, but would also reduce pressure on the traditional training system. In order to achieve this, we recommend that:

- The remit of the MMC Programme Board be widened to include reform of the SAS grade;
- Responsibility for regulating the training received by SAS doctors be given to PMETB, and subsequently to the GMC;
- 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;
- Employers make use of the new SAS contract to ensure consistent access to and funding for training and development and to develop extended roles for SAS doctors. (Paragraph 172)

16. These changes would ensure that the SAS grades become a recognised part of the training system, providing a genuine alternative to traditional training posts and giving doctors the opportunity to develop specific skills to a very high standard. This would significantly increase the overall flexibility of the training system and greatly reduce the need for temporary FTSTA posts. It would also ensure that the UK no longer has a two-tier medical workforce and that in future all doctors are either in training or fully trained. (Paragraph 173)

The consultant workforce

17. The changes introduced by MMC also have significant implications for the consultant workforce. Shorter overall training times and increasing sub-specialisation both point to a need for greater differentiation within the consultant grade. 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 184)

18. We were surprised that the Secretary of State was not able to say whether he remains committed to the NHS Plan aspiration of moving from consultant-led to consultant-delivered care in the NHS. This is a critical question with fundamental implications for the size and nature of the consultant workforce, and for the role of the training

system. We recommend the Department resolve this issue 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, potentially throwing medical workforce planning into still more confusion and further damaging relations with the medical profession. This decision should not be taken lightly. (Paragraph 185)

19. We are also concerned by the apparent absence of any systematic basis for calculating postgraduate training numbers, something which should have been established as part of the MMC reforms. It is unclear whether the number of training posts is determined by the number of doctors seeking training, by the current capacity for training in the NHS, by the future clinical needs of the health service, or by some combination of these factors. We agree with Professor Tooke that “workforce policy objectives must be integrated with training and service objectives”. 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 186)

The supply of doctors

20. The Committee supports the Government’s long-standing policy of increasing the self-sufficiency of the UK for its medical workforce. The welcome expansion to the number of doctors trained in the UK, which began in 1999, means that the number of non-EEA doctors entering the UK training system needs to be carefully managed. There is a widespread consensus that some restrictions to opportunities for non-EEA doctors are required in order to protect opportunities for UK graduates and the considerable investment of UK taxpayers. (Paragraph 228)
21. The Government’s handling of this important and sensitive issue has been appalling. Despite beginning its pursuit of self-sufficiency in 1999, the Government made no real attempt to change the status of non-EEA doctors until 2006. In particular, we found the CMO’s excuse (outlined in para. 210) weak and unconvincing. Its efforts since then, involving the Department of Health, the Home Office and the Treasury, have been poorly planned, badly communicated and inadequately co-ordinated. This lack of co-ordination was amply demonstrated by the failure of the Department of Health and the Home Office to arrange for their respective Ministers to give evidence to the Committee on the same day. (Paragraph 229)
22. Worst of all, the Government’s many initiatives failed to prevent open access to training places for doctors from across the globe in both 2007 and 2008. Hundreds of UK graduates have been unable to continue with their training as a result. Tens of thousands of non-EEA doctors, meanwhile, have suffered inconsistent and undignified treatment. (Paragraph 230)
23. The Department of Health proposes to use its guidance to employers to protect opportunities for UK graduates in future. The legality of the guidance remains in question, however, and will not be finally established until May 2008. The Department has already twice failed to enforce its guidance and is running a grave

risk by relying on a single legal decision as the basis of its medical workforce policy. The Department's guidance does, however, represent a good way to restrict non-EEA applications while allowing overseas doctors to train in hard-to-fill specialties. 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 231)

24. If the Department's guidance is not found to be lawful then the situation looks uncertain. Surprisingly, the Home Office made no suggestions for dealing with this eventuality. Recent Immigration Rules changes are limited in scope, contradict wider immigration policy and were acknowledged to be only a "stop gap" solution by the Home Office itself. Charging non-EEA doctors for postgraduate training would be impractical and the impact would be difficult to predict. 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 232)
25. The general move towards increased self-sufficiency should not prevent the NHS from offering a limited number of training opportunities to non-EEA doctors for international development purposes. We recommend that the Department of Health work with the 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 233)

Managing reform

26. The management of the introduction of the MMC reforms by the Department of Health was inept. Key policy decisions and the processes for making and documenting them were ineffective and the medical profession, while frequently consulted, rarely influenced critical decisions. The governance systems for the programme were far too complicated, roles and responsibilities were ill-defined and lines of accountability were irrational and blurred. The arbitrary division of responsibilities between the Chief Medical Officer and the Workforce directorate was a fatal fault line within the management of the programme. (Paragraph 300)
27. Project management for the introduction of changes to specialty training was equally poor. Much of the key planning for the 2007 changes took place in a mad scramble at the end of 2006. The "big bang" approach to the reforms and the failure to pilot any of the new arrangements proved particularly serious errors. Individual risks to the project were assessed, but problems were not made known to senior officials and there was no risk management of the project as a whole. As a result, the Department did not recognise the deficiencies within the programme and could not prevent implementation from going ahead prematurely. Project management decisions took little account of the needs and concerns of applicants themselves and communication with junior doctors was appalling. (Paragraph 301)
28. The leadership shown by the Department of Health during this period was totally inadequate. Despite being the architect of the reforms, the Chief Medical Officer

chose not to take on a clear leadership role and thus did not accept overall responsibility for the 2007 crisis. The confidence of the medical profession in the current CMO has been seriously damaged by MMC. Serious criticisms of the CMO have arisen in part because of the ambiguity of the role. We recommend that the job description be reviewed to define the role more accurately and then publicised to facilitate wider understanding of the CMO's duties and responsibilities. (Paragraph 302)

29. 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. (Paragraph 303)
30. 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 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;
 - All future policy development decisions should be approved by the MMC Programme Board;
 - A document reviewing the principles behind the MMC reforms should be agreed by the Programme Board and published by August 2008;
 - Meetings and decisions of the Programme Board must be properly minuted and attendance at the Programme Board should be consistent;
 - All future changes should be piloted and evaluated;
 - A “big bang” approach to reform should be avoided wherever possible in future;
 - Communication with junior doctors should be improved and a single source of authoritative information established; and
 - 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 given his distant relationship with MMC. (Paragraph 304)

31. In particular, these changes should help to ensure that the new Programme Board represents a genuine partnership between the Department of Health, the NHS and the medical profession. Such an approach is vital if the new Board is to avoid the weaknesses and pitfalls which affected the previous UK Strategy Group and the Douglas Review group. (Paragraph 305)
32. 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.
 - 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.
 - 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.
 - 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.
 - Ministers and officials should set more realistic timescales for introducing major changes, and should be prepared to delay implementation if necessary. (Paragraph 306)
33. The leaders of the medical profession itself were also ineffective, divided by factional interests and unable to speak with a coherent voice. The weak and tokenistic nature of the Academy of Medical Royal Colleges was exposed by the MMC crisis. We therefore recommend that the Royal Colleges review the role of the Academy of Medical Royal Colleges and consider replacing it with an executive body which has the authority to make decisions on behalf of all the Colleges. (Paragraph 307)

Organisational responsibilities

34. There are a number of organisations involved in the design and delivery of medical training at local and national level. Although led by the Department of Health, the MMC programme placed an onus on all of these groups to work coherently and constructively. The causes of and responses to the crisis of 2007 provide clear evidence of widespread failure to co-ordinate thought and action. The Secretary of State attributed the breakdown of the MMC programme to a “systems failure”. We agree. (Paragraph 344)

Commissioners and providers of training

35. 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.
- 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.
- 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.
- 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.
- 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 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.
- 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 345)

Regulation and inspection

36. 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.
- 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 358)

The Department of Health

37. Significant reform of the Department of Health's relationship with the medical training system is required. The Department became too involved in detailed implementation of MMC, and particularly of the MTAS recruitment system, losing sight in the process of the programme's strategic aims. Despite consulting frequently with medical groups, the Department also failed to adequately reflect the wishes of the profession in its plans, leading to a breakdown in this key relationship. We therefore recommend that the Department:

- Establish a clear distinction between its policy-making activities and its support for the detailed implementation of policy;
- 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;
- 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; and
- Reduce its direct involvement with policy implementation, ceding control to Postgraduate Deaneries, Royal Colleges and employers. (Paragraph 367)

NHS Medical Education England

38. The Tooke Review's proposal to create a new arms-length body, NHS: MEE, to oversee medical training was strongly supported by the medical profession, but opposed by other key groups including Deaneries, SHAs and employers. NHS: MEE offers a number of potential benefits. First, a new body would provide a dedicated forum for improving medical training, free from external pressures and influences. Secondly, NHS: MEE would be able to work specifically on implementing many of the Tooke Review's other proposals. Thirdly, a ring-fenced budget would ensure that funding for medical training could not be used for other purposes. And finally, neither the Department of Health nor Strategic Health Authorities have proved themselves capable of leading the reform of the medical education system, as witnessed by the debacle of 2007. (Paragraph 381)

39. The creation of NHS: MEE would also have a number of potential risks and disadvantages, however. Chief among these is that a body dedicated to medical education alone would cause medical workforce planning to become further isolated from wider health service planning. In addition, there are already numerous organisations involved with medical training, and it seems unlikely that creating another one would improve the coherence of the reform programme. Equally, if the

Department is serious about devolving more responsibility to local organisations, then creating another national body would run counter to this ambition, as well as contradicting the Department's recent efforts to reduce the number of arm's-length bodies. Establishing a new organisation would be expensive and time-consuming and would potentially disrupt the implementation of future change. Finally, the theoretical independence of arm's-length bodies has often proved illusory in practice, at times allowing responsible Departments to abrogate responsibility for key issues without relinquishing ultimate control of policy. (Paragraph 382)

40. In view of the scale of the 2007 crisis and the "systems failure" identified by the Secretary of State, there is a clear need for strong central co-ordination of future changes to medical training. The NHS: MEE as envisaged by the Tooke Review would be, however, a step too far. The MMC Programme Board already brings together the medical profession, the Department of Health and the NHS and can therefore assume this co-ordinating role, provided that it is swiftly strengthened and reconstituted as we propose. We therefore 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 383)

Glossary

AMRC	Academy of Medical Royal Colleges
BAPIO	British Association of Physicians of Indian Origin
BMA	British Medical Association
CCT	Certificate of Completion of Training
CESR	Certificate of Eligibility for Specialist Registration
CMO	Chief Medical Officer
COGPED	Committee of GP Education Directors
COPMeD	Conference of Postgraduate Medical Deans
DH	Department of Health
EEA	European Economic Area
EWTD	European Working Time Directive
FCO	Foreign and Commonwealth Office
FTSTA	Fixed-Term Specialty Training Appointment
FY1/2	Foundation Year 1/2
GMC	General Medical Council
HSMP	Highly Skilled Migrant Programme
JDC	Junior Doctors Committee
MMC	Modernising Medical Careers
MPET	Multi-Professional Education and Training
MTAS	Medical Training Application Service
NCCG	Non-Consultant Career Grade
NHS: MEE	NHS Medical Education England
PMETB	Postgraduate Medical Education and Training Board
PRHO	Pre-Registration House Officer
SAS	Staff Grade and Associate Specialist
SHA	Strategic Health Authority
SHO	Senior House Officer
SpR	Specialist Registrar
SRO	Senior Responsible Owner or Senior Responsible Officer; the terms are used by the Department of Health interchangeably
ST(n)	Specialty Registrar (year)

Formal Minutes

Thursday 24 April 2008

Members present:

Mr Kevin Barron, in the Chair

Mr Peter Bone
Jim Dowd
Sandra Gidley

Stephen Hesford
Dr Doug Naysmith
Dr Richard Taylor

Draft Report (Modernising Medical Careers), proposed by the Chairman, brought up and read.

Ordered, That the Chairman's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 383 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Third Report of the Committee to the House.

Ordered, That the Chairman make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for printing with the Report.

[Adjourned till Wednesday 30 April at 9.00 am

Witnesses

Thursday 15 November 2007

Sir Liam Donaldson KB, Chief Medical Officer, **Professor Martin Marshall**, Deputy Chief Medical Officer, **Ms Clare Chapman**, Director General of Workforce, and **Mr Nic Greenfield**, Deputy Director of Workforce, Department of Health

Thursday 6 December 2007

Professor Sir John Tooke, Dean of Peninsula Medical School, Head of the Tooke Inquiry, and **Sir Jonathan Michael**, Deputy Managing Director, BT Healthcare, Member of the Tooke Inquiry Panel

Dr Richard Marks, Head of Legal Team, and **Mr Matthew Jameson Evans**, Press Co-ordinator, RemedyUK, and **Professor Steve O’Rahilly**, University of Cambridge, member of Fidelio

Thursday 13 December 2007

Professor Alan Crockard, Former National Director, MMC (England), and **Professor Shelley Heard**, Former National Clinical Advisor to MMC

Dr Jo Hilborne, Former chair, Junior Doctors Committee, British Medical Association, **Dr Ian Wilson**, BMA Consultants Committee and MMC Programme Board member, British Medical Association, and **Dr Ramesh Mehta**, President, British Association of Physicians of Indian Origin

Mr Mark Johnston, Managing Director, Methods Consulting

Thursday 17 January 2008

Professor Dame Carol Black, Chair, Academy of Medical Royal Colleges, **Mr Bernard Ribeiro**, President, Royal College of Surgeons, and **Dr Bill Reith**, Chair of Postgraduate Training Board, Royal College of General Practitioners

Professor Elisabeth Paice, Dean Director, London Deanery, and Chair, Conference of Postgraduate Medical Deans, **Professor David Sowden**, Dean, East Midlands Healthcare Workforce Deanery and Senior Responsible Officer for MMC, Department of Health (from January 2008), and **Professor Sarah Thomas**, Dean, South Yorkshire and South Humber Postgraduate Deanery

Thursday 24 January 2008

Professor Peter Rubin, Chair, Postgraduate Medical Education and Training Board, **Professor Neil Douglas**, Head, MTAS Review Group, and **Professor Sir Nick Wright**, Warden, Barts and the London School of Medicine and Dentistry

Ms Anne Rainsberry, Director of Workforce, NHS London, **Dr Moira Livingston**, Strategic Head of Workforce and Deputy Medical Director, NHS North East, and **Ms Sian Thomas**, Deputy Director, NHS Employers

Monday 18 February 2008

Ms Lorraine Rogerson, Director of Policy, and Head of Profession at the Border and Immigration Agency, Home Office, and **Ms Judith Macgregor**, Director for Migration, Foreign & Commonwealth Office

Rt Hon Alan Johnson MP, Secretary of State for Health, **Mr Hugh Taylor**, Permanent Secretary, **Sir Liam Donaldson KB**, Chief Medical Officer, and **Ms Clare Chapman**, Director General of Workforce, Department of Health

List of written evidence

The following memoranda were published as *Modernising Medical Careers: Written evidence*, HC 25–II, Session 2007–08

MMC

- 1 Department of Health
- 2 Dr Pete Jones
- 3 Richard Cove
- 4 Graham Robertson
- 5 Professor David Curtis
- 6 The Royal College of Radiologists
- 7 Diana Morgan
- 8 The Academy of Medical Sciences
- 9 Dr Clive Peedell
- 10 Anna Peek
- 11 Dr Schramm-Gajraj
- 12 Catherine Macdonald
- 13 James Jenkin
- 14 Mums4Medics
- 15 NHS Workforce Review Team
- 16 Yorkshire Deanery
- 17 English Postgraduate Deans Group
- 18 Mersey Deanery
- 19 The Medical Women's Federation
- 20 North Western Deanery
- 21 Dr Gordon Caldwell
- 22 Association of Surgeons of Great Britain and Ireland
- 23 Queen Victoria Hospital NHS Foundation Trust, East Grinstead
- 24 Penelope Jane Berry
- 25 Alison Matheson
- 26 NACT UK
- 27 Postgraduate Medical Education and Training Board
- 28 Royal College of Paediatrics and Child Health
- 29 The Royal College of Surgeons of England
- 30 Roger Fox
- 31 British Orthopaedic Association and the Specialty Advisory Committee in Trauma and Orthopaedic Surgery
- 32 NHS London and London Deanery
- 33 Professor Alan Crockard
- 34 Committee of General Practice Education Directors and the Society for Academic Primary Care
- 35 British Medical Association
- 36 Dr J L W Parker
- 37 British Orthopaedic Trainees' Association (BOTA)

- 38 RemedyUK
- 39 Lindsay Cooke
- 40 Margaret Demaine
- 41 Royal College of Physicians of Edinburgh
- 42 Royal College of Physicians
- 43 Royal College of Psychiatrists
- 44 British Geriatrics Society
- 45 NHS Employers
- 46 Georgina Wilson
- 47 Association of Surgeons in Training
- 48 British Society for Rheumatology
- 49 Royal College of General Practitioners
- 50 Fidelio
- 51 Dr Alan Bosley

List of further written evidence

The following written submissions were received after the publication of *Modernising Medical Careers: Written evidence*, HC 25–II, Session 2007–08. They are reproduced with the Oral evidence in Volume III of this Report.

- 1 Department of Health (MMC 01A)
- 2 Postgraduate Medical Education and Training Board (MMC 27A)
- 3 British Medical Association (MMC 35A)
- 4 NHS Employers (MMC 45A)
- 5 Work Psychology Partnership (MMC 52)
- 6 Dr Graham Winyard (MMC 53)
- 7 Dr Jack Dummer (MMC 54)
- 8 British Association of Physicians of Indian Origin (BAPIO) (MMC 55)
- 9 Professor Dame Carol Black (MMC 56)
- 10 Professor Dame Carol Black (MMC 56A)
- 11 Conference of Postgraduate Medical Deans (COPMeD) (MMC 57)
- 12 Methods Consulting (MMC 58)
- 13 Foreign & Commonwealth Office (MMC 59)
- 14 Home Office (MMC 60)
- 15 Professor Sir John Tooke (MMC 61)
- 16 NHS Education for Scotland (MMC 62)

Reports from the Health Committee

The following reports have been produced by the Committee in this Parliament. The reference number of the Government's response to the Report is printed in brackets after the HC printing number.

Session 2007–08

First Report	National Institute for Health and Clinical Excellence	HC 27 (Cm 7331)
Second Report	Work of the Committee 2007	HC 337

Session 2006–07

First Report	NHS Deficits	HC 73 (Cm 7028)
Second Report	Work of the Committee 2005–06	HC 297
Third Report	Patient and Public Involvement in the NHS	HC 278 (Cm 7128)
Fourth Report	Workforce Planning	HC 171 (Cm 7085)
Fifth Report	Audiology Services	HC 392 (Cm 7140)
Sixth Report	The Electronic Patient Record	HC 422 (Cm 7264)

Session 2005–06

First Report	Smoking in Public Places	HC 436 (Cm 6769)
Second Report	Changes to Primary Care Trusts	HC 646 (Cm 6760)
Third Report	NHS Charges	HC 815 (Cm 6922)
Fourth Report	Independent Sector Treatment Centres	HC 934 (Cm 6930)

The following reports have been produced by the Committee in the 2001–05 Parliament.

Session 2004–05

First Report	The Work of the Health Committee	HC 284
Second Report	The Prevention of Thromboembolism in Hospitalised Patients	HC 99 (Cm 6635)
Third Report	HIV/AIDS and Sexual Health	HC 252 (Cm 6649)
Fourth Report	The Influence of the Pharmaceutical Industry	HC 42 (Cm 6655)
Fifth Report	The Use of New Medical Technologies within the NHS	HC 398 (Cm 6656)
Sixth Report	NHS Continuing Care	HC 399 (Cm 6650)

Session 2003–04

First Report	The Work of the Health Committee	HC 95
Second Report	Elder Abuse	HC 111 (Cm 6270)
Third Report	Obesity	HC 23 (Cm 6438)
Fourth Report	Palliative Care	HC 454 (Cm 6327)
Fifth Report	GP Out-of-Hours Services	HC 697 (Cm 6352)
Sixth Report	The Provision of Allergy Services	HC 696 (Cm 6433)

Session 2002–03

First Report	The Work of the Health Committee	HC 261
Second Report	Foundation Trusts	HC 395 (Cm 5876)
Third Report	Sexual Health	HC 69 (Cm 5959)
Fourth Report	Provision of Maternity Services	HC 464 (Cm 6140)
Fifth Report	The Control of Entry Regulations and Retail Pharmacy Services in the UK	HC 571 (Cm 5896)
Sixth Report	The Victoria Climbié Inquiry Report	HC 570 (Cm 5992)
Seventh Report	Patient and Public Involvement in the NHS	HC 697 (Cm 6005)
Eight Report	Inequalities in Access to Maternity Services	HC 696 (Cm 6140)
Ninth Report	Choice in Maternity Services	HC 796 (Cm 6140)

Session 2001–02

First Report	The Role of the Private Sector in the NHS	HC 308 (Cm 5567)
Second Report	National Institute for Clinical Excellence	HC 515 (Cm 5611)
Third Report	Delayed Discharges	HC 617 (Cm 5645)