

## ASPIRING TO EXCELLENCE – FINDINGS AND RECOMMENDATIONS OF THE INDEPENDENT INQUIRY INTO MODERNISING MEDICAL CAREERS LED BY PROFESSOR SIR JOHN TOOKE

### Introduction

The Tooke Report was published on 8 October 2007. It is an interim report, published with conclusions and draft recommendations, reproduced below. The Inquiry Team will be meeting with interested parties in all four countries to receive feedback comment during October and November, and the Final Report and Recommendations will be published in December. The Report covers a wide range of topics, not just those relating to the immediate situation that precipitated the Inquiry. The implementation of Modernising Medical Careers (MMC), Foundation Schools, relations with universities, workforce planning, regulation and the structure of postgraduate medical education are covered.

### Recommendation 1

The principles underpinning postgraduate medical education and training should be redefined and reasserted, building on those originally articulated in 'Unfinished Business' but in particular emphasising flexibility and an aspiration to excellence. In devising policy objectives the interdependency of educational, workforce and service policies must be recognised.

### Recommendation 2

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

### Recommendation 3

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

### Recommendation 4

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

### Recommendation 5

There needs to be a common shared understanding of the roles of the doctor in the contemporary healthcare team. Such clarity must extend to the service contribution of the doctor in training, the certificated specialist, the GP and the consultant. Such issues need to be urgently considered by key stakeholders and public consensus reached before the end of 2008. Education and training need to support the development of the redefined roles.

### Recommendation 6

DH should strengthen policy development, implementation, and governance for medical education, training, and workforce issues, embracing strong project management principles and addressing specifically a) clearer roles and responsibilities for a single Senior Responsible Officer, b) clear roles and accountability for senior DH members, c) better documentation of key decisions on policy objectives and key policy choices, d) faster escalation and resolution of 'red risks'.

### Recommendation 7

The introduction of necessary changes stemming from this report should i) involve all relevant stakeholders especially professional representatives, ii) abide by best principles of project and change management include trialling where appropriate and feasible, iii) be subject to rigorous monitoring and evaluation.

### Recommendation 8

Recognising the interdependency of education, clinical service and research DH should strengthen its links not only within the Department and with NHS providers but also with other Government Departments, particularly the Department for Innovation, Universities and Skills and the Department of Business, Enterprise and Regulatory Reform. Ministers should receive annual progress reports on the development and functioning of such links.

### Recommendation 9

At a local level Trusts, Universities and the SHA 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.

### Recommendation 10

All four Departments of Health in the UK and the four Chief Medical Officers must be involved in any moves to change medical career structures. In many instances it seems likely that the Department of Health in England will continue to have a lead role but from time to time, collective agreement may determine that lead responsibility for specific issues passes to another Health Department and/or its Chief Medical Officer. Regardless of which Department leads, accountability should be explicit and every effort made to acknowledge the views of the four countries.

### Recommendation 12

DH Workforce should urgently review its medical workforce advisory machinery to ensure that it receives integrated and independent advice on medical workforce issues to inform/complement SHA and local deliberations. Both national and devolved workstreams must be adequately resourced. The medical workforce advisory machinery should also take account of national policies impacting on the workforce such as the shift of more care to the community. Revisions to the current arrangements need to reflect the following principles:

Medical workforce planning needs to embrace the consensus view of the role of the doctor referred to in Recommendation 5.

Plans should be based on robust information on available and projected medical specialist skills, requiring relevant databases.

Whilst recognising that doctors are just one part of the workforce, sufficient attention and resource need to be devoted to medical workforce planning reflecting doctors' crucial roles and the expense involved in their development.

A national perspective needs to be integrated with regional requirements, particularly with regard to the maintenance of sufficient subspecialty expertise to meet the needs of the nation, and the overall health of clinical academia.

Consideration should be given to the creation of an arm's length body, a National Institute for Health Education, NIHE, mirroring NIHR to undertake commissioning of higher specialist training that is not required in every locality. The criteria for the award of such training positions should reflect the Trust's performance in relation to training, innovation and clinical outcomes.

Professional advice to the medical workforce advisory machinery needs to include that from doctors at the cutting edge of their discipline with the foresight to project potential developments in healthcare.

Regional workforce plans should be subject to a national oversight and scrutiny advisory committee with service, professional and employer representation. Such oversight should encourage local responsiveness and acknowledge issues facing the devolved administrations whilst ensuring national consistency on roles and standards.

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

### Recommendation 13

The Panel recommends that DH should work with the GMC to create robust databases that hold information on the registered/certificated status of all doctors practising in the UK. This will provide an inventory of the contemporary skill base and number of trained specialists/subspecialists in the workforce as well as those in training for such positions to inform workforce planning.

### Recommendation 14

The content of higher specialty training and the numbers of positions will be informed by dialogue between the Colleges, employers, and medical workforce advisory machinery to allow finer tuning of the nature of the specialist workforce to reflect rapidly evolving technical advances and the locus of care.

### Recommendation 15

Explicit policies should be urgently developed and implemented to manage the transitional 'bulge', caused by the integration of eligible doctors into the new scheme, with appropriate credit for prior competency assessed experience.

### Recommendation 16

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

### Recommendation 17

Career aspirations and choices should be informed by accurate data on likely employment prospects in all branches of the profession and the likely competition ratios based on historical data, supplemented by professionally agreed foresight projections. Such information should be updated annually by the redesigned medical workforce advisory machinery and made publicly available so as to inform would be medical students, students and trainees. Medical schools should play a greater role in careers advice including i) information in prospectuses concerning career destinations and likely competition ratios, ii) offering selective components of the programme to allow experience in discrete specialties, iii) formal personalised advice/mentoring.

### Recommendation 18

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

### Recommendation 19

There should be enhanced opportunities for training in medical management during postgraduate training years to fuel an increase in clinically qualified managers and an awareness of the interdependency of clinicians and managers in the pursuit of optimal healthcare.

Agree	Disagree	Caveat

### Recommendation 20

Doctors in training should be better represented in the management structures of Trusts to ensure that they better understand service pressures and priorities and Trusts better appreciate their service role and training needs.

Agree	Disagree	Caveat

### Recommendation 21

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

Agree	Disagree	Caveat
Comment		

### Recommendation 22

Recognising i) the importance of linking workforce supply and demand, ii) the very recent devolution of workforce commissioning function to SHAs in England, we recommend that this situation prevails for the moment for initial Postgraduate Medical Training subject to the forging of closer links at all levels with the Higher Education sector. A formal review of the compliance with Service Level Agreements between DH and the SHAs relating to commissioning training and the functionality of the arrangements should be undertaken in 2008/9. Any deficiencies should prompt urgent consideration of a National Institute for Health Education (as outlined in Recommendation 12) assuming the commissioning function.

### Recommendation 23

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

### Recommendation 24

The Medical Postgraduate Deanery function in England should be formally reviewed to address whether i) the relationships and accountabilities are currently optimal ii) the present arrangements meet redefined policy objectives of optimal flexibility in postgraduate training and aspiration to excellence, and the NHS imperative of equity of access. Any new arrangements should conform to redefined principles, referred to in Recommendation 1, co-developed to govern postgraduate training.

### Recommendation 25

Postgraduate Medical Deans should have strong accountability links to medical schools as well as SHAs in line with Follett appraisal guidelines for clinicians with major academic responsibilities. Such arrangements will improve links with medical pedagogical expertise and will facilitate the educational continuum from student to continuing professional development.

### Recommendation 26

Reflecting the fact that Postgraduate Medical Education and Training involves service, academic and workforce dimensions, it is proposed that the Foundation School concept be developed further as Graduate Schools, on a trial basis initially, where supported locally. The characteristics of such Schools, the precise nature of which would depend upon local circumstances and relationships, need to reflect the crucial interface function played by the medical Postgraduate Deanery between the service, the profession, academia and workforce planning/commissioning. Graduate Schools would involve Postgraduate Deans, Medical Schools, Clinical Tutors, Royal College and Specialist Society representatives and would have strong links to employers/service and SHAs. The Graduate Schools could also oversee the integrated career development of the trainee clinical academic/ manager (see Recommendation 41), as well as NIHR faculty.

### Recommendation 27

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

### Recommendation 28

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

### Recommendation 29

Training implications relating to revisions in postgraduate medical education and training need to be reflected in appropriate staff development as well as job plans and related resources. Compliance with these requirements should form part of the Core Standards.

Agree	Disagree	Caveat
Comment		

### Recommendation 30

PMETB should be assimilated in a regulatory structure within GMC that oversees the continuum of undergraduate and postgraduate medical education and training, continuing professional development, quality assurance and enhancement. The greater resources of the GMC would ensure that the improvements that are needed in postgraduate medical education will be achieved more swiftly and efficiently. To this end the assimilation should occur as quickly as possible.

Agree	Disagree	Caveat

### Recommendation 31

Under the Medical Act, Universities already have responsibility with regard to FY1. By breaking the linkage with FY2, it will be possible to guarantee an FY1 position in the new graduate's local Foundation School subject to prevailing local selection processes. The linkage between FY1 and FY2 should cease for 2009 graduates.

Agree	Disagree	Caveat

**Recommendation 32**

FY1 should be reviewed to ensure that i) harmonisation with year 5 is optimised; ii) the curriculum more clearly embraces the principles of chronic disease management as well as acute care; iii) competency assessments are standardised and robust. In future, doctors in this role should be called Pre-Registration Doctors.

Agree	Disagree	Caveat

**Recommendation 33**

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

Agree	Disagree	Caveat

**Recommendation 34**

At the end of FY1 doctors will be selected into one of a small number of broad based specialty stems: e.g. medical disciplines, surgical disciplines, family medicine, etc. During transition, 'run-through' training could be made available after the first year of Core, for certain specialties and/or geographies that are less popular than others. Core Specialty Training will typically take three years and will evolve with time to encompass six six month positions. Care will be taken during transition to ensure the curricula already agreed with PMETB are delivered and the appropriate knowledge, skills, attitudes and behaviours are acquired in an appropriately supervised environment.

Agree	Disagree	Caveat

**Recommendation 35**

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

Agree	Disagree	Caveat

**Recommendation 36**

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

Agree	Disagree	Caveat

**Recommendation 37**

Satisfactory completion of assessments of knowledge, skills, attitudes and behaviours will allow eligibility for i selection into Trust Registrar positions\* in the relevant area or ii selection into Higher Specialist Training. Doctors in Higher Specialist Training will be known as Specialist Registrars, those selected into General Practice specialty training will be known as GP Registrars (equivalent to ST3 and beyond).

**Recommendation 38**

The newly named Trust Registrar position\* (formerly termed Staff Grade) must be destigmatised and contract negotiations rapidly concluded. The advantages of the grade (accrual of experience in chosen area of practice, consistent team

environment) need to be made clear. Trust Registrars should have access to training and CPD opportunities. They should be eligible for a reasonable limited number of applications to Higher Specialist Training positions according to the normal mechanisms and also to acquisition of CESR through the Article 14 route.

#### **Recommendation 39**

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

#### **Recommendation 40**

Selection into Higher Specialist Training to the role of Specialist Registrar will be informed by the Royal Colleges working in partnership with the Regulator. The Panel proposes that in due course this will involve assessment of relevant knowledge, skills and aptitudes administered several times a year via National Assessment Centres introduced on a trial basis for highly competitive specialties in the first instance. A limited number of opportunities to repeat the National Assessment Centre tests following further experience will be determined. Candidates will apply via Postgraduate Deaneries or Graduate Schools. Application will take place three times a year on agreed dates. Save in the most exceptional of circumstances, candidates will be restricted in the number of local programmes to which they may apply (and to the number of occasions on which they may apply). They will use a common national form with specialty specific questions and will provide their standardised assessment score/ranking along with a structured CV. This will avoid the once a year appointment system with its inherent risks to service delivery. Graduate Schools linked to the 30 UK Medical Schools would reduce the size of Units of Application and address the family-unfriendly situations that arose therefrom. Shortlisted candidates will be subject to a structured interview for final selection.

#### **Recommendation 41**

The current Academic Clinical Fellowships in England allowing c25% of programme time for research methodology training and development of research proposals should be integrated with Core Specialty Training. There will be a need to ensure that those entering an academic training path in the devolved nations are not disadvantaged when moving between research and clinical activities. Opportunities equivalent to ACFs should be competitively available for those wishing to develop educational, management, and public and global health skills, subject to available resource, through modular Masters programmes.

#### **Recommendation 42**

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

#### **Recommendation 43**

Successful completion of Higher Specialty Training as confirmed by assessments of knowledge, skills and behaviours will lead to a CCT. Higher specialist exams, where appropriate, administered by the Royal Colleges, may be used to test experience and broader knowledge of the specialty and allow for credentialing of subspecialty expertise gained post CCT and aid selection to consultant positions.

#### **Recommendation 44**

To be eligible for a Consultant Senior Lecturer appointment, the applicant should possess a CCT in the relevant specialty area. Higher specialist College exams could be tailored to limited subspecialty expertise, recognising the narrower scope of practice that some clinical academics may need to embrace.

#### **Recommendation 45**

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