Aspiring to Excellence- Scottish Government Consultation on Professor Sir John Tooke's Recommendations

Analysis of Consultation Responses

June 2008

Acknowledgements

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Executive Summary

Professor Sir John Tooke published his report on Modernising Medical Careers (MMC) "Aspiring to Excellence" on 8 January 2008. This report suggests a reworking of many aspects of postgraduate medical education (PGME) and contains detailed recommendations (full details available at www.mmcinquiry.org.uk). In Scotland, the Scottish Government recognise that some of the recommendations made by Sir John will need further discussion on a UK basis.

In January 2008 the Scottish Government issued the consultation paper *Aspiring to Excellence- Scottish Government Consultation on Professor Sir John Tooke's Recommendations* to consultees and stakeholders as part of the process of taking this discussion forward. Respondents were asked to comment on a range of issues and proposals. The nature of these issues, and a summary of the responses received, are given in the following sections.

Governance

Whether the governance arrangements within the MMC organisational structure in Scotland are sufficiently robust?
What work can be done by Scotland at UK level to meet the recommendation made by Sir Tooke to "Redefine and reassert principles underpinning postgraduate medical education" to ensure UK consistency, where appropriate?
Suggestions of other work to improve the organisational structure of postgraduate medical education and the career framework in Scotland?

- Ten respondents expressed the view that the governance arrangements in Scotland were sufficiently robust. In contrast, eight expressed the view that they were not. Many respondents, including those who answered positively, made suggestions as to improvements that could be made to the governance arrangements. The two issues that were most frequently raised in this respect were communication and representation. A number of respondents thought that communication within the governance arrangements needed to be significantly improved, whilst a number of respondents made suggestions as to whom they believed should be better represented within these arrangements.

- A commonly expressed view by respondents was that consistency at UK level was required in PGME so as not to reduce opportunities for trainees or to risk the movement of trainees within the UK.

The role of the doctor

Whether the role of the doctor needs reviewed; the role taken by doctors in service delivery during training; whether all services need a judgement safe/ unsupervised doctor; and the approach towards defining the role of a trained doctor taken by the Scottish Government.

- All respondents who answered this question agreed that there was a need to review the role of the doctor before it would be possible to move to a

healthcare system delivered by trained doctors, although a number of respondents stressed the urgency of this work.

- A majority of those who responded to this question, eighteen respondents, disagreed with the proposal that doctors in training should be "*supernumerary to service requirement*", arguing that service provision was in fact central to training.

- A majority of respondents agreed that a 'judgment safe'/ 'unsupervised' doctor was needed for all services, although a number questioned these actual concepts.

- The majority of respondents agreed with the Scottish Government's approach towards defining the role of a trained doctor.

Medical workforce planning

Who should determine medical training numbers in Scotland?
Whether Scotland should be trying to align the number of training places with the number of trained doctors required by National Health Service (NHS) Scotland?

- The majority of respondents agreed that it was appropriate for the Scottish Government to determine the level of controlled medical training numbers.

- There was no consensus with respect to whether Scotland should try to align the number of training places with the number of trained doctors required by NHS Scotland, with a range of views being expressed.

Role of the Scottish Advisory Committee on the Medical Workforce

Whether the remaining roles of the Scottish Advisory Committee on Medical Workforce (SACMW) could be remitted to NHS Boards?

- A majority of respondents disagreed with the suggestion that the remaining roles of the Scottish Advisory Committee on the Medical Workforce could be remitted to NHS Boards, with a number of respondents stressing the importance of central scrutiny and/or national responsibility for these posts.

Commissioning and management of PGME

Whether the development of Directors of Medical Education (DMEs) and flexibilities around regional arrangements will add value and clarity to responsibilities for postgraduate medical education at service level?
The proposed role for NHS Education for Scotland (NES).

- The majority of respondents agreed that the development of DMEs and flexibilities around regional arrangements will add value and clarity to responsibilities for postgraduate medical education at service level.

- The majority of respondents expressed support for the proposed role of NES.

Streamlining regulation

The proposed merging of the General Medical Council (GMC) and the Postgraduate Medical Education Training Board (PMETB).

The majority view was in favour of merging the GMC and PMETB but some concerns were expressed about this.

The structure of PGME

Changes to the structure of postgraduate medical training whilst further discussions are ongoing.

The majority of respondents agreed with the proposal that changes to the structure of postgraduate medical training should await further discussion on the future shape of the medical workforce and that change should be minimised until that is clearer.

GP Training

The length of general practice training.

A majority of respondents agreed with RCGP's proposal to work towards an extension of mandatory training for GPs from 3 years to 5 years. The view was expressed that changes to the complexity of GP practice in recent years necessitated such an extension to this training period

Equality issues

The implications of all proposals for equality groups.

Most respondents did not feel that the proposals would raise specific issues for equality groups.

Background

Professor Sir John Tooke published his report on Modernising Medical Careers (MMC) "Aspiring to Excellence" on 8 January 2008. This report suggested a reworking of many aspects of postgraduate medical education (PGME) and contained detailed recommendations (full details available at www.mmcinquiry.org.uk).

Modernising Medical Careers (MMC) is the UK-wide long-term programme of action to transform the medical workforce through redesign of postgraduate medical education (PGME). The main objective ultimately is to improve patient experience by improving PGME and thus ensuring that those completing postgraduate programmes are better prepared to work as trained doctors in the modern NHS. The MMC approach is competency based and programmatic.

In Scotland, the Scottish Government recognise that some of the recommendations made by Sir John will need further discussion on a UK basis. In this respect, in 2008 the Scottish Government issued the consultation paper *Aspiring to Excellence-Scottish Government Consultation on Professor Sir John Tooke's Recommendations* to consultees and stakeholders as part of the process of taking this discussion forward, as well as making this paper available on the Scottish Government's website. A list of the consultees and stakeholders to whom this paper was distributed can be found in **Annex A**.

This paper focused on the actions the Scottish Government are taking forward in Scotland. The main sections outline the Scottish Government's views and planned work being taken forward. Each section had a set of questions to which consultees and stakeholders were invited to respond. Respondents were asked to provide their views on:

- whether the governance arrangements within the MMC organisational structure in Scotland are sufficiently robust
- the work that can be done by Scotland at UK level to meet the recommendation made by Sir Tooke to "*Redefine and reassert principles underpinning postgraduate medical education*" to ensure UK consistency, where appropriate
- suggestions of other work to improve the organisational structure of postgraduate medical education and the career framework in Scotland
- the role of the doctor: whether this needs reviewed; the role taken by doctors in service delivery during training; whether all services need a judgement safe/ unsupervised doctor; and the approach towards defining the role of a trained doctor taken by the Scottish Government
- who should determine medical training numbers in Scotland
- whether Scotland should be trying to align the number of training places with the number of trained doctors required by NHS (National Health Service) Scotland
- whether the remaining roles of the Scottish Advisory Committee on Medical Workforce (SACMW) could be remitted to NHS Boards

- whether the development of Directors of Medical Education (DME) and flexibilities around regional arrangements will add value and clarity to responsibilities for postgraduate medical education at service level
- the proposed role for NHS Education for Scotland (NES)
- the merging of the General Medical Council (GMC) and the Postgraduate Medical Education Training Board (PGMET)
- changes to the structure of postgraduate medical training whilst further discussions are ongoing
- the length of general practice training
- the implications of all proposals for equality groups

A total of 19 questions were in included in the consultation paper. A response form was provided to assist consultees in responding to the paper. The following report constitutes an analysis of responses received to *Aspiring to Excellence- Scottish Government Consultation on Professor Sir John Tooke's Recommendation*.

A copy of the consultation paper is available at the following link: www.scotland.gov.uk/Publications/2008/01/07144119/0

Responses

A total of thirty-one responses were received to the consultation paper *Aspiring to Excellence- Scottish Government Consultation on Professor Sir John Tooke's Recommendations*. Of these responses, twenty-six were received from organisations, whilst five were received from individuals.

Ten respondents, roughly a third of those responding, answered all questions posed in the consultation paper. Questions 4,5,6,7,8,11,12,13,16 were the questions most frequently answered, each being answered by either twenty-four or twenty-five respondents. In contrast questions 10 and 19, both relatively broad questions asking for further comments, received the least number of responses- sixteen and twelve responses respectively.

For many questions a number of respondents made comments rather than giving a direct expression of agreement or disagreement. For this reason the number of respondents agreeing with a question added to the number of respondents disagreeing with a question may not total with the number of respondents who replied to the question.

Only two organisations requested that their response be treated in confidence. However, thirteen organisations and individuals did not make their preferences clear in this respect. Their responses have, therefore, been treated in confidence by default. In the following analysis, unattributed views will be those of organisations or individuals whose response has been treated in confidence.

A full list of all organisations who submitted a response is provided in **Annex B**. All non-confidential responses can be found on the Scottish Government website at www.scotland.gov.uk and in hard copy available from the Scottish Government Information & Library Service, Saughton House, Broomhouse Drive, Edinburgh EH11 3XD.

The analysis

The following analysis provides an overview of the range of comments received in response to each question. The consultation process was designed to give a wide range of interested parties an opportunity to submit their views. However, the process was not designed to achieve a representative sample of respondents, and the analysis has to be seen in that context.

Views of respondents

Governance and organisational arrangements

The consultation paper *Aspiring to Excellence- Scottish Government Consultation on Professor Sir John Tooke's Recommendations*, set out MMC governance arrangements in Scotland, including the role and relationship between the two new Scottish boards, the Specialty Training Programme Board (STPB) and the Selection and Recruitment Delivery Board (SRDB). Views were sought in relation to 3 relevant questions. Full details of these can be found in the consultation paper (available from the Scottish Government website www.scotland.gov.uk).

Question 1: In your view, are the current governance arrangements sufficiently robust? What further structures and actions, if any, should be taken to improve governance arrangements in Scotland?

Twenty-three respondents provided a response to this question. Of these, ten agreed that the governance arrangements were sufficiently robust. A further five gave what can be described as a 'mixed' response, making positive comments but also highlighting areas where they thought that further improvements were required. Eight of those who responded to this question felt that the governance arrangements were not sufficiently robust. These respondents did not give a single reason for expressing this view, but rather highlighted a number of structures and actions which could improve the governance arrangements.

A wide range of views were expressed by respondents in terms of structures and actions that could improve governance arrangements in Scotland. The two issues that were most prominent in this respect were 'communication' and 'representation/input'. A view which was frequently expressed was that communication needed to be improved at all levels within the current governance arrangements. To give one example, in their response *NHS Highland* argued that there was currently a lack of adequate "*communication between SHHD* [now Scottish Government Health Directorates, SGHD]*, the Performance Board, the SDRB, the Deaneries and the actual NHS Boards*". Similar arguments were made by other respondents regarding various other aspects of the governance arrangements.

The issue of a lack of representation or input was another issue that was frequently raised by respondents. In this respect it was argued that:

- there is a lack of academic representation in the Programme and Delivery Boards (British Medical Association Scotland, BMA Scotland)
- the Scottish Academy Trainees Group should be represented on the STPB (Academy of Medical Royal Colleges & Faculties in Scotland, AoMRC Scotland)
- there needs to be broad speciality and regional representation on the STPB (Scottish Standing Committee of Association of Anaesthetists of Great Britain and Ireland, SSC AAGBI)
- more input is required from NHS Boards (NHS Highland)

- membership of the SRDB should incorporate greater professional involvement at speciality level (The Royal College of Physicians of Edinburgh, RCPE; Royal College of Anaesthetists RCoA)
- more representation is required from relevant trainee groups/bodies (Royal College of Physicians and Surgeons of Glasgow, RCPSG; Royal College of Physicians and Surgeons of Glasgow Trainees' Committee, RCPSG Trainees Committee)
- more public input is required (Scottish Health Campaigns Network, SHCN)
- there should be an HR Director (e.g. the chair of the MMC HR group) to strengthen service representation on the STPB[1];

In addition to the issues of communication and representation, respondents made a wide range of other comments and suggestions. These included that:

- coordination between the four nations needs to be improved (University of Edinburgh, U of E, AoMRC Scotland);
- there is a need for more consistency between the Speciality Boards (BMA Scotland);
- the position of the MMC HR Subgroup in relation to other structures needs to be clarified (BMA Scotland);
- rather than having each board co-chaired, one senior accountable officer, this being the chief medical officer, should be in charge;
- the significance and role of the Speciality Training Boards is unclear;
- Speciality Boards' creation of sub-groups, "*which has started taking decisions away from the main board*", is "*unacceptable*" (BMA Scotland);
- regional groups which have both NES and NHS staff as members should be formally linked to the STPB and SRDB;
- more information is required about how the SRDB will engage with Speciality Training Boards, Scottish Academy Colleges, or other stakeholders at speciality level;
- the Scottish Academy of the Royal Colleges risks a Scottish bias by value of its resident colleges;
- links with NHS Boards need to be improved (NoSPG, North of Scotland Planning Group);
- "*regional groups are needed to 'operationalise' the strategic policy*" (NHS Dumfries & Galloway)
- It is unclear how STPB link to Scottish Government workforce planning;

One respondent felt that the governance arrangements were unnecessarily complex and should be simplified, whilst a couple of respondents felt that the governance arrangements should be kept under review (NES).

Question 2: What are your views on what can be done by Scotland at UK level to meet the recommendation made by Sir Tooke to "Redefine and reassert principles underpinning postgraduate medical education" to ensure UK consistency where appropriate?

[1] Unattributed views express the perspective of respondents whose answers have been treated in confidence. For more details please refer to the Responses section above.

Twenty-three respondents answered this question. A view frequently expressed by respondents was that consistency is required across the UK. One respondent noted that the "*Programme Board in England defined a set of Principles, reproduced at p.9 of the Secretary of State for Health's response to 'Tooke'*", and expressed their support for these (UoE). Another respondent expressed their endorsement of the key principles of MMC originally agreed by the four departments of health in 2003 (NES). One respondent argued that current principles are primarily the result of English views, and would benefit from additional discussion between NHS Scotland and the Scottish Colleges. Another respondent noted that the "*structure and cooperative working relationships within the Scottish Speciality Training Boards is a particular example of good practice that may inform the development of Medical Education England*" (RCoA). One respondent emphasised that steps should be taken to ensure that Scotland is adequately represented on all relevant UK bodies.

A concern expressed by a number of respondents was that any lack of consistency across the UK would lead to a reduction in opportunities for trainees, with movement being threatened. Some speciality bodies emphasised that their speciality needed to be regarded as UK-wide "*and therefore training programmes and selection to training programmes need to be harmonised on a UK basis*" (Royal College of Paediatrics and Child Health Scotland, RCPCH Scotland).

Respondents also took this opportunity to make a range of other comments. In this respect it was suggested that:

- clarity is required with respect to a Certificate of Completion of Training;
- many services in hospital would benefit from a doctor trained to 4-5 years post qualification, capable of delivering front line care in high volume emergency services. Such doctors would benefit from an accreditation system that would ensure their skills were transferable;
- inflexibility in run-through training needs to be corrected but without forcing trainees to make career choices before they are ready;
- the recommendation for the abandonment of Foundation Year 2 is precipitous;
- if run through training is continued in Scotland but not elsewhere in the UK, speciality training opportunities will need to be matched to core training output;
- the resourcing and funding of training a specialist is not currently fully recognised- an Additional Cost of Training funding line should be produced;
- NES should be recommended as a model for England and Wales (NHS Highland, NoSPG).

Question 3: What other work do you think should be undertaken in Scotland to improve i) the organisational structure of postgraduate medical education? and ii) the career framework, in Scotland?

Twenty two respondents answered this question. Some respondents made reference to the review of governance undertaken by NES, either expressing their

support for this or arguing that further comments should await its publication. Some respondents took this opportunity to emphasise that they believed that a period of stability was now required, allowing the recent changes time to bed in before any further changes were introduced.

One respondent suggested that if the organisational structure is to be focused more on a specialty basis and less on geographical deaneries, then account needs to be "*taken of the need for geographical stability for trainees*". Further, this respondent expressed the view that in most specialties it should be possible for training to be delivered within a single deanery (BMA Scotland). Another respondent commented that there "*needs to be a clearer definition of the role of the 7 Specialty Training Boards and their relationship with Deaneries, NES and recruitment teams*" (Ninewells Hospital & Medical School). One respondent thought that in order to ensure that local provision is given appropriate priority a senior board member given specific responsibility for postgraduate medical education within each provider health board should be appointed. Another respondent suggested that the "*organisational structure could be improved by instituting a 'faculty'/institute forum incorporating Colleges, deaneries, universities, workforce planners...that would bridge an important gap between education and service planning/policy and also by the identification and funding of the Additional Cost of Training*" (RCSEd). Another respondent expressed the view that the current consultation process on governance needed to enshrine the roles of the Royall Colleges, Deaneries, Medical Schools and NES.

One respondent suggested that arrangements need to be instigated to minimise the disruption caused to NHS Boards by the movement of trainees at short notice.

One respondent suggested that there is a need to rewrite the PMETB curricula to take account of workforce need. Another respondent suggested that, following Tooke's recommendations, longer generic training was required before a choice of specialty is made (Dumfries and Galloway Royal Infirmary).

Some respondents focused on the need to make changes to ensure that training is given appropriate priority. Suggestions in this respect included giving greater recognition to training in consultant job plans; appointing an individual with board level responsibility for training and introducing "*quality markers of training that are given similar priority to other targets*" (AoMRC Scotland). Another respondent contended in this respect that employers need to ensure that training, education and research supervision are regarded as key components of the specialist role, and not as "add-ons" for extra credit.

With respect to general practice, one respondent contended that achieving consistency will require GP training programme directors having responsibility for hospital placements as they do for general practice placements.

A number of respondents argued that further discussion of the career framework in Scotland should await work on reviewing the role of the doctor and/or NES's review of governance. In terms of those respondents who did advance their view of what work could improve the career framework in Scotland, a range of views were expressed, including the following:

- clarity is required on the role of the consultant grade and whether CCT holders will be employed as consultants (AoMRC Scotland);
- trainees should have more time to choose a career pathway (SSC AAGBI);
- there must be consistency across the UK in anaesthesia (SSC AAGBI)
- better careers advice, informed by workforce planning, is required at all levels;
- the training requirements of non-consultant grade doctors need to be considered (NHS Highland);
- debate regarding a consultant-led or a consultant-based service needs to be resolved (RCSEd);
- "*urgent discussion is required on 'uncoupling' in anaesthesia training and developing core training, particularly around the value of maintaining consistency across the UK*" (RCoA);
- work is required to address "*the bulge of trainees who will gain a CCT in 2011*" (RCoA);
- the "*service gaps resulting from EWTD 2009*" need to be quantified and addressed (RCoA);
- a clearly defined structure for Staff Grade posts is necessary;
- what the service means by specialists must be defined;
- a clearer link between service posts and opportunities for training needs to be established;
- any work undertaken to develop a career framework for the medical workforce needs to have strong service input through MSG;

Finally one respondent expressed the view that clarity is required "*around the possibility of decoupling, the length of GP training, the possibility of a sub-Consultant grade and an unequivocal message that the number of junior doctors in training will be reduced, to act as a spur to undertake the challenging and expensive process of redesigning rotas*" (NHS Dumfries and Galloway)

The Role of the Doctor

Sir John Tooke recommended that there is a need to more precisely define the varied roles of the doctor. The Scottish Government's view is that a more fundamental piece of work is required to define the different roles of the consultant, registered specialist, General Practitioner and doctor in training. Doctors should be trained to the level that allows them to meet patient needs of a certain degree of complexity, and models of service delivery should be built around patient needs, which is delivered by trained doctors rather than doctors in training.

The consultation paper noted that the Scottish Government planned to ask a multi-professional NHSScotland group, led by the service through the Scottish Association of Medical Directors (SAMD), supported by the Workforce Planning Unit in the Scottish Government Health Workforce Directorate (SGHWD) to begin this work in the first half of 2008. They will be asked to determine the basic building blocks that are required in a service delivered by trained doctors as part of multi-disciplinary delivery teams, and to develop a methodology that will allow local services to plan their medical workforce in that way. The group will engage stakeholders through a series of multi-professional workshops across the country.

Views were sought in response to a number of questions on this topic.

Question 4: Do you agree there is a need to review the role of the doctor before we can move to a healthcare system delivered by trained doctors?

Twenty-four respondents answered this question. All respondents who replied agreed on the need for the role of the doctor to be reviewed. One respondent expressed the view that this should be done not just in relation to the Tooke report but also in relation to the Temple Report. Some respondents noted, though, that work to define the role of the doctor should not delay changes from taking place. The view was expressed by a couple of respondents that work to define the role of the doctor could not be carried out separately from work to define the role of other health professionals (Scottish National Blood Transfusion Service, SNBTS; Royal College of Ophthalmologists (Scottish Affairs), RCoO (SA)). Another respondent emphasised that reviewing the role of the doctor should not be a reason for delaying the training of more specialists.

One respondent expressed the view that a trained doctor is not necessarily a consultant, whilst another argued that the difference between a consultant and a registered specialist needs to be clarified (North of Scotland Planning Group, NoSPG). One respondent thought that the "*boundaries of the work of the doctor in training should be defined by the curricula of individual Colleges where clear lines and levels of clinical supervision should be outlined depending on demonstrated competency*" (RCoA). Another respondent noted that:

"*Tooke's comments at section 4.4 of his interim report that the doctor's required capacity to 'appraise evidence and parallel process competing hypothesis' are 'grossly underestimated in any 'Skills Escalator' representation of role acquisition' are a noteworthy caution to any attempt to deconstruct the doctor's role into disseminable sections*" (RCPE).

One respondent queried the term 'trained doctor', asking how this distinction can be made within the context of a service that supports lifelong learning.

Question 5: Currently doctors in training are an integral part of service delivery. Do you consider that in future doctors in training should be largely 'supernumerary' to service requirement?

Twenty-five respondents answered this question. A majority, eighteen, of those who responded, disagreed with the proposal that doctors in training should be "*supernumerary to service requirement*". Four respondents expressed neither agreement nor disagreement but argued that a balance needed to be struck between the training needs of doctors on the one hand and having service delivery too dependent on doctors in training on the other. One such respondent contended that the "*service delivery component of doctors in training should be determined by the*

training requirement" (RCSEd). One respondent expressed direct agreement with the proposal.
Amongst those respondents who expressed disagreement, the central reason given was that service provision was an integral aspect of medical training, and that the two could not be divorced from each other. In other words medical training was, at least in part, experiential, and this experience was best obtained through service delivery. One respondent noted the significant workforce implications that could result if doctors in training were to become supernumerary (NHS Highland). However, many of the respondents who disagreed stressed that supervision, support and a managed education process were essential elements of training, whilst many respondents also stressed that the service needs to become less dependent on doctors in training.

One respondent suggested that:

"*There could be a role for a system of intense training 'modules', perhaps two months out of the year and rotating around trainees on a rota, where the trainee is supernumerary and so more free to focus on a dedicated area of learning*" (BMA Scotland).

Question 6: In your view do all services need a judgement safe/unsupervised doctor? If not, which services are the exceptions? How should we take discussions on this issue further?

Twenty-four respondents answered this question. A majority of those directly responding to this question, nine, agreed that all services need a judgement safe/ unsupervised doctor, with five respondents disagreeing. A number of respondents took issue, though, with the concept of 'judgement safe', arguing that this needs to be defined, particularly with respect to its relationship to the concept of a 'trained doctor' (NES). One respondent emphasised that "'*judgement-safe is not an absolute, and is context dependent*" (University of Edinburgh, UoE). One respondent offered their own definition in this respect:

"*Judgement-safe is the ability to make decisions in regard to patient's short and long-term care that will not adversely affect their health and wellbeing. This relies on core knowledge, the acquisition and delivery of skills appropriate to the speciality, and the insight to recognise shortcomings and deficiencies*" (BMA Scotland).

Two respondents emphasised that all doctors should in fact be judgement safe, with one arguing that "*one of the key professional responsibilities of a doctor is to recognise limitations and seek senior support where necessary. Clearly, the need for supervision declines with training and experience*" (RCPE). Further, this respondent emphasised that 'judgement safe' and 'unsupervised' needed to be recognised as different concepts.

Of those respondents who disagreed, a number gave examples of procedures they felt could be performed by individuals other than a judgement-safe/unsupervised doctor. These included routine ultra sound scanning, and endoscopy (individual

response); another respondent noted that a doctor may be safe to put in an intravenous line but not to perform surgery (Dumfries & Galloway Royal Infirmary). Other respondents focused on procedures that could be performed by health care professionals other than doctors, such as "*pre-admission assessment, endoscopy, intensive care, minor surgery and chronic disease managements*" (NoSPG).

One respondent argued that the competency based nature of the RCPCH training curriculum should make it "*possible to establish and therefore match the competences required for each service or part of a service and therefore establish whether a service or part of the service requires the need for a judgement safe/ unsupervised doctor*" (RCPCH Scotland). In this respondent's view, discussions "*require to be led by the SGHD but include Colleges, service and BMA representation*". Another respondent felt that the question itself was unclear "*we are not aware of any services that should be delivered without the input of an unsupervised doctor who has completed appropriate training. Within services however there are clear tasks which may be safely completed by doctors in training who have previously demonstrated supervised competence*" (NHS Dumfries and Galloway).

Question 7: Do you agree with our approach towards defining the role of a trained doctor? In your view, what other work should we be doing to improve definition of the role of the doctor and/or to improve medical workforce planning.

Twenty-four respondents answered this question. The majority of respondents who gave a direct response to this question, eight, agreed with the Scottish Government's approach towards defining the role of a trained doctor.

Two respondents argued that establishing the definition of the role of the doctor was necessary before any discussion could take place in terms of medical workforce planning. Again, a couple of respondents argued that, rather than just being focused on the doctor's role, this process should be about defining patient needs and, once these have been identified, establishing how a range of health professionals could meet these needs (NHS Highland; NoSPG).

Many respondents made suggestions with regard to whose views should be taken into account in the process of attempting to define the role of the doctor. Of those respondents who made suggestions in this respect, the role of medical royal colleges was frequently stressed. A couple of respondents argued that the views of the public should be taken into consideration and that there should be some lay representation in this process. Another respondent stressed that the discussions "*require to be led by the SGHD but include Colleges, service and BMA representation*" (RCPCH Scotland).

The BMA Scotland's response included a detailed discussion of its view of what the role of the doctor is, and detailed criticism of what it perceived as the possible underlying rationale for the introduction of a 'registered specialist', something which it believed had been mooted.

A number of respondents emphasised different factors which need to be taken into account in medical workforce planning. These included developments in technology, such as e-Health/ telehealth (NHS Highland), the needs of hospitals/ acute care in rural areas (Dumfries & Galloway Royal Infirmary; NHS Highland) and the retirement plans of those in post (AoMRC Scotland; NHS Highland; NoSPG). With respect to the latter, one respondent suggested that data held by colleges and speciality societies could usefully be drawn upon in this respect. One respondent argued that an international perspective needs to be brought into this planning process, from European Union, United States and Commonwealth countries (SNBTS).

One respondent emphasised that medical workforce planning needs to be "*flexible to accommodate unexpected increases in workload eg anti-VEGF treatments for macular degeneration*" (RCoO (SA)). Another respondent argued that in developing plans "*we would encourage the Scottish Government Health Directorates and NHS Scotland to look at the overall costs of care provided by particular providers rather than simply focusing on 'unit costs' (i.e. salary)*". In this respondent's view, the unit costs of consultants should be considered in relation to increased efficiency and decreased ancillary costs. "*We therefore consider that there should continue to be an expansion of consultants and GPs despite the more modest funding increases projected over the next few years*" (BMA Scotland). One respondent argued that "*local workforce planning needs to become more sophisticated and linked more clearly to trainee outputs*".

Finally one respondent argued against the whole approach of medical workforce planning, arguing that "*overall there is too much top down interfering with manpower planning and not enough attention paid to developing a market economy in medical graduates*" (SNBTS).

Medical Workforce Planning

The consultation paper *Aspiring to Excellence- Scottish Government Consultation on Professor Sir John Tooke's Recommendations* set out the Scottish Government's approach to medical workforce planning in the wake of the publication of the National Workforce Planning Framework for NHSScotland in 2005, and discussed recent changes that have taken place in this respect.

Undergraduate medical students

Further, the consultation paper set out recent trends in the setting of numbers of undergraduate medical students, as well as possible future developments in the context of comparisons with England and Australia.

Postgraduate medical training

Finally, the consolation paper noted that the Scottish Government's aim with respect to postgraduate medical training is to balance supply with NHS Board workforce demand. Developments in the area of postgraduate medical training were discussed along with issues of resources. These sections can be read in full in the consultation paper itself, available on the Scottish Government's website (www.scotland.gov.uk).

A number of questions sought views in relation to these issues.

Question 8: In your view do you consider it appropriate that the Scottish Government determines medical training numbers? If not, which other organisation/body would be more appropriate and why?

Twenty-four respondents answered this question. The majority of respondents to this question, twenty-three, agreed that it was appropriate for the Scottish Government to play this role of determining training numbers. One respondent disagreed.

The one respondent who disagreed with the proposal that the Scottish Government should determine the medical training numbers argued in favour of giving free rein to the market:

"*There should be a market of doctors and unemployment tolerated. There should only be intervention in shortage specialties*" (SNBTS).

Many of those who agreed with the proposal, however, also added provisos. Some respondents argued that planning should be undertaken at UK level (SSC AAGBI; AoMRC Scotland) with some respondents stressing this with respect to a particular speciality: "*paediatric subspecialty training…must be seen within a UK context*" (RCPCH).

Whilst endorsing the role of the Scottish Government, a number of respondents identified groups and bodies that they felt should have an input into this process. Included in this respect were the Royal Colleges, Specialty Societies/ Bodies, Specialty Training Boards, NES and ' the service' more generally, with one respondent stating that it "*would be appropriate that there is a body which reflects the views of Colleges, Deaneries, Medical Schools and the service to ensure that all stakeholders have a voice*" (RCoSEd).

Question 9: Please outline any suggestions you have to improve the process for determining the level of controlled medical training numbers.

Nineteen respondents answered this question. In answering this question, a number of respondents stressed factors that they felt needed to be taken into account in the medical workforce planning process. Issues identified in this respect included changes in technology, the impact of part-time working, the Working Time Directive and patient need. The most frequently identified issue was, though, retirement dates with one respondent suggesting that a national database linking NES data on trainees with payroll and other data could provide an important source of quantitative data.

Some respondents identified bodies and groups that they felt should have input into the planning process. Included in this respect were 'colleges and specialist societies', NES as well as the 'medical profession' more generally. One respondent argued more broadly that this process should be transparent with clear opportunities to participate (NES). One respondent argued that NHS Boards need to be more accurate and accountable for this process. One respondent commented that:

"*Determination of training numbers must take three criteria into account: definition of*

roles, clarity of patient need and finally stability- both in terms of the training programmes and impact on the service" (NoSPG)
Another respondent suggested that:

"*Health Boards need to have a common vision of the future, common workforce assumptions and a common template and guidance to allow them to reach a valid conclusion. The template and guidance should be determined based on the work of the multi-professional Scottish workforce group looking at the role of the doctor*".

Question 10: Do you have any further views or comments on postgraduate training in Scotland?

Sixteen respondents answered this question. There was little overlap in respondents' comments, with a wide range of different issues being raised. Responses included the following views that:

- decisions urgently need to be reached;
- the service needs of remote and rural communities need to be addressed (NES; NoSPG);
- "*there is now a lack of locums for Doctors in training who move between MMC interviews*" (Dumfries & Galloway Royal Infirmary);
- more emphasis needs to be placed on ensuring post-CCT opportunities (SSC AAGBI);
- individuals in the current "*bulge*" of graduates must not be disadvantaged because of this (BMA Scotland);
- non-medically qualified practitioners could be limiting junior doctors access to certain procedures (BMA Scotland);
- UK wide selection is required, particularly for popular specialties with high competition ratios (RCPE);
- equality, diversity and discrimination, both direct and indirect, should be issues that are integral to basic training (individual response);
- incremental changes works better than a 'big bang' (RCoSEd);
- uncoupling of CMT and HST is needed to ensure the most cost-effective use of training posts in dermatology;
- fair implementation of MMC requires effective selection mechanisms, particularly for the popular specialties with high competition ratios.

Finally, one respondent argued that considerable gaps could be identified in foundation doctors' clinical knowledge, this being ascribed to "*the uptake of problem based learning within university teaching rather than a structured progressive curriculum*". This respondent expressed the view that future consultants will have considerably less experiential learning: "[*c*]*urrently there is a feeling that the acquisition of knowledge and the development of judgement are areas of development which are significantly lacking*" (NHS Dumfries and Galloway).

Question 11: Historically Scotland has trained many more doctors than needed by NHSScotland at a senior level (Calman Review www.scotland.gov.uk/Publications/2005/06/2992339). In your view do you think that Scotland should be trying to align the number of training places with the number of trained doctors required by NHSScotland?

Twenty-four respondents answered this question. There was little unanimity in response with nine respondents agreeing and eight respondents disagreeing. Further, seven respondents gave what can be described as 'mixed' answers, offering comment but expressing neither direct agreement nor disagreement with the proposal.

Some respondents commented that a degree of flexibility should be retained within the system (Dumfries & Galloway Royal Infirmary; NoSPG) particularly with respect to "*the changing needs of the population*" (NHS Highland). A number of respondents argued that alignment of training places should take place at UK level rather than within Scotland (Ninewells Hospital & Medical School; NHS Highland).

Two respondents were concerned that alignment would lead to a lack of competition, which might result in "*mediocrity*" (NHS Dumfries and Galloway; SSC AAGBI).

Two respondents focused on Scotland's traditional role of training international students, discussing this in positive terms. One of these suggested that research should be undertaken to determine the number of international students that remain in Scotland for their professional career after training before any decision is taken. The other respondent expressed the view that the "*Scottish economy benefits from the export earnings of educational institutions (by means of student fees) as well as from the consumption of goods and services by those attending them*". Due to this, the "*Scottish Government should regard this as an export opportunity*" (UoE).

Finally, a couple of respondents focused on the importance of national and international movement of doctors, arguing that this was both positive and inevitable and that planning needs to take this into account. As one respondent put this, the "*medical workforce is a global workforce and it would be short-sighted not to take this into account*" (NoSPG).

Scottish Advisory Committee on the Medical Workforce (SACMW)

The consultation paper noted that SACMW has only two remaining roles, these being the approval of staff grade posts – the only posts subject to national control - and the regrading of Staff Grades to Associate Specialists. The Scottish Government recommended that the roles currently fulfilled by SACMW should be remitted to local NHS Boards with immediate effect. Further details of these roles are detailed in the consultation paper itself, available on the Scottish Government's website (www.scotland.gov.uk).

Question 12: Do you agree with our view that the remaining roles of the Scottish Advisory Committee on Medical Workforce could be remitted to NHS Boards?

Twenty-four respondents answered this question. A majority of respondents, thirteen, disagreed with this proposal, whilst nine respondents agreed. A number of these respondents stressed that they felt that there was requirement for central scrutiny and/or national responsibility for these posts. One respondent commented

that "*it makes no sense to have training posts under national control and the service posts not under national contro*l". One respondent contended that this would particularly be the case if the SAS (Staff and Associate Specialist) grade becomes the norm as without "*some central scrutiny the SGHD would not know the shape and size of its workforce*" (SSC AAGBI). A number of other comments were made. These included that:

- equal opportunity was more likely to be achieved at a Scottish rather than a local level;
- the SACMW's role should continue "*at least until there is explicit agreement on the shape and nature of the future medical workforce*" (RCoA);
- whilst SACMWs current role is "*outdated*" there "*should be some other body to carry out the functions described*" (RCoSEd);
- "*there continues to be a need for a mechanism for the appointment of associate specialists*";
- there "*is a very high and potentially extremely counterproductive likelihood of lack of coordination in the resulting process*" (RCSEd).

One respondent expressed the view that relaxing national controls might lead to a subsequent relaxing of eligibility criteria, this being detrimental to patient care. Further, this respondent contended that poor quality jobs outwith national terms and conditions of service may also be created; there would be a loss of "*national monitoring to ensure that appropriate doctors have been appointed at the appropriate level*". This respondent also noted that SACMW has an important role in ensuring "*that the creation of staff grade posts and associate specialist regradings are appropriate*" (BMA Scotland).

One respondent argued that the role of SACMW needs to "*be reviewed in light of changes to the role and purpose of non-consultant career grades*". Further its "*role in planning the NCCG* [Non-Consultant Career Grade] *workforce may be questionable or redundant under the employment arrangements that fall from the new SAS contract*" (NES). Finally, one respondent who was in support of the proposals commented that if the roles are remitted to NHS Boards then there should be "*some method of assessing Boards' use of these powers*" (NHS Dumfries and Galloway).

Commissioning and Management of Postgraduate Medical Education and Training

In the consultation paper the structures already in place, and in development, for commissioning and managing postgraduate medical education are set out, along with a number of questions. The details of the structures can be found in the consultation paper itself, available on the Scottish Government's website (www.scotland.gov.uk).

Question 13: Do you agree that the development of Directors of Medical Education and flexibilities around regional arrangements will add value and clarity to responsibilities for postgraduate medical education at service level?

Twenty-five respondents answered this question, with a majority of respondents, twenty-one, expressing agreement that the development of Directors of Medical Education (DMEs) and flexibilities around regional arrangements will add value and clarity to responsibilities for postgraduate medical education at service level.

The one respondent who expressed direct disagreed noted that it appeared "*clearly undesirable to have Directors for Medical Education for each of fourteen Health Boards*" and questioned whether "*the workforce* [could] *justify this number of posts and the overhead in terms of costs?*" (SNBTS).

Of the respondents who agreed, two contended that adequate funding would have to be in place for this post. One respondent voiced the concern that "*the DME would answer to the Medical Director. This may under-value the post…Consideration should be given to strengthening the role of the Postgraduate Dean*" (SSC AAGBI).

A couple of respondents made comments with respect to arrangements for the North of Scotland, whilst another respondent made more general reference to the importance of regional arrangements, with there being a "*strong regional dimension for how these responsibilities can be discharged*". The two respondents focusing on the north of Scotland stressed that a regional approach should be pursued in this area due to the size of health boards (NHS Highland; NoSPG).

Amongst other comments made, the view was expressed that:

- this "*could easily become a token job if not accountable for aspects of workforce planning*";
- "*clear time for training and priority for training are at least as important*" (AoMRC Scotland);
- "*training is a national or UK wide activity, and directors will need to take national factors into account and be flexible, ensuring that all specialist interests are integrated and adequately represented*";
- "*it is not yet proven that this should be a Board level appointment*" (NHS Dumfries and Galloway).

Question 14: What are you views on this role for NHS Education for Scotland, which is different from the organisation in the other UK countries?

Twenty-two respondents answered this question. The majority of respondents who replied to this question voiced their support for NES and the role outlined for it. Whilst endorsing this role, one respondent commented that "*discussions should also include the profession via the Scottish Academy*" (RCoA). One respondent, however, suggested that the Postgraduate Committee for Medical and Dental Education would be a more streamlined organisation to perform this role. Amongst other comments made were that:

- "*DME arrangements need to be tailored to meet the needs of NHS Scotland and indeed of particular health boards and their local education providers. The role should be flexible in its interpretation and capable of responding to changing demands*" (NES);

- "*a (Scottish) national approach will be overdue in this area*" (SNBTS)
- "*NES should be more pro-active in adjusting the numbers of training posts to meet anticipated workforce needs*";
- the "*DME should have accountability to NES in the first instance*" (SSC AAGBI)
- "*the North of Scotland Region needs to be a more prominent voice in the organisational development within NES*" (NHS Highland)
- the "*recommendation to merge the GMC and PMETB is partially supported*" (NHS Dumfries and Galloway)
- "*Colleges and service representatives are willing to contribute more in this area of education and training delivery*" (RCSEd)

One respondent expressed the view that "*there are currently a number of areas where the organisation of training…can occasionally conflict with the employment of trainee medical staff at a Board level. This is particularly the case where Training Programme Directors can modify a trainee's programme to include movement between Health Boards and this can affect protection and travel expenses. This can be done at short notice and in a fairly unpredictable manner*". A potential solution, in this respondent's view, would be to "*expand the current role of NES and include in their remit the employment of trainee medical staff as well as the organisation and quality assurance of their training programme*".

Streamlining Regulation

In the consultation paper, the Scottish Government's support for the further alignment of GMC and PMETB policy and process was set out. The publication of the White Paper, *Trust, Assurance and Safety,* followed a UK wide consultation by the Department of Health on the recommendations of two reviews - of medical and non-medical regulation - undertaken in the wake of the Shipman Inquiry. The response to that consultation from the Scottish Government was informed by stakeholder events held across Scotland. The plans for change set out in *Trust, Assurance and Safety*, and their predicted impact in Scotland, are set out in the consultation paper itself, available on the Scottish Government's website (www.scotland.gov.uk).

Question 15: What are your views on the recommendation to merge the General Medical Council (GMC) and the Postgraduate Medical Education Training Board (PMETB)?

Twenty-two respondents answered this question. A majority of respondents who directly answered this question, fourteen, voiced their support for the proposal to merge the GMC and the PMETB. A number of respondents commented that they did not directly answer this question as they thought that this decision had already been taken in a UK context.

Of the two respondents who did not support the proposed merger, one commented that this appeared to be "*a political and not an operational decision…the combining of training and regulatory functions would appear at face value to have the potential for conflict of interest*" (SNBTS). Another respondent gave a 'mixed' response

commenting that they could "*see the logic of this but have concerns about the concentration of powers this represents*" (SHCN).
A couple of respondents who voiced support for this recommendation argued that the new structure must recognise Scotland's devolved healthcare system. One respondent commented that this constituted an opportunity "*to recognise the expertise in all aspects of training associated with the roles of Colleges and Academies across the UK*" (RCoA). Finally one respondent suggested the benefit of delay "*until PEMTB's QA mechanism is firmly in place*" (RCoSEd).

One respondent commented that "*there appear to be no marked differences between the style and flexibility of the GMC in response to undergraduate medical education, and the style and working adopted by PMETB in the past few years*". Whilst another respondent observed that the "*General Medical Council…has other roles relating to fitness to practice etc. and so a further independent body would be required to undertake supervision of this role*" (NHS Dumfries and Galloway).

Structure of Postgraduate Medical Training

In the consultation paper the Scottish Government stated its view that the structure of PGME needs to be shaped so it can deliver the workforce fit for the future and that the restructuring of PGME should follow as a consequence of determining the training needs of the future workforce rather than medical roles being determined by the training the workforce has received. The consultation paper set out the current structure of PGME and highlighted the actions that NES is currently undertaken in this respect, and sought comments on the Scottish Government's views on this issue. The details of the structures, and the actions of NES can be found in the consultation paper itself, available on the Scottish Government's website (www.scotland.gov.uk).

Question 16: Do you agree with our view that changes to the structure of postgraduate medical training should await further discussion on the future shape of the medical workforce and that we should minimise that change until that is clearer? If not, why not and what are your suggestions?

Twenty-four respondents answered this question. A majority of those directly answering this question, fifteen, agreed that further changes to the structure of postgraduate medical training should await further discussion on the future shape of the medical workforce and that such changes should be minimised until that is clearer. Eight respondents expressed disagreement.

Of those respondents who disagreed, one argued that there was an urgent need to extend training (Dumfries & Galloway Royal Infirmary), whilst another argued that these developments should be considered in tandem (RCoA). Another noted that the uncoupling of foundation training and the competitive split at ST 2/3 had the support of the profession generally and should take place immediately.

Of those respondents who agreed, a number stressed that decisions were urgent, for instance with respect to the review of Foundation Training. In contrast, one

commented that we "*should evaluate whether the current MMC model of training meets the needs of stakeholders before making further changes*" (BMA Scotland), whilst another commented that changes "*should await definition of the future of the workforce*" (SSC AAGBI). Another respondent noted that change is already underway in the rest of the UK "*and it is important that the UK has a common training scheme*" (RCoSed).

The following other suggestions and comments were made:

- support for retention of the two year Foundation Programme, due to the educational opportunities it provides (BMA Scotland) or for a delay in any decision in this respect (RCPE);
- decisions to uncouple specialty training will need to be specialty specific (BMA Scotland);
- it is "*essential that Colleges are asked to deliver on their commitment to provide guidance on transferable competencies*" (BMA Scotland);
- in a "*UK wide marke*[t], *we should not disadvantage our training programmes, for example by not uncoupling CMT from specialist training*";
- "*it's crucial that GPs understand their role in tackling health inequalities in ways that are defined at a community level*" (Aberdeen City Council);
- "*Run-through training is evident in other countries' training regimes, but it is possible for core training and run-through training to co-exist in the same specialty, with the proviso that there is flexibility to allow for lateral movement in the early years of training*" (RCSEd);
- "*a 2-3 year broad-based specialty programme (medicine, surgery, psychiatry etc) after FY would be a valuable enhancement to MMC*";
- "*selection for specialty training (ST 3/4 – 5/7) should be on the basis of performance in FY and a broad-based programme…in research or in an NHS post*".

GP Training

In the consultation paper it was noted that the Royal College of General Practitioners (RCGP) are keen to work towards an extension of the mandatory training period for GPs from the current 3 years to 5 years. The consultation paper noted that, while the Scottish Government would support in principle the exploration of a move towards a 5 year training period for GPs in the UK, they believed that this would require assessment of the educational rationale for this, what would be the context and content of extended training and the funding and resource issues including the availability of trainers and training practices (suitable premises). Further details can be found in the consultation paper itself, available on the Scottish Government's website (www.scotland.gov.uk).

Question 17: What are your views on the length of General Practice training and why?

Twenty-one respondents answered this question. In answering this question, many respondents focused on RCGP's proposal to work towards an extension of the mandatory training period for GPs from the current 3 years to 5 years. A considerable majority of respondents who focused on this aspect of the question,

thirteen out of sixteen respondents, agreed with the suggestion of expanding General Practice training. One respondent who disagreed commented that the "*present system produces well-trained competent GPs and does not need to be increased*" (SHCN). Another respondent who disagreed noted that they saw "*no pressing demand to increase the training for GP principals*" and believed that "*it already has a first class GP service*". One respondent expressed the view that:

"*Before making a final decision on general practice training, we need to see if there is actually a consensus that the quality of GP training is lacking and review whether this has a negative impact on secondary care. In the absence of some evidence that this change will help us deliver strategic change in the relationship between primary and secondary care, it is difficult to justify an increase to five years*".

Of those who agreed, some respondents stressed the ways in which General Practice had changed in recent years, for instance through the "*emphasis on the management of complex conditions*". This increased complexity necessitated an extension in the duration of training (NES, BMA Scotland). Another respondent stressed that General Practice is "*as important as highly specialised training*" and the duration of training should reflect this (UoE). Another respondent claimed that "*only*" 50% of General Practice Trainees have undertaken paediatric training placements "*and in view of the major commitment of primary care to paediatrics & child health, we feel experience of a paediatric training placement is essential*" (RCPCH). One respondent contended that the "*evolving pattern of care within the NHS is based on an assumption that more care will be provided within communities, led by generalist doctors*" Because of this "*the training for these doctors must ensure that they are fit for* [the] *purpose*" (NHS Dumfries and Galloway).

Amongst other comment were that:

- the "*extension of GP training should be appropriately focused throughout on the GP curriculum to ensure that the training is highly relevant to the trainees' future GP Career*" (BMA Scotland);
- there should be no attempt "*to use GP trainees to fill rota gaps in hospital services*" (BMA Scotland);
- GP trainers must be consulted on proposed changes to GP education (BMA Scotland);
- changes in the training of GPs "*must not denude the hospital service of support provided currently by trainees who may seek GP training*" (RCPE);
- an "*increase in the length of the hospital component of General Practice training might be more appropriate than an increase on the current 18 month General Practice attachment*" (NHS Dumfries and Galloway)
- many hospitality specialities currently train GP's within their units and they should not be disadvantaged by this lengthening.

General Questions

The consultation paper included 2 more general questions, one seeking views on equality issues and one inviting any other relevant comment.

Question 18: Do you think that any of the proposals set out in this consultation document will raise any specific issues for any of the equality groups (including race, disability, age sexual orientation, gender or religion and belief)?

Twenty three-respondents answered this question. A majority, nineteen expressed the view that the proposals contained in the document *Aspiring to Excellence-Scottish Government Consultation on Professor Sir John Tooke's Recommendations* would raise no specific issues for equality groups.

Of those four respondents who thought that there were equality implications, the main issue raised related to gender equality. One respondent felt that there "*must be more emphasis on, and consideration for, flexible and part-time working and training*" (BMA Scotland). Another respondent noted that workforce "*planning discussions will have to take into account the increasing number of female medical undergraduates and hence there may be sex equality issues*" (RCoSEd). Finally, one respondent commented that "*I strongly recommend that an Equality Impact Assessment be integral to Aspiring to Excellence*" (individual respondent).

Question 19: Do you have any other comments you would like to make?

Twelve respondents took the opportunity to make further comments, with a wide range of issues being highlighted in this respect. Comments included the following:

- the need for the "*ability to appoint locums to vacant posts between MMC interviews*" (Dumfries & Galloway Royal Infirmary);
- the importance of ensuring the ability to deliver service in remote and rural settings (SSC AAGBI; NoSPG);
- the possibility "*of Scottish born medical students being offered free training in return for a commitment to working in the Scottish NHS for an agreed period following qualification*" (SHCN);
- encouragement of the "*Scottish Government to recommend reorganisation of the current training system with uncoupling of CMT and ST posts as soon as possible*";
- the importance of exposing undergraduates to different health care systems (NHS Highland);
- "*The National/MMC Recruitment process has reduced the ability of doctors in training to choose their region. The system requires to be refined to ensure both geographical and specialist choice are offered without prejudice*" (NHS Highland);
- flexibility is required so that young doctors do not feel that they are having to choose their specialist pathway to early (NHS Highland);
- there should be the "*ability to be able to undertake CCT equivalent training outwith set MMC programmes*" (NHS Highland);

- issue of locum doctors at various stages of specialty training needs to be addressed (NHS Highland);
- more acknowledgement of the role of Medical Colleges, Academies and Professional Associations is warranted (RCoA).

RCoSEd included its response to the Tooke interim report with its consultation response, whilst the RCPCH also made a number of comments with respect to the Tooke report itself.

Summary

Key points from the responses are highlighted below:

Governance

A majority of respondents thought that governance arrangement were sufficiently robust, although , many also had suggestions as to further improvements that could be made. The need for better communication and a need for better representation within the governance structures were frequently mentioned issues in this respect.

A commonly expressed view by respondents was that consistency at UK level was required in PGME so as not to reduce opportunities for trainees or to risk the movement of trainees within the UK.

The role of the doctor

All respondents offering a view thought that there was a need to review the role of the doctor before it would be possible to move to a healthcare system delivered by trained doctors- although a number of respondents stressed the urgency of this work. A majority of those offering a view disagreed with the proposal that doctors in training should be "*supernumerary to service requirement*", arguing that service provision was in fact central to training. A small majority of respondents agreed that a 'judgment safe'/ 'unsupervised' doctor was needed for all services, although a number questioned these actual concepts. The majority of respondents agreed with the Scottish Government's approach towards defining the role of a trained doctor.

Medical workforce planning

The majority of respondents agreed that it was appropriate for the Scottish Government to determine the level of controlled medical training numbers. There was no consensus with respect to whether Scotland should try to align the number of training places with the number of trained doctors required by NHS Scotland, with a range of views being expressed.

Role of the Scottish Advisory Committee on the Medical Workforce

A majority of respondents disagreed with the suggestion that the remaining roles of the SACMW could be remitted to NHS Boards, with a number of respondents stressing the importance of central scrutiny and/or national responsibility for these posts.

Commissioning and management of PGME

The majority of respondents agreed that the development of DMEs and flexibilities around regional arrangements will add value and clarity to responsibilities for postgraduate medical education at service level.

The majority of respondents expressed support for the proposed role of NES.

Streamlining regulation

The majority view was in favour of merging the GMC and PMETB but some concerns were expressed about this. Amongst the concerns raised were that combining training and regulatory functions would have the potential to result in a conflict of interest, and that the new structure must take into account Scotland's devolved healthcare system.

The structure of PGME

The majority of respondents agreed with the proposal that changes to the structure of postgraduate medical training should await further discussion on the future shape of the medical workforce and that change should be minimised until that is clearer.

GP Training

A majority of respondents agreed with RCGP's proposal to work towards an extension of mandatory training for GPs from 3 years to 5 years. The view was expressed that changes to the complexity of GP practice in recent years necessitated an extension of this training period.

Equality issues

Most respondents did not feel that the proposals would raise specific issues for equality groups, although possible gender equality implications, particularly around the issue of flexible working, were noted by a small number of respondents.

Annex A

List of consultees (by email)

Community Health Partnerships
DH and Devolved Health Authorities
MSG (Management Steering Group)
NHS Chairs
NHS Chief Executives & HR Directors NHS Boards
NHS Employee Directors
NHS Employers
NHS Medical Directors
PFPI Directors (Patient Focus Public Involvement)
Royal Colleges in Scotland (3 Presidents)
The Academy of Royal Colleges and Faculties in Scotland
The Board for Academic Medicine in Scotland
NES PG Deans and deaneries
Undergraduate Deans, Medical Schools
NES Specialty Boards
Regional Workforce Development Directors
Scottish Health Council
SWAG (Scottish Workforce & Staff Governance Committee)
Universities / academic contacts
SPF (Scottish Partnership Forum)
Voluntary Health Scotland (plus req circ to organisations)

Stakeholders

British International Doctors Association Scotland (BIDA)
British Association of Physicians of Indian Origin (BAPIO)
British Dental Association
British Medical Association
Fair For All (plus req circ to organisations)
General Medical Council
GLADD (Gay and Lesbian Assoc of Dr and Dentists)

Core Recipients

Departmental Committee Liaison Officer
Commission for Equality and Human Rights
CoSLA
Health and Sport Committee Clerk Scottish Parliament
Local Authorities
MSPs
Legal Deposit Library
SG Library
SPICE

Annex B

Two organisations responding to the consultation requested that their response should be treated in confidence. However 13 individuals and organisations did not indicate their preference in this respect, and it has not subsequently proved possible to confirm this. For this reason, these 13 responses have also, by default, been treated in confidence.

Organisations

Aberdeen City Council
Academy of Medical Royal Colleges & Faculties in Scotland
British Medical Association Scotland
Dumfries & Galloway Royal Infirmary
NHS Dumfries and Galloway
NHS Education for Scotland
NHS Highland
Ninewells Hospital & Medical School
North of Scotland Planning Group
Royal College of Anaesthetists
Royal College of Ophthalmologists (Scottish Affairs)
Royal College of Pediatrics and Child Health Scotland
Royal College of Surgeons of Edinburgh
Scottish National Blood Transfusion Service
Scottish Standing Committee of Association of Anaesthetists of Great Britain and Ireland
University of Edinburgh

Ten other organisations

Individuals

Five individuals

Abbreviations Used

AoMRC Scotland	Academy of Medical Royal Colleges & Faculties in Scotland
BMA	British Medical Association
DME	Directors of Medical Education
GMC	General Medical Council
MMC	Modernising Medical Careers
NCCG	Non-Consultant Career Grade
NES	NHS Education for Scotland
NHS	National Health Service
NoSPG	North of Scotland Planning Group
PGME	Post Graduate Medical Education
PMETB	Postgraduate Medical Education Training Board
QA	Quality Assurance
RCGP	Royal College of General Practitioners
RCoA	Royal College of Anaesthetists
RCoO	Royal College of Ophthalmologists
RCPCH	Royal College of Pediatrics and Child Health Scotland
RCPE	Royal College of Physicians of Edinburgh
RCPSG	Royal College of Physicians and Surgeons of Glasgow Trainees' Committee
RCSEd	Royal College of Surgeons Edinburgh
SACMW	Scottish Advisory Committee on Medical Workforce
SAS	Staff and Associate Specialist
SHCN	Scottish Health Campaigns Network
SDRB	Service Delivery and Regulatory Body
SGHD	Scottish Government Health Directorate
SNBTS	Scottish National Blood Transfusion Service
SSC AAGBI	Scottish Standing Committee of Association of Anaesthetists of Great Britain and Ireland
STPB	Specialty Training Programme Board
UoE	University of Edinburgh

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