Contents

Foreword

Section 1: Context
How to use this guide
Background to MMC
Current arrangements for doctors in training
So why change it?
Current issues in medical workforce planning

Section 2: MMC in detail
MMC – proposed arrangements
Core features

Section 3: Planning for MMC
Action plan & timetable of events
Six step guide to planning the workforce
Transition arrangements

Section 4: FAQs

Section 5: Good practice examples
Modernising Medical Careers
Workforce Review Team (WRT) guide to assessing staff information
Good practice example

Section 6: Useful contacts
MMC Team
Deanery Leads
Web links
Who’s who

Section 7: Glossary of terms and acknowledgements

First published June 2005
If you require further copies of this title please visit
www.healthcareworkforce.org.uk

Copyright
© 2005 National Workforce Projects (NWP). All rights reserved.
This material is for the use of organisations within healthcare
and may not be reproduced by third parties for profit.
We are pleased to present this Modernising Medical Careers Workforce Planning Resource Pack – one of a series of workforce resources developed by the NHS for the NHS.

Modernising Medical Careers (MMC) is a wide-ranging programme that is set to reform every aspect of a doctor's career. The programme aims to improve patient care by delivering a modernised and focused career structure for doctors through a major reform of postgraduate medical education. The impact of this reform will be felt in service delivery, workforce planning and development.

The aim of this workforce planning resource pack is to provide useful background information as well as practical examples, which illustrate the potential workforce implications of the changes.

This pack is aimed at all staff involved in planning the workforce – be they MMC leads, workforce, service and HR planners, medical trainers or clinical leaders of doctors, nurses and therapists in Trusts and Primary Care Trusts (PCTs).

This pack is based on current understanding. If you find this printed version helpful, updates of the MMC project are available at the Modernising Medical Careers website on www.mmc.nhs.uk

As we learn more and have new things to share we will put resource pack updates on the National Workforce Projects website www.healthcareworkforce.org.uk for you to download for inclusion within your pack.

Professor Shelley Heard
Deputy Dean Director London Deanery, Chair of COPMeD’s Workforce Group, MMC Foundation Programme Advisor

Rachael Charlton
Director, NHS National Workforce Projects Team
Context
How to use this guide
Background to MMC
Current arrangements for doctors in training
So why change it?
Current issues in medical workforce planning
Section One:

How to use this resource pack.

This resource pack describes the current training programme for doctors and explains how MMC will affect future training arrangements. In particular, the pack highlights the workforce planning implications associated with MMC and offers practical examples and questions for organisations to consider.

This pack is designed to be used by all staff involved in planning the workforce – be they MMC leads, workforce, service and HR planners, medical trainers or clinical leaders of doctors, nurses and therapists in Trusts and PCTs. The pack has been broken down into sections allowing access to the material in its entirety or by individual section.

Suggested uses of the pack include:

• As reference material – to help inform the development of Trust, PCT or Strategic Health Authorities (SHAs) workforce plans.
• As part of staff development days in individual departments – to help raise awareness and inform local debate.
• As part of a facilitated training programme – to provide reference material and support the sharing of good practice.

Content of the pack includes:

A description of the current training programme for doctors and associated workforce planning difficulties.

An explanation as to how MMC will affect future training arrangements and the implications of this on local workforce plans are as follows:

Key:

- MMC changes
- Workforce planning checklists
- Workforce planning issues

The pack includes examples of best practice and frequently asked questions (FAQs) that other organisations have developed to solve common issues. As organisations develop their thinking these sections will be updated electronically as downloadable files via the NWP portal [www.healthcareworkforce.org.uk](http://www.healthcareworkforce.org.uk)

The guide includes all the contact details of the teams working in this area to enable organisations to follow up any issues raised.
Background to MMC

In 2000 the Government made a commitment in *The NHS Plan* to reform Senior House Officer (SHO) grade training in the UK. As a result the Chief Medical Officer Sir Liam Donaldson produced the consultation document *Unfinished Business – Proposals for the reform of the Senior House Officer Grade* which proposed a new approach to postgraduate medical education. *Modernising Medical Careers* was published in February 2003 and is the response from the four UK Health Ministers to *Unfinished Business*. It sets a new direction for postgraduate medical education aimed at improving patient safety through developing and requiring the demonstration of well defined competencies for doctors in training.

The follow up document *Modernising Medical Careers: the next steps* included the suggestion from the four Health Ministers that the SHO grade should not be reformed in isolation and announced the aim to reform specialist training alongside the development of the foundation programme.

Modernising Medical Careers (MMC) aims to improve patient care by delivering a modernised and focussed career structure for doctors through a major reform of postgraduate medical education.

The initiative has a number of key features:

- The development of demonstrably competent doctors who are skilled at communicating and working as effective members of a multi-disciplinary team
- A competency based foundation programme which provides doctors with an opportunity to develop experience in a wide range of clinical areas before embarking on specialist training
- A post-foundation programme of specialty training with opportunities for additional specialisation
- Supporting high standards by developing and implementing robust new methods of assessment across postgraduate medical education.

The features highlighted above will be discussed in more detail later in this pack; however it is important to emphasise the point that MMC is a key enabler for initiatives such as ‘Hospital at Night’ and the Working Time Directive (WTD). From a workforce planning perspective it is also important to recognise that MMC is just one of a number of radical reforms being implemented across the NHS. These include Electronic Staff Record (ESR), Changing Workforce Initiatives, Agenda for Change, Improving Working Lives (IWL), the National Programme for IT (NPFT) and Payment by Results. All of these initiatives will change the nature of the NHS workforce in the next five years and organisations will need to plan for the combined effects of these changes, not for each development in isolation.
Current arrangements for doctors in training

Currently, post-graduate medical training is made up of a mix of highly structured and assessed placements in the Pre Registration House Officer (PRHO) and Specialist Registrar (SpR) grades. At the SHO grade there are some structured rotations which are specialty specific but significant numbers of doctors also undertake self-constructed and directed experience at this grade. Each step of the process involves an element of competitive entry to the next level that can extend the overall training time whilst the trainee waits for the next opportunity.

The training process assumes all trainees will progress through to a consultant grade or GP principal. Although this is the case for some, in practice others will not progress in such a linear fashion. This issue is exacerbated where there is a lack of career counselling and career guidance at the crucial SHO training period.

Current arrangements – hospital specialties

- UK trained doctors usually undertake five years as an undergraduate medical student and one year, post-graduation, as a pre-registration house officer (PRHO). Trainees can then choose to undertake a period of training as an SHO or move into the GP Vocational Training Scheme.
- Doctors training in the hospital specialities normally spend at least three years’ basic specialist training as an SHO and then apply for a post as a Specialist Registrar (SpR). This training is highly structured and usually takes a minimum of 5 years. There is competitive entry to both SHO and SpR training.
- In many specialities there are a limited number of specialty posts and doctors may have to repeat SHO experience whilst waiting for an SpR post. This bottleneck hampers the progression of doctors and results in doctors taking longer to qualify due to poor choices in SHO placements.
- Certificate of Completion of Specialist Training (CCST) programmes are based on minimum periods of training. Training is finished once that time has been completed, subject to satisfactory assessment at every stage.
• Once a doctor in the hospital-based specialties has attained their CCST they are deemed to be trained and are eligible to apply for a Consultant post. It is essential that consultants continue to keep up to date and ensure on-going professional development throughout their careers.

Current arrangements – General Practitioners

- There are two routes through to become a GP. After completing the PRHO year doctors can opt for the GP Vocational Training Scheme which is a three year programme or they can continue in SHO posts approved for general practice and transfer into the GP registrar training at a later date.
- Doctors undertaking the vocational training scheme normally undertake three years’ vocational training with two years as a senior house officer (SHO) and one year as a GP registrar.
- GP training regulations are based on minimum periods of training. Training is finished once that time has been completed, subject to satisfactory assessment at every stage.
So why change it?

Issues in the structure of medical training

The career path from medical student to consultant has traditionally been a mix of highly structured programmes and self-constructed experience. Due to the competitive entry to the Specialist Registrar (SpR) grade there is no defined end point to SHO training and the length of time spent in the grade can vary enormously.

The SHO grade is made up of a mix of Basic Specialty Training programmes and includes the option to self-construct a training programme. There are marked variations in the amount of service SHOs provide in different posts and inconsistency in the quality of supervision and training they receive.

SHOs have to make important career decisions, yet many do not know where to go for careers advice and guidance and often make premature or poor career decisions. Once locked into a specialty path it is very difficult to change tack, even within associated specialties.

Unfinished Business found that there are no robust mechanisms for regularly appraising performance nor for formal assessment at the SHO grade. Poor performance is not reliably recognised or addressed. SHO progress to SpR is measured largely on the ability of an SHO to pass Royal College Examinations and perform well at interview.

Whilst there are clear processes for assessing performance within the SpR grade, the system for SHOs is less robust leaving the possibility of outstanding issues to be addressed within the SpR grade. This remedial training occurs well into a doctors career when such issues are harder to address than if they had been resolved earlier during SHO training.

In constructing their experience in the NHS, some doctors find it difficult to differentiate between SHO training posts that are accredited as counting towards their experience and trust staff posts that do not. In the past doctors have become ‘lost’ in the system and not gained the complete range of experience they need to progress to an SpR placement.

It is not uncommon for there to be bottle necks for SHOs trying to find places as SpRs in certain specialties. In some specialties there can be as many as 30 applicants for each place, while in others, available training opportunities may not be filled. This variation in popularity of specialties, coupled with a lack of career counselling may result in doctors remaining in SHO posts for many months or years while they try unsuccessfully to gain entry into competitive specialties.
Current Issues in medical workforce planning

- Information on the number and type of trainees is patchy. Deaneries know the detail of PRHO and SpR trainees as they organise their placements, however, there is no accurate data on the total SHO population across the NHS, broken down by training and non training posts.

- In some NHS organisations there is a lack of workforce planning across medical and non medical staff. In other organisations planning occurs within the professional groups rather than across care areas.

- Although Deaneries have workforce information on SpRs, there is little robust data on the destination of SpRs post CCST. We do not have a clear idea if trainees take up posts in the area where they train, move around the country or travel abroad.

- Many Trust and PCTs have not yet identified the impact of MMC on the future workforce or included it in their organisations workforce plans. As the implementation of the specialty grade progresses the impact of these changes will be felt in the next five years.

- Apart from the LDP planning process there is little medium term planning of 3-5 years in many organisations. (NWP are developing a range of planning frameworks that may help in this area)

- The impact assessment of MMC needs to include the combined affect of other initiatives such as the Working Time Directive (WTD), Agenda for Change, Payment by Results and the Changing Workforce Initiatives.
Section 2

MMC in detail

MMC - proposed arrangements

Core features

two
Section Two:

MMC in detail
Proposed arrangements for doctors in training
From August 2005 all UK medical graduates and those medical graduates outside the UK who are eligible for provisional registration with the General Medical Council (GMC) will undergo two years of foundation training. Doctors in these programmes will be required to demonstrate their competence against explicit assessed standards. Doctors will have the opportunity to gain experience in a range of specialties before choosing a particular specialty to pursue.

The plan post the foundation years (F1 and F2) is still in development and will be specialty specific. This includes discussions as to the length of the specialty training (potentially up to seven years).

It is anticipated that specialty training will deliver consultants who can demonstrate safe judgment and the professional skills and knowledge to give patients the care they need, whilst maintaining high standards of training and accreditation. This new training model will be flexible and allow doctors to adapt their training to accommodate changes in medical technology and provide the right numbers of doctors to meet changing service needs. The diagram below shows the career progression based on MMC.

Proposed arrangements – hospital specialties
Proposed arrangements – GP training

Core features of the proposed arrangements:

- A Foundation Programme of two years for medical graduates. This outcome based Foundation Programme will replace the present PRHO year and the first year of SHO training. Registration with the General Medical Council will follow after successful completion of the first year. The programme will provide participants with experience in a range of specialties and settings. This will develop competencies to ensure good medical practice, and which will be relevant to any future career.

- The Foundation Programme will be followed by structured Specialty Training which will take the trainee to their Certificate of Completion of Training (CCT), allowing for flexibility to meet service and personal development needs. These specialty programmes will need to be approved by the Postgraduate and Medical Training Education Board (PMETB).

- Throughout the Foundation Programme and Specialty Training there will be reliable and valid assessment programmes for all doctors throughout training.

- The new competency based programme facilitates a ‘step on – step off’ approach. This will greatly improve the opportunities for women and men to work flexibly or perhaps take breaks in their careers and will promote fairness and opportunity at all stages of a doctor’s career in line with Improving Working Lives (IWL) best practice.

- The NHS is aiming to increase the shift in patient experience into primary care. This will require an expansion in the number of medical students across the NHS and a review of the ways of working across all professions in the healthcare teams. The Foundation Programme allows a broad experience both in primary care and the hospital setting so that doctors of the future will better understand the complete patient journey.

- The details of the MMC changes are outlined above, the timescale of the changes are outlined in Section 3 of this guide.
The following table highlights the impact of MMC on the current arrangements

<table>
<thead>
<tr>
<th>Current arrangements</th>
<th>Proposed arrangements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postgraduate training is currently not uniformly appraised nor formally assessed across all the grades. No robust mechanisms exist to identify and address poor performance.</td>
<td>The Foundation programme ensures that all UK graduates will receive similar training for the F1 and F2 years. Training will be regularly assessed to demonstrate competence.</td>
</tr>
<tr>
<td>No defined end point to SHO training which means doctors can stay in this grade for a considerable amount of time.</td>
<td>At the end of Foundation Programme year 2 trainees will be assessed and if successful will be accredited as having achieved the foundation programme competencies.</td>
</tr>
<tr>
<td>The career path within medical training is not straightforward and there is little structured career guidance or counselling within the programmes.</td>
<td>The new MMC structure will have within it robust mechanisms for career management at all stages of the medical career.</td>
</tr>
<tr>
<td>There exist bottlenecks for SHOs to find places as SpRs in certain specialties yet other specialties are not able to fill the places available.</td>
<td>The structure of MMC facilitates clear progression through the grades, dependent on demonstrating competences at each stage. This together with improved career guidance should enable all trainees to find a match for their skills in a particular specialty.</td>
</tr>
<tr>
<td>Currently PRHOs and SHOs are allocated study time within the working week. Many trainees do not take 100% of their allotted time due to the pressures of service delivery.</td>
<td>MMC will encourage all trainees to use the allocated time for study leave and study leave will be used in a more structured way in the foundation programme.</td>
</tr>
</tbody>
</table>
Planning for MMC
Action plan & timetable of events
Six step guide to planning the workforce
Transition arrangements

three
Section Three:

Planning for MMC

Action Plan – what should workforce planners be doing now?

The first year of foundation placements are due to start in August 2005. Planners need to have a clear idea of how MMC will affect their local healthcare community and the effect on their organisation. Planners will need to work with their local MMC implementation lead and assess the impact on the workforce of the organisation. Initially implementation of the changes to the foundation programme will be incremental however the impact on the workforce will be more significant in the next three to five years as the period of transition comes to an end and new specialist training programmes are introduced.

The workforce planning checklists and issues raised in this pack are based on the workforce planning six step guides already developed by NWP that are available at www.healthcareworkforce.org.uk

Timetable of events

At the time of publication it is anticipated that MMC will be implemented along the timeframe outlined in the MMC Foundation programme Curriculum and the MMC Operational Framework documents.

Foundation programme pilots have been running since 2003 and the scheme is due to commence fully in August 2005 with the first MMC cohort due to enter specialist training in August 2007.
Planning the workforce

The main emphasis of workforce planning for MMC is to look at the initial implementation issues and then to try to predict the likely future staffing requirement and the steps needed to meet that staffing need. The danger with current individual organisations workforce planning models is that they concentrate on the workforce numbers in isolation or vision the future without checking if the numbers will meet that need.

Trust and PCTs will have to address MMC at the same time as responding to range of other initiatives. SHAs, Trusts and PCTs will have to identify what the structure of the organisation will look like following the implementation of a range of initiatives such as WTD, Agenda for Change, Payment by Results, IWL and the Changing Workforce initiatives. Currently all these plans are being taken forward in isolation but the combined effect of these changes in the next five years will markedly change the number, structure and role of the workforce in the NHS.

Six step guide to planning the workforce.

Step 1 Defining the plan

- **Timescale** – Organisations will need to decide the timescale for their MMC planning. The implementation of MMC will take place as outlined on the previous page but the effect of the implementation will be felt for the next five years and needs to take account of planning the medical workforce for the next 15-20 years. Organisations need to plan for the medium and long term effects on the service delivery and ways of working for the staff that will result from the implementation of MMC.

- **The function of MMC workforce planning** is to take a view of possible future events to enable preparation for the outcomes. The plan will establish a direction of travel and the implications for staffing numbers following the implementation of MMC. A large element of the plan will involve visioning possible scenarios based on an analysis of current trends. One way of clarifying what the plan is for is to focus on what decisions it will support. Action plans need to be made today to deal with tomorrow’s MMC issues.

- **Getting the scope right is important** – too narrow and it will miss important factors – too wide and there is a risk that the planning becomes unmanageable. The scope of the MMC plan needs to take account of the changes that will be taking place across primary care, secondary care and the independent sector and not the impact on each trust in isolation. It also needs to include a wide range of professional groups that will be important in developing innovative solutions to the MMC implementation.
Step 1 checklist

Is the scope of the plan agreed with all stakeholders? This will include secondary care trusts, primary care trusts and the independent sector.

Have you agreed which stakeholder organisations and services are covered by the plan?

Are you clear on what assumptions are being made and what issues are non-negotiable within the plan?

Are there clear structures for visioning the financial implications for the plan?

Have you agreed the level of detail used to classify staff and services?

Have you agreed the geographical area of the plan?

Does your plan include a timescale agreed with all stakeholders?

Have all the different staff groups been covered by the plan? This needs to include all staff involved in the development of the solutions to the MMC implementation.

By following the six step guide at the end of step 1 you will have agreed:

- A clear timescale for the plan
- A clear outline of the function of the plan (what decisions will the plan support)
- The scope of the plan agreed with all stakeholders.
- The staff groups affected by the plan
- The external organisations affected by the plan
- A clear framework for the inclusion of the financial impact of the plan
- Assumptions of what is in / out of the plan

Further details of the six step guide are available at www.healthcareworkforce.org.uk
Step 2 Visioning the future

- **Visioning the future** gives a picture of what the service, or workforce will be like when we have achieved the desired outcomes. Developing a vision is generally an excellent way of ensuring engagement of all the stakeholders in the planning process.

  The planning for the impact of MMC groups will have to look wider than simply the structure of medical careers. The broader focus of the new foundation and specialty training grades will impact on primary care and the solution to many of the staffing issues rest within nursing and allied health professions rather than medical staffing.

  The vision needs to be as broad as possible and include the effects across all stakeholders, both internal and external.

  What will the NHS be like after the implementation of MMC?
  What will your particular health economy look like?
  What will be the effect of all the current changes coming to fruition? (MMC, WTD, single pay scale, teams working differently and NPFIT).

- **Goals, targets and objectives** – in order to make progress towards the future more measurable, it is common to define specific targets and objectives. Goals such as successful transfer of trust grade doctors to training grades or achieving a steady state of service delivery following the full implementation of MMC, help the organisation focus on clear outcomes. These statements will give a focus to the final action plan and outcomes of the MMC plan and need to be referred back to during the planning process. The statements need to be as detailed as possible, measurable and achievable within the timeframe identified.

- **Scenario planning** – Once the goals of the organisation have been identified and a vision of the future has been created these can be used to create a range of scenarios or ‘what if’ pictures of the future. This scenario’s can be broad assumptions of future events but must take into account external and internal changes. Some scenarios can take an extreme stance but it is best to keep to a range that is within expected possibilities. It is also best to keep these scenarios relatively simple at this stage; adding complexity will involve lengthy debate but not improve the overall plan.
Step 2 checklist

Is there a clear vision of the future implementation of MMC for the organisation that includes all staff groups and the impact on services outside the host organisation?

Is there a clear statement of the values that the organisation wants to demonstrate after the implementation of the MMC plan?

Is there a clear statement of goals that the organisation wants to achieve in the future implementation of MMC?

Does the plan contain the details of all the external drivers that will affect the organisation during the timescale of the plan?

Have you developed a range of scenarios that capture all the possible future changes? Scenarios will need to include the impact of WTD, Agenda for Change, Payment by Results, the Consultant and GP contract and new ways of working across all staff groups.

By following the six step guide at the end of step 2 you will have agreed:

- A clear vision for the organisation after the implementation of MMC
- A clear statement of the values that underpin the implementation of MMC
- A set of goals that will act as reference points during the design and implementation of MMC
- An understanding of the external drivers that will shape the health economy during the timescale of MMC
- A range of possible scenarios that describe the design and implementation of MMC

Further details of the six step guide are available at www.healthcareworkforce.org.uk
Step 3 Assessing demand

- **What we mean by workforce 'demand',** we mean the numbers and types of people needed to achieve the planned service activities and what skills they need to possess.

  Planning workforce demand cannot be done in isolation. It needs to be done as an integral part of the wider service and financial planning process. Workforce demand will be driven by the planned delivery of services but workforce is also a limited resource, like finance, which may constrain the services that can be delivered.

  Demand numbers in MMC cannot be identified by looking forward from the current structures; this will constrain the demand to today's model of working. Demand will need to be worked up from the visioning and scenarios identified in section 2. This will have the advantage of including the new ways of working and new staffing structures that result from MMC.

  It is crucial in step 2 to spend time in developing the vision and scenario planning possible futures, this time is never wasted when it comes to the development of the new MMC plan.

- **Impact on the delivery of education and training –** The implementation of MMC has many implications for the current ways of medical training that will impact on service delivery. As part of moving trust grade doctors into the specialty training grades there will be implications for both the medical trainees and the qualified staff acting as supervisors.

  Currently all SHOs in training posts have protected study time, and the implementation of MMC should pull the existing trust grade doctors into training posts. The more staff the trust has in training grades the less overall time is available to service delivery. In addition, the staff in training need supervision from senior qualified staff. This is vital to ensure patient safety and good educational standards for the trainees, but again the more trainees in the organisation the more time that will need to be given over to assessment and teaching.

  The structure of the training will also have an impact on service, the current PRHO training places a majority of trainees into secondary care organisations. The new foundation course gives a much broader experience across many organisations, often on four month placements. With the introduction of primary care placements into foundation training, the potential net effect may be less medical staff in secondary care settings, and this may also place a strain on the supervisory capacity within primary care and other service providers.

- **Productivity –** The planning for long term improvements in productivity in the NHS will play a large part in how the workforce is configured in the future. Productivity improvement is about achieving more service activity for a given level of workforce input. Increasing productivity is commonly misunderstood as trying to make people work harder. While improved motivation will, no doubt, produce some measurable improvements, the significant gains come through using a scarce workforce resource more effectively. The Department of Health recently released the Gershan Report which sets specific targets for improvements in productivity that includes expected gains from changing service models and investment in new technology.

  Gershan, Sir Peter. (2004) HM Treasury releasing resources to the front line: independent review of public sector efficiency
• **New ways of working** – In planning future staff numbers the issue of new ways of working needs to be taken into account. Staff at any level typically spend a large part of their time undertaking tasks that do not require their level of training or skill. These tasks can often be successfully transferred to other workers. Where these are existing types of staff this is often referred to as changing the skill mix; in other cases the transfer may require the development of new roles. In the development of MMC, although there is an increase in the number of medical students coming into the training programme, new ways of working will have to be developed across many professional groups in order to continue to meet the service need. The solution to many of the workforce planning problems in the NHS will not be answered by more numbers of qualified staff, as these will continue to be in short supply, but in all staff groups working differently and utilising unique skills across the team.

**Step 3 checklist**

1. **Has the plan identified the broad staff demand from the goals and scenarios in step 2?**
2. **Does the new plan take account of all the external changes, such as the WTD implementation for 2009 and Agenda for Change outlined in step 2?**
3. **Does the plan include improvements in productivity identified in detail for the plan?**
4. **Have new ways of working been identified in the visioning and scenarios in step 2 and included in the plan?**
5. **Have new service models have been envisioned and included at the goal setting stage?**

By following the six step guide at the end of step 3 you will have agreed:

- A clear breakdown of the demand for staff after implementation of MMC
- A clear numerical breakdown of staffing demand (including new staff roles).
- Identified improvements in productivity as part of the plan
- Identified possible new ways of working across staff groups
- Identified possible new service models as part of the plan.

Further details of the six step guide are available at [www.healthcareworkforce.org.uk](http://www.healthcareworkforce.org.uk)
Step 4 Assessing supply

• Current Workforce: What are the characteristics of the current workforce? The starting point for assessing supply is the workforce that you have got now. This not only tells you how far current demands are being met but will form the core of the future workforce. Developing the skills of the existing workforce is as important to the supply strategy as recruitment or training of new staff.

As part of MMC organisations will have to identify all the staff groups in medical education in order to identify all of the issues. In many organisations there is a lack of clarity regarding which posts are accredited for training and which are solely for service delivery, therefore clear numbers for the current staff structures need to be identified:

– Medical students in education that will form the bulk of the future training supply
– PRHO training posts
– SHO training posts
– Trust Doctor posts (not training posts)
– SpR posts
– NCCG posts
– Posts currently filled by locum staff
– Consultant staff posts

• Options: What are the options for developing the workforce supply? Having established the existing workforce and the likely changes as a result of step 3, we need to understand what we can do to control future supply so that it meets demand.

The main options will include:

– Recruitment – The only recruitment that increases overall supply is that which attracts individuals not currently in the healthcare workforce. Recruits who transfer from other healthcare employers may meet the needs of the individual employer but do not add to the overall supply in the labour market. The two main sources of recruitment which add to supply are:
  - Returners – i.e. those who are not currently working in healthcare.
  - Overseas recruits
– Retention – This falls into two main groups. If the attrition rates for trainees can be decreased then more doctors will complete the training programme and continue a career in the NHS. Reductions in staff turnover will also retain more staff overall and improve staffing numbers. However, some turnover is inevitable and desirable to enable people to progress and widen their experience.
– Increasing commissioning numbers for medical schools – steps are already in place to increase the numbers of trainees going through medical school; these numbers however have an inbuilt five year lag until they enter the foundation programme due to the length of the undergraduate course.
– Effective utilisation – The effective workforce can be increased by attention to a range of factors e.g. reduction in absence, better deployment, well designed skill mix etc.
– Developing the existing workforce – Increasing the skills of the existing workforce not only makes them more effective in their current jobs but also creates a potential pool of staff for promotion and enhanced roles. Even where formal training is not provided on promotion, there is effectively a cost associated with their development as individuals become more proficient at the job.
New ways of working: What are the options for working differently? – Step 3 looked at the ways in which new ways of working can be used to modify demand. On the other side of the equation they can also be used to enhance supply. Many supply problems arise as a result of the long lead times associated with training people to fulfill traditional professional roles. In addition the changing demographics of the UK population mean that there will not be as many school leavers entering professions in the NHS in the future. In the next ten years the overall working population will shrink as the large numbers of the population reaching retirement age is not matched by the small number of school leavers entering employment.

Step 4 checklist

- Have the current medical training numbers have been collated and analysed?
- Have the current commission numbers for other staff groups been analysed and rolled forward for the period of the plan?
- Is the organisation clear as to the effect of the MMC implementation on service delivery?
- Have options been analysed and costed for increasing the workforce supply?
- Have the options for working differently been analysed and costed?

By following the six step guide at the end of step 4 you will have agreed:

- A clear breakdown of the supply of staff after implementation of MMC
- A clear numerical breakdown of the current staffing supply.
- Analysed the impact of implementing MMC on the organisation
- Analysed the options for increasing workforce supply.
- Identified possible new ways of working across staff groups

Further details of the six step guide are available at www.healthcareworkforce.org.uk
Step 5. Developing an action plan

Step 2 (Visioning) and step 3 (Assessing demand) will have given you a picture of future workforce requirements and the future organisational developments that will be taking place.

The next step is to build up an action plan that takes the first steps towards a positive outcome from that vision. The plan will identify issues that need addressing now to avoid the development of large gaps between the workforce demand and supply.

The key stages in this action planning will be:

- **Mapping the vision scenarios and workforce supply onto demand**
  Steps 3 and 4 will have given us a picture of how workforce demand and supply are likely to grow. By comparing these forecasts we can get a picture of where gaps between supply and demand are likely to occur over the period of the plan. Gaps can occur both in the overall numbers of staff available and also in the skills that they have. More subtle gaps can arise in terms of the flexibility of the workforce i.e. numbers may be satisfactory but it may be difficult to cover peaks and troughs of workload i.e. the deployment may not be right.

- **How likely are the gaps?**
  If you have mapped more than one scenario into your demand or supply assessment it can be useful to plot these into the comparison of supply and demand to give an estimate of how likely supply and demand are to balance.

- **How big is the impact on service of each gap likely to be?**
  Once the supply and demand assessments have been put together it is likely that a number of gaps will be identified. In developing the action plan, we need to prioritise our actions on those gaps which present the highest risk. One way in which to think about it is in terms of hot spots and cold spots:

  - **Hot spots**
    Potential gaps which are hot spots are those which are likely to have a major impact on service delivery. Clearly there may be many factors that come together in workforce planning for the specialist medical roles but examples from the past include the issue of Therapeutic Radiographers, where it was recognised a few years ago that staff shortages were likely to threaten the delivery of the NHS Cancer Plan.

  - **Cold spots**
    On the opposite side of the assessment there is under utilisation of skills or scope for flexibility.

    Even in medical roles there are cold spots. The Hospital at Night Project has shown that only a small proportion of the time that junior doctors spend on call requires medical skills and that by radically rethinking working practices it is possible to provide cover with fewer doctors and considerably increase the job satisfaction of those who are working out of hours.

    It is also possible to turn hot spots into cold spots. For example, if a critical clinical skill is only possessed by a single professional group, it may be possible to train a wider group of people to safely carry out the activity.
Action Planning: How should the options be combined in an action plan or strategy?

By this stage, you have already identified and selected the options that are most likely to 'succeed'. These are the options that will:

- Have the greatest chance of reducing the gap in supply and demand.
- Are affordable
- Directly reduce the risk to service delivery.
- Allow for the greatest degree of flexibility in the future, as we can never anticipate exactly what future requirements may be.
- You'll need to set out clearly what the selected strategies are, how much they will cost (or cost-avoid), what the timeframes involved will be and how they complement each other.
- Where possible and appropriate, increases in numbers or skills levels can be demonstrated. Organisational requirements can also be identified such as training placement capacity and support or an illustration of a new care pathway, showing the workforce implications.

Step 5 checklist

- Have you compared the workforce supply and demand figures for each scenario?
- Have you undertaken a gap analysis of each scenario?
- Have you identified the hot spots in the gap analysis?
- Have you identified any cold spots in the gap analysis?
- Have you costed your favourite options?
- Have you drawn up an action plan based on your best option?
- Have you identified what steps need to be taken now as part of your action plan?

By following the six step guide at the end of step 5 you will have agreed:-

- A clear understanding of the scenarios supply and demand figures
- Have undertaken a gap analysis and understand the size of the gap.
- Have identified hot and cold spots in the future implementation of MMC on the service.
- Have a clear idea of the financial implications of the options.
- Have a clear action plan for the option that delivers the best solution at a realistic budget.
- Have identified (and taken) the first steps in implementing the action plan.

Further details of the six step guide are available at www.healthcareworkforce.org.uk
Step 6. Implementation and review

The whole purpose of a plan is to bring about change. The workforce plan will be of little value if nothing happens as a result of it. Similarly if the planned actions do not bring about the changes that are desired the plan will need to be reviewed to find out why and what can be done to get back on course.

- **Measuring progress: Are we making progress towards the goals?**
  
  When we defined the goals for the plan we should have made sure that they were measurable. The key issue at this stage is to make sure that we are measuring them and taking action if they are not being achieved.

  It is important not to confuse measuring progress with performance management. This measurement is primarily for the benefit of the organisations that are responsible for delivering the plan and helping them to take corrective action. The measures may be similar but good progress monitoring should enable organisations to avoid adverse performance management assessments.

- **Course corrections: If progress is not as expected, what actions are needed to stay on course?**
  
  If the monitoring processes are effective, they will throw up early warnings when the plan is not on course to achieve its goals. However good the planning, there will always be a degree of uncertainty in predicting the outcomes of the actions in the action plan. When warnings are received the first thing to do is review the action list.

- **Reviewing the plan: Is the plan still valid? If not, how does it need to be reworked?**
  
  There may come a point at which the regular cycle of monitoring, review and course correction can no longer ensure that the goals of the plan are achieved. At this point a more radical revision of the plan may be needed. The advantage of using a systematic step approach to planning such as the one set out in the six step planning guide is that a clear process has been mapped. It’s therefore relatively easy to retrace your steps to find out which part of the planning was ‘flawed’ or insufficiently robust.

  The full six step guide for MMC can be downloaded from the NWP portal at www.healthcareworkforce.org.uk

- **Transition period**

  The details of the transition period for the implementation of MMC have not been fully outlined at the current time. The structure of the transition period and the practical planning issues associated with transition will be published as soon as possible.

  Updates to the resource packs will be available as downloadable files from www.healthcareworkforce.org.uk
Frequently Asked Questions (FAQs)

Q: When is it going to happen?
A: The Foundation Programme starts in August 2005. Trainees will undertake two years of foundation training, often in one health economy but across different sectors, gaining experience through a series of placements. Although each programme is for two years, doctors will fully register with the GMC after one year (Foundation Year 1, ‘F1’) provided they attain the required competence level.

Following the foundation programme doctors will be able to compete for entry into specialist training, although the precise details of the new training programmes and entry into them are still to be agreed.

Q: Will there be local variations?
A: All foundation trainees will need to achieve the identified foundation competencies, but there is likely to be local variation in the delivery of the Foundation Curriculum, in order to achieve these.

Specialty programmes are currently determined by the Royal Colleges and accredited by the Specialist Training Authority and the Joint Committee on Post Graduate Training for General Practice. In September 2005 they will be accredited by PMETB. Postgraduate Deans are responsible for their implementation by commissioning and quality controlling training in trusts and primary care.

Q: What about international recruits?
A: The recruitment of EU graduates requiring provisional registration with the GMC through the UK healthcare system will be through fair and open competition into the foundation training. Doctors who are eligible for limited registration with the GMC will apply for F2 programmes.

Doctors entering into specialty training will remain on the current structure until 2007. When PMETB is operational, overseas doctors will be able to apply to it for consideration of their training qualifications and experience under articles 11 and 14. Some doctors may, through the this process gain direct entry to the Specialist Register; others may need to undertake additional training or gain further experience or qualifications before this can be achieved.

NHS Careers provides advice on entry into training programmes and is available at www.nhscareers.nhs.uk

Q: What are the service challenges related to MMC?
A: Trainees will usually undergo four month placements rather than 6 month placements during foundation training which will require careful planning and an increased number of inductions within an organisation.

The development of a consultant-based service may lead to increased costs, NHS organisations will need to employ consultants following their CCT, at consultant salaries, earlier than the current structure. In addition it is not clear from where the growing cost of providing continuing professional development (CPD) for consultants will be met.
Q: Who decides training numbers? and how can the numbers be influenced? – how many Consultants and GPs?

A: Specialty workforce recommendations are made by the Workforce Review Team (WRT) who take account of the advice from all the key stakeholders. As Local Delivery Plans only cover three years – dealing with waiting time targets/system redesign including workforce planning – they express short-term needs to which the system can’t possibly respond within the timeframe.

Q: Can non consultant career grades get onto the specialist register?

A: There is a new route to the specialist register which offers opportunities for doctors who currently work to a senior level in trusts, often referred to as Associate Specialists or Staff Grade doctors, to have their seniority, expertise and level of responsibility recognised. The Postgraduate Medical Education Training Board (PMETB) has been established as an independent organisation to oversee the quality of medical education and training and with a particular remit for issuing certificates of eligibility to enter the specialist register. Trainees currently enter the specialist register through achieving a CCST (a certificate of completion of specialist training), which follows on from successful completion of a specialist training programme.

Under articles 11 and 14 of PMETB doctors can submit documentation that supports their experience, training and qualifications, to be considered by PMETB. PMETB will then assess the submission to decide whether such experience and qualifications are equivalent to the current requirements of entry to the specialist register.

PMETB have the authority to issue a Certificate of Eligibility under articles 11 and 14, when all the criteria have been met. With a Certificate of Eligibility the doctor can be entered on the specialist register. Being on the specialist register is a requirement in order to be eligible for application for a consultant position.

PMETB intend to go live in September 2005 and will start to implement articles 11 and 14 at this point.

This will have workforce implications both in identifying potentially more doctors who are able to apply for consultant posts and for general practice but also, if they are successful, could result in a deficit of service delivery. This is due to the contractual differences between a consultant and associate specialist post in such areas as management time, study leave and clinical sessions worked in a week.

Q: What is the impact on other professions and their training?

A: Issues include:
- training bottlenecks;
- advanced practitioners;
- assessment burdens – e.g. building capacity for nurses to do assessments;
- training burdens.
Good practice examples
Modernising Medical Careers
Workforce Review Team (WRT) guide to assessing staff information
Good practice example
Section Five:

Good practice examples

This section is designed to contain local examples of good practice and outlines of initiatives for the implementation of the MMC changes. This section may include examples from Trusts, PCTs and Deaneries gathered together by the local MMC teams.

As this section is designed to be flexible for each organisation, only a few examples have been included in this initial version to act as a prompt. On the following pages you will find examples of an SHAs approach to local specialty modelling, plus an insight into the handling of information by the Workforce Review Team.

It is hoped that the MMC leads in each organisation will populate this section with local initiatives to build up a resource that will assist the implementation of MMC.

NWP will publish further updates of this section as best practice for the implementation of MMC to be shared nationally. Updates will be available on the healthcare workforce portal at www.healthcareworkforce.org.uk
Modernising Medical Careers

Local Specialty Modelling

Severn and Wessex Deanery has established a senior level MMC Steering Group which covers the “footprint” of the Deanery.

In addition to clinicians and managers from its area being actively involved in the work of this Steering Group, Hampshire and Isle of Wight SHA/WDC is developing a proactive programme to ensure that there is robust thinking behind MMC and that it is implemented effectively with the potential impact on service identified.

This includes exploring how MMC might be implemented within one of the local clinical services.

It was agreed to focus on Urology as the first specialty because of work already undertaken at a national level to develop arrangements for specialty training and because of its relatively small, manageable size.

Although it was originally proposed to focus purely on services within the SHA area, the fact that training programmes and trainee rotations have been historically organised on a Wessex Deanery basis means that it would be easier to conduct this work on the same basis.

The services involved are based in the following locations within Hampshire and Isle of Wight, Dorset and parts of Wiltshire and Avon:

- Basingstoke
- Bath
- Bournemouth
- Dorchester
- Isle of Wight
- Portsmouth
- Salisbury
- Southampton
- Swindon
- Winchester
These range from major tertiary centres to a variety of district general hospitals over a wide geographical area.

Limited information is held centrally on the medical staff involved, although the Specialty Training Committee Chair had carried out a ‘census’ in December 2004 and has made available the resulting schedule of medical staff of all grades excluding SHOs and PRHOs.

As part of establishing a robust baseline, each lead consultant urologist has been asked to confirm or amend the information held and to add any missing details.

Once this information is complete, it will be applied to the national model developed by the Workforce Review Team. Different scenarios will be tested to gauge the potential impact over the next few years in terms of doctors ‘available’ each year and at each level of seniority. This will indicate potential problems of ‘over supply’ and ‘under supply’ of medical staff.

In tandem, information will be sought on

- Current activity levels and future levels anticipated by the Trusts themselves and their main commissioners.
- Significant changes in the nature of the service itself such as the extent to which work may be provided at primary care level, extent of ‘substitution’ by advanced nurse practitioners etc.

Although this may be a lengthy piece of work, it is seen as a useful tool in helping to assess the practical impact of MMC on clinical specialties.

**Hampshire and Isle of Wight Strategic Health Authority**

**Workforce Development Confederation**
Workforce Review Team (WRT) guide to assessing staff information

An essential requirement of forecasting the workforce configuration under MMC is to establish the current workforce configuration. The quantity and quality of data regarding the medical workforce is of a higher standard than in any other area of the workforce. However each element of the data has it’s own features which a workforce planner needs to be aware of when gathering data.

The following table identifies what data is available and its associated issues.

### Consultants

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Quality warning</th>
</tr>
</thead>
</table>
| DH Census   | • By virtue of counting only the number of consultants within the NHS workforce, often important workforce numbers working in the health workforce are not included; e.g. the hospice and prison workforce  
• The census is completed by HR staff and not by the staff themselves. This can often mean staff being counted in the wrong group, e.g. a paediatric cardiologist may be counted under paediatrics or cardiology |

### Specialist Registrars

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Quality warning</th>
</tr>
</thead>
</table>
| DH Census         | This staff group has similar issues to those outlined above and in addition…  
• SpRs, as part of their training programme, often rotate over wide geographic areas. Therefore numbers by SHAs are subject to variation which the census will not record  
• Occasionally, some doctors on the SpR pay scale are counted as in the registrar group. However, depending on the speciality and geography, this will include a different proportion of trust doctors and/or fellows. A proportion of these doctors are not in educationally approved posts and therefore are not on a career path to become a consultant. |
| Deanery Monitoring| • The annual monitoring will provide information on the numbers of SpRs in training and their expected CCST date. The expected CCST date is not fixed for an individual and will vary due to educational need. Depending on a number of issues, the actual numbers who achieve CCST in a given year is significantly different from the expected numbers identified previously.  
• The fact that a doctor has achieved a CCST does not automatically put the doctor into a consultant post. Depending on a number of issues, not all CCST holders become consultants |
Senior House Officers

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Quality warning</th>
</tr>
</thead>
<tbody>
<tr>
<td>DH Census</td>
<td>As with SpRs, but the proportion in non-training posts is higher than for the registrar group</td>
</tr>
<tr>
<td>Deaneries</td>
<td>Deaneries know how many educationally approved SHO posts exist. But they do not know which posts are held by whom. SHO posts are not identified by years, it is therefore very difficult to determine the total number of SHOs by “Years in Service”</td>
</tr>
<tr>
<td>Clinical Directors</td>
<td>The directors will know which SHO is in each post. However SHOs rotate typically every 6 months. So results from the significant task of surveying SHO posts would be out-of-date by the time the survey was completed</td>
</tr>
</tbody>
</table>

Non Consultant Career Grades / Senior Associate Specialists

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Quality warning</th>
</tr>
</thead>
<tbody>
<tr>
<td>DH Census</td>
<td>Has the same issues as for consultants</td>
</tr>
<tr>
<td></td>
<td>SAS grades are generally viewed as doctors who have decided not train to be a consultant for what ever reason. However this group will include CCST holders who have decide not to take up a consultant post, again for a number of different reasons</td>
</tr>
</tbody>
</table>
Good practice example
This space is for your local best practice examples.
Useful contacts

six
Section Six:

Useful contacts

Modernising Medical Careers
The Modernising Medical Careers team is working with colleagues around the country to develop and implement a better way of training tomorrow's doctors. The website www.mmc.nhs.uk is the central information source for the MMC project, with specific information on Foundation Programmes and all the latest news about MMC. If you have a specific query please contact your local Deanery in the first instance. If you would like to contact the MMC please write to

Modernising Medical Careers
New Kings Beam House,
London SE1 9PJ

Department of Health
www.dh.gov.uk

National Workforce Projects
The National Workforce Projects (NWP) team supports NHS organisations to achieve their workforce objectives through the development and implementation of a range of workforce skills, change management, information and planning tools. www.healthcareworkforce.org.uk

Workforce Review Team
The Workforce Review Team (WRT) works at a national level on behalf of the NHS in England and it is responsible for co-ordinating and synthesising intelligence from local and national bodies on workforce supply and demand. It determines priorities and makes recommendations to the Workforce Programme Board on the distribution of national training funding. It also makes recommendations to Strategic Health Authorities on priorities for training and ways of addressing problem areas across all NHS services. www.hiowwdc.nhs.uk/workforce_review_team/index.htm
Deaneries

Please contact your local Deanery to get a better idea of what is happening in your local area.

**Eastern Deanery**
Block 3, Ida Darwin Site, Fulbourn, Cambridge, CB1 5EE
Deanery Website: [www.easterndeanery.org](http://www.easterndeanery.org)
Dean: Professor Huw Jones
Email: huw.jones@easterndeanery.nhs.uk
Telephone: 01223 888 4822
MMC lead: Dr Jonathon Waller
Email: jonathan.waller@easterndeanery.nhs.uk
Telephone: 01223 888 4846

**Kent Surrey and Sussex Deanery**
7 Bermondsey Street
London, SE1 2DD
Deanery Website: [www.kssdeanery.ac.uk/](http://www.kssdeanery.ac.uk/)
Dean: Dr David Black
Email: DBlack@kssdeanery.ac.uk
Telephone: 0207 415 3401
MMC lead: Dr Graeme Dewhurst
Email: graeme.dewhurst@rws-tr.nhs.uk
Telephone: 0207 415 3403

**Leicestershire Northamptonshire & Rutland Deanery**
Lakeside House, 4 Smith Way
Grove Park, Enderby
Leicester, LE19 1SS
Deanery Website: [www.lnrdeanery.nhs.uk](http://www.lnrdeanery.nhs.uk)
Dean: Dr Derek Gallen
Email: derek.gallen@lnrdeanery.nhs.uk
Telephone: 0116 295 7623
MMC lead: Mr Davinder Sandhu
Email: Mch17@leicester.ac.uk
Telephone: 0116 295 7623
PLANNING FOR A 21ST CENTURY WORKFORCE

London Deanery
20 Guildford Street
London, WC1N 1DZ
Deanery Website: www.londondeanery.ac.uk
Dean: Professor Elisabeth Paice
Email: Epaice@londondeanery.ac.uk
Telephone: 0207 692 3355
MMC lead: Professor Shelley Heard
Email: sheard@londondeanery.ac.uk
Telephone: 0207 692 3362

Mersey Deanery
1st Floor, Hamilton House, 24 Pall Mall
Liverpool, L3 6AL
Deanery Website: www.merseydeanery.ac.uk
Dean: Dr David Graham
Email: david.graham@merseydeanery.nhs.uk
Telephone: 0151 285 2212
MMC lead: Mr Rob Gillies
Email: robert.gillies@merseydeanery.nhs.uk
Telephone: 0151 285 2037

Northern Deanery
10-12 Framlington Place
Newcastle upon Tyne, NE2 4AB
Deanery Website: mypimd.ncl.ac.uk/PIMD_new1
Dean: Professor Peter Hill
Email: Peter.hill@ncl.ac.uk
Telephone: 0191 222 6772
MMC lead: Dr Moira Livingston
Email: m.m.livingston@newcastle.ac.uk
Telephone: 0191 222 7290
North Western Deanery
4th Floor, Barlow House, Minshull St,
Manchester, M1 3DZ
Deanery Website: www.mwpgmd.nhs.uk
Dean: Professor Jacky Hayden
Email: j.hayden@nwpgmd.nhs.uk
Telephone: 0161 234 6168
MMC lead: Claire Grout
Email: c.grout@nwpgmd.nhs.uk
Telephone: 0161 234 6188

Oxford Deanery
The Triangle, Roosevelt Drive
Headington,
Oxford, OX3 7XP
Deanery Website: www.oxford-pgmde.co.uk
Dean: Dr Michael Bannon
Email: mbannon@oxford-pgmde.co.uk
Telephone: 01865 740660
MMC lead: Dr Anne Edwards
Email: aedwards@oxford-pgmde.co.uk
Telephone: 01865 740660

South West Peninsula Deanery
John Bull Building,
Research Way,
Tamar Science Park,
Derrysford,
Plymouth PL6 8BU
Dean: Dr Martin Beaman
Email: rose.hill@peninsuladeanery.ac.uk
Telephone: 01752 247433
MMC lead: Dr Georgia Jones
Email: georgia.jones@peninsuladeanery.ac.uk
Telephone: 01752 247197
South Yorkshire & South Humber Deanery
South Yorkshire & South Humber Postgraduate Deans Office
Ground Floor, Don Valley House
Savile Street East
Sheffield, S4 7UQ
Deanery Website: www.sywdc.nhs.uk
Dean: Dr Sarah Thomas
Email: sarah.thomas@wdconfed.nhs.uk
Telephone: 0114 226 4436
MMC lead: Dr Peter Taylor
Email: peter.taylor@wdconfed.nhs.uk
Telephone: 0114 226 4436

Trent Deanery
Faculty of Medicine & Health Science
Centre of Postgraduate & Continuing Education
Floor 15, Tower Building
University of Nottingham
University Park
Nottingham, NG7 2RD
Deanery Website: www.trentdeanery.nottingham.ac.uk
Dean: Dr David Sowden
Email: liz.mcnuilty@nottingham.ac.uk
Telephone: 0115 846 7312
MMC lead: Dr David Sowden
Email: liz.mcnuilty@nottingham.ac.uk
Telephone: 0115 846 7312

Severn and Wessex Deanery
Highcroft, Romsey Road
Winchester, Hampshire
SO22 5DH
Deanery Website: www.wessex.org.uk/medical/
Dean: Professor Graham Winyard
Email: graham.winyard@wessexdeanery.nhs.uk
Telephone: 01962 893 829
MMC lead: Dr Malvena Stuart-Taylor
Email: malvena.stuart-taylor@wessexdeanery.nhs.uk
Telephone: 01962 893814
West Midlands Deanery
Institute of Research & Development
Birmingham Research Park
Vincent Drive, Edgbaston
Birmingham, B15 2SQ
Deanery Website: [www.wmdeanery.org](http://www.wmdeanery.org)

Dean: Professor Steve Field  
Email: stephen.field@wmdeanery.org  
Telephone: 0121 414 6958

MMC lead: Dr Andrew Whitehouse  
Email: a.b.whitehouse@bham.ac.uk  
Telephone: 0121 414 6958

Yorkshire Deanery
The Department for NHS Postgraduate Medical & Dental Education
NHS Executive Northern and Yorkshire
University of Leeds, Willow Terrace Road
Leeds, LS2 9JT
Deanery Website: [www.yorkshiredeanery.com](http://www.yorkshiredeanery.com)

Dean: Professor William Burr  
Email: w.burr@yorkshiredeanery.com  
Telephone: 0113 343 1500

MMC lead: Dr Michael Harran  
Email: m.harran@yorkshiredeanery.com  
Telephone: 0113 343 1518
Useful weblinks

Academy of Medical Royal Colleges
www.aomrc.org.uk/

The Royal College of Anaesthetists
www.rcoa.ac.uk/

The Royal College of General Practitioners
www.rcgp.org.uk/

The Royal College of Nursing
www.rcn.org.uk/

The Royal College of Obstetricians and Gynaecologists
www.rcog.org.uk

The Royal College of Ophthalmologists
www.rcophth.ac.uk/

The Royal College of Paediatrics and Child Health
www.rcpch.ac.uk/

The Royal College of Pathologists
www.rcpath.org/

The Royal College of Physicians of Edinburgh
www.rcpe.ac.uk/
The Royal College of Physicians of London
www.rcplondon.ac.uk/

The Royal College of Physicians and Surgeons of Glasgow
www.rcpsglasg.ac.uk

The Royal College of Psychiatrists
www.rcpsych.ac.uk/

The Royal College of Radiologists
www.rcr.ac.uk/

The Royal College of Surgeons of Edinburgh
www.rcsed.ac.uk/content/

The Royal College of Surgeons in Ireland
www.rcsi.ie/

The Royal College of Surgeons of England
www.rcseng.ac.uk/

The Royal Society of Medicine
www.roysocmed.ac.uk/
### Who's who?

<table>
<thead>
<tr>
<th>Body</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postgraduate Medical Education and Training Board (PMETB)</td>
<td>The remit of PMETB is to develop a single, unifying framework for postgraduate medical education (PGME) and training across the UK.</td>
</tr>
<tr>
<td><a href="http://www.pmetb.org.uk">www.pmetb.org.uk</a></td>
<td></td>
</tr>
<tr>
<td>General Medical Council (GMC)</td>
<td>The GMC has strong and effective legal powers designed to protect patients and maintain the standards the public have a right to expect of doctors.</td>
</tr>
<tr>
<td><a href="http://www.gmc-uk.org/index.htm">www.gmc-uk.org/index.htm</a></td>
<td></td>
</tr>
<tr>
<td>Skills for Health</td>
<td>The work of Skills for Health is central to the strategic development of the health sector UK workforce. The content and breadth of the Skills for Health programme covers linkages with all major workforce development initiatives.</td>
</tr>
<tr>
<td><a href="http://www.skillsforhealth.org.uk">www.skillsforhealth.org.uk</a></td>
<td></td>
</tr>
<tr>
<td>National Association of Clinical Tutors (NACT)</td>
<td>NACT aims to promote and develop Postgraduate Medical Education and to represent and support Clinical Tutors at National and Regional level.</td>
</tr>
<tr>
<td><a href="http://www.nact.org.uk">www.nact.org.uk</a></td>
<td></td>
</tr>
<tr>
<td>Conference of Postgraduate Medical Education Deans of the</td>
<td>COPMeD works in close association with College Regional Speciality Advisers. They contract with Trusts and others and ensure that Trusts, GP Training practices and Health Authorities provide suitable learning environment to meet the expectations of specialist and generalist medical and dental training.</td>
</tr>
<tr>
<td>UK (COPMeD)</td>
<td></td>
</tr>
<tr>
<td><a href="http://www.copmed.org.uk">www.copmed.org.uk</a></td>
<td></td>
</tr>
<tr>
<td>Medical Research Council (MRC)</td>
<td>MRC is a national organisation funded by the UK taxpayer. They promote research into all areas of medical and related science with the aims of improving the health and quality of life of the UK public and contributing to the wealth of the nation.</td>
</tr>
<tr>
<td><a href="http://www.mrc.ac.uk">www.mrc.ac.uk</a></td>
<td></td>
</tr>
<tr>
<td>Committee of General Practice Education Directors (COGPE</td>
<td>The Committee supervises the appointment, education and certification of GP trainees.</td>
</tr>
<tr>
<td>D)</td>
<td></td>
</tr>
<tr>
<td><a href="http://www.cogped.org.uk">www.cogped.org.uk</a></td>
<td></td>
</tr>
</tbody>
</table>
Glossary of terms and acknowledgements
Section Seven:

Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agenda for Change</td>
<td>The NHS modernisation programme and job evaluation scheme.</td>
</tr>
<tr>
<td>AMRC</td>
<td>The Academy of Medical Royal Colleges was established in 1976 to coordinate the work of the medical royal colleges and faculties. For further information and for links to each of the medical royal colleges, please refer to the Academy of Medical Royal Colleges.</td>
</tr>
<tr>
<td>CCST</td>
<td>The Certificate of Completion of Specialist Training (CCST) is awarded after the successful completion of specialty training.</td>
</tr>
<tr>
<td>DH</td>
<td>Department of Health.</td>
</tr>
<tr>
<td>WTD</td>
<td>Working Time Directive is a piece of health and safety legislation and will result in a maximum 13-hour shift for a doctor resident in a hospital. This applies to all trainee doctors from August 2004 and will be implemented across all grades by 2009.</td>
</tr>
<tr>
<td>GMC</td>
<td>General Medical Council – The General Medical Council licenses doctors to practise medicine in the UK under the provisions of the Medical Act 1983.</td>
</tr>
<tr>
<td>GMS</td>
<td>General Medical Services contract – The GMS contract is the mechanism for providing funding to individual GP practices and was introduced in 2003. It has two elements of funding – a basic payment for every practice, and further payments for specified quality measures and outcomes.</td>
</tr>
<tr>
<td>GPR</td>
<td>GP Registrars – a fully registered practitioner who is being trained for general practices under an arrangement approved by the Secretary of State</td>
</tr>
<tr>
<td>MPET</td>
<td>Multi-professional Education and Training budget also known as Health Workforce Learning and Development budget.</td>
</tr>
<tr>
<td>NCCG</td>
<td>Non Consultant Career Grade – Provides clinical services with a clinical team that are specific to a chosen specialty is accountable to a consultant or senior clinical practitioner and may practice in a largely autonomous capacity within a limited field.</td>
</tr>
</tbody>
</table>
NPFIT

National Programme for Information Technology in the NHS is bringing modern computer systems into the NHS to improve patient care and services. Over the next ten years it will connect over 30,000 GPs in England to almost 300 hospitals and give patients access to their personal health and care information, transforming the way the NHS works.

NTNs

National Training Numbers are awarded by Postgraduate Deaneries to trainees competitively appointed into the Specialist Registrar grade. A database of trainees that possess an NTN is maintained by each Deanery. Trainees are assessed on a regular basis to monitor their progress through the structured training programme. On receipt of an NTN the indicative expected date of completion of training is notified to the new SpR.

NWP

The National Workforce Projects (NWP) team supports NHS organisations to achieve their workforce objectives through the development and implementation of a range of workforce skills, change management, information and planning tools.

PCTs

Primary Care Trusts.

PRHO

Pre-Registration House Officer – A doctor undertaking basic clinical training for the purpose of obtaining full General Medical Council registration.

SHO

Senior House Officer – Hospital based postgraduate training grade for General Professional Training, Basic Specialist, Training or Vocational, Training in General Practice.

SpR

Specialist Registrar – the grade of doctor undertaking specialist training across some 65 different specialties

SAS

Staff and Associate Specialist Grades – The SAS grade doctor is a term created to describe doctors in a variety of posts in hospital medicine where service delivery has been seen as the sole role and not part of a more rounded long-term career path.

WRT

The Workforce Review Team (WRT) works at a national level on behalf of the NHS in England and it is responsible for co-ordinating and synthesising intelligence from local and national bodies on workforce supply and demand. It determines priorities and makes recommendations to the Workforce Programme Board on the distribution of national training funding. It also makes recommendations to Strategic Health Authorities on priorities for training and ways of addressing problem areas across all NHS services.

For further information see: www.healthcareworkforce.org.uk/workforce
Acknowledgements

The Modernising Medical Careers (MMC) Workforce Planning Resource Pack has been developed by National Workforce Projects (NWP) working in partnership with the MMC team at the Department of Health. NWP is undertaking a range of workforce related developments to support national and local workforce planning and this is the first in a range of resource packs for workforce planners across healthcare.

The contribution of many people to the development of the MMC Workforce Planning Resource Pack is gratefully acknowledged. In particular, the many individuals from the workforce planning domain across the UK who made their time and expertise available through discussion and written comments to the project team. Without this input it would have not been possible to develop the resource pack.

Finally, the hard work and expertise of the team responsible for the development of the MMC Workforce Planning Resource Pack who worked to tight deadlines and many versions of the draft pack to bring this about.

Contributors

Nigel Burgess  Head of Workforce Planning & Information, North Central London SHA
Judy Curson  Director, WRT
Martyn Dell  Medical Workforce Development Manager, Hampshire and Isle of Wight SHA
Derek Gallen  Postgraduate Dean, Leicestershire Northamptonshire & Rutland Deanery
Carrie Goddard  Communications Lead, MMC team
Claire Grout  Modernising Medical Careers Project Manager, North Western Deanery
Shelly Heard  Deputy Dean Director, London Deanery Chair of COPMeD’s Workforce Group
Bryan Kessie  Portfolio Project Manager, NWP
Dominic Hurndall  Programme Lead, MMC team
Andy Knapton  Data Modeller, WRT
Karen Lees  Workforce Performance Manager, Cheshire and Merseyside SHA
Moira Livingston  Associate Postgraduate Dean, Northern Deanery
Rosie Lusznat  Director of Specialty Education, Wessex Deanery
Jim Smith  Project Manager, WRT
Tanya Wilkinson  Project Manager, NHS Estates

We hope you have found this document useful. If you have any feedback on the style of this pack or examples of good practice that you’d like to share please email to Bryan Kessie at bryan.kessie@nwpnhs.org.uk