

Programme Title: **Modernising Medical Careers**  
Health Gateway Project Number: DH 331

## **Health Gateway Programme Review 0**

### **– Strategic Assessment**

**Version Number:** final.1

**Date of Issue to SRO:** 21 September 2006

**Organisation:** Department of Health

**Health Gateway Programme Review Dates:** 19 to 21 September 2006

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**Health Gateway Programme Review Team Leader:**

**Health Gateway Programme Review Team Members:**

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## **Background**

### **The aims of the programme:**

MMC is a policy to ensure all doctors are properly and fully trained, to standards set by the relevant statutory body, so that all are competent to provide the majority of front-line medical management and care for patients, and are trained to support patients and families in a National Health Service fit for 21st century.

It will significantly reduce the extent to which medical services are delivered by doctors in training, improve the quality and safety of services delivered to patients, increase the efficiency and productivity of medical teams working in hospitals and provide doctors in training with an improved programme of training and professional development.

### **The driving force for the programme:**

If hospitals continued to rely on junior doctors to deliver a very large proportion of medical services in hospitals there is a risk that wider efforts to improve patient experience and address concerns about patient safety would not progress. For their part, consultants would continue to carry a heavy supervisory burden, limiting the time they have available for activities requiring their exclusive attention, with negative impacts on both hospital efficiency and their own experience of working within the NHS.

The challenges facing the NHS under the working time directive have resulted in a series of related workforce reforms and there is evidence to suggest that the current workforce structure for doctors is not sustainable if the 2009 workforce target is to be met.

It will only be possible for the current system to change and the workforce challenges of the future to be met with the simultaneous:

- Introduction of national standards and requirements for training;
- Redesign of specialty training for doctors; and
- Introduction of a new core of fully trained doctors to deliver much of the care currently provided by junior doctors.

### **The procurement status:**

This is not a procurement-based programme.

### **Current position regarding Health Gateway Programme Reviews:**

This is the first Gateway Review of the programme. There was a Healthcheck in August 2005.

## **Purposes and conduct of the Health Gateway Programme Review**

### **Purposes of the Health Gateway Programme Review**

The primary purposes of a Health Gateway Programme Review 0 are to review the outcomes and objectives for the programme (and the way they fit together) and confirm that they make the necessary contribution to Ministers' or the departments' overall strategy.

Appendix A gives the full purposes statement for a Health Gateway Programme Review 0.

### **Conduct of the Health Gateway Programme Review**

This Health Gateway Programme Review 0 was carried out from 19 September to 21 September 2006 at MMC, New Kings Beam House, London.

The Review Team would like to thank the Programme Team and stakeholders for their support and openness, which contributed to the Review Team's understanding of the Programme and the outcome of this review.

## **Conclusion**

The programme has made significant progress since the OGC Healthcheck in August 2005. It is on course to deliver the revised training and development required to produce the next generation of doctors. The rollout of Foundation training had been successful, albeit with some teething troubles which were resolved.

The schedule for rollout of the specialty training is now tight and congested with many milestones in a short time. The key elements should be deliverable even though some elements might slip.

There are two major external risks to do with funding and the status of IMGs. These are outside the control of the programme team but contingency action needs to be developed further. The major internal risk lies with the online application system MTAS where the schedule is too close for comfort and would not normally be regarded as acceptable for an IT project. There are some mitigations and the fallback is to run with a manual system. A key delivery point has been missed and our main recommendation is that a very clear "drop dead" date be set for MTAS failing which the manual approach would be triggered.

There are no clear evaluation criteria, performance or benefit targets yet in place. These ought to exist and will certainly need to be established before the MMC team disbands and responsibility hands over to other bodies for which the roles and responsibilities for MMC need to be clear.

## **Status**

There is one recommendation calling for immediate action hence the overall status of the Programme is Red-as defined below.

**Red – To achieve success the programme should take remedial action immediately.**

**Amber – The programme should go forward with actions on recommendations to be carried out before further key decisions are taken that affect the potential success of the programme.**

**Green – The programme is on target to succeed but may benefit from the uptake of recommendations.**

Recommendations from the previous Healthcheck have been acted upon and any residual issues are commented upon in this report.

## **Findings and Recommendations**

### **1: Policy and organisational context: preconditions for success**

MMC is a major transformation of the education and training framework for doctors and has widespread DH, ministerial and stakeholder support. There is clear direction set out in the MMC strategy which is owned by the vast majority of key stakeholders. Although much work has been undertaken to develop and implement the framework, significant questions remain to be addressed, specifically relating to the ongoing costs of implementation and the impact on service provision. There is some evidence that programme objectives are aligned with other aspects of the NHS reform framework, but the SRO and Programme Board should satisfy themselves that the dependency with other major policy initiatives is fully understood. There should also be provision to ensure that MMC can be realigned in future as new policies emerge.

There is some confusion amongst stakeholders as to whether there are one or two SROs. It is strongly advised that any programme has a single SRO with clearly defined responsibility. We were assured that there is a single SRO, but this fact needs to be made clear and appropriate terms of reference promulgated. There is also a significant sponsor role from the DCMO who co-chairs the programme board. This responsibility as distinct from the SRO needs to be made clear.

#### **Recommendation 1: Set out the roles and responsibilities of the SRO and the DCMO.**

Governance arrangements are, on the whole, clearly set out and well-established. Most arrangements appear to be working well with the exception of the UK Strategy Group for which the role is less clear. Although the Group forms a key function in maximising harmonisation in programme development and implementation across the four UK countries, there is some confusion as to whether its primary role is strategic or operational. This needs to be clarified and in so doing the membership could be reviewed. It was impressed on us that a Group centred on the four Chief Medical Officers would be more effective at reaching timely decisions. There is also some complexity in attempting to implement MMC across the four UK countries, each with its own accountability and governance frameworks. Key decision-makers (e.g. CMOs) need to be present at UK Strategy Group meetings to ensure that interdependencies are recognised and action taken to minimise delays in implementation wherever possible.

Most key personnel appeared to be aware of their roles in the programme governance arrangements. There is good evidence that the programme team has brought in skills and capabilities it needs to plan and achieve the necessary outcomes. There is also evidence that the programme team is realistic about the complexity of the changes and how they can be managed.

There is a “lessons learned” register in place but this has not been kept up to date or used actively. We were assured that there are in fact a number of significant lessons and they need to be logged and acted upon.

## **2: The business case: scope and stakeholders**

Although no single business case exists for the programme as a whole, there is a clear description of the programme's policy drivers and objectives and these have been, in the main, well communicated across the programme's various stakeholder groups. There is clear and consistent understanding of the programme's objectives and aims but overall outcomes and benefits have not yet been identified in a benefit realisation programme or tracking system.

Further work needs to be undertaken to identify the number of 'run-through' training places and the impact of this on trainees and the service. It is understood that this is work-in-progress. This is critical to the next phase of the programme.

Links with stakeholders and other professional groups have generally been good.

Links to other policy initiatives and how MMC will enable improved implementation of the wider reform agenda needs to be made more explicit. MMC links with the DH workforce and CMO policy areas appear to be well established.

Whilst the programme has clearly defined major deliverables (e.g. the foundation programme), there is little evidence that critical success factors have been made explicit. The programme has also undertaken insufficient work on evaluation criteria to test the programme's effectiveness and work should be undertaken on this as soon as possible.

Communication with stakeholders is generally effective and it was widely acknowledged that significant progress has been made to reach all key audiences. It was, however, also recognised that further work needs to be undertaken in communicating with the service regarding implications for service delivery and it is understood that this is work-in-progress.

Successful implementation of MMC depends on availability of funding. There is some recognition that the underlying and subsequent costs of implementation, particularly to the service are, as yet, unknown. The financial situation of the NHS and the devolution of funds to SHAs have been identified as major risks to programme implementation.

## **3: Review of current phase**

Significant progress has been made since the Healthcheck in August 2005. The current position is:

- greater clarity about the scope and deliverables has been secured;
- the team has been strengthened;
- sound governance arrangements and a solid structure with a number of workstreams are in place;
- a robust communication strategy has been developed and
- progress is reported clearly to the programme management boards.

The nature of the training system is such that the key target dates cannot slip. A number of deadlines for completion of tasks have slipped leading to a significant bunching of milestones. This could lead to over commitment of

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resources. A key item on the critical path is the delivery of the electronic system for recruitment and selection (MTAS) where a milestone called LORA (the Last Opportunity to Revise Assumptions) regarding the Foundation rollout has been missed. MTAS is under a separate SRO, but MMC is heavily dependent on it.

**Recommendation 2: Identify a clear breakpoint for the MTAS project beyond which the contingency arrangement should be activated.**

Reports are made to a number of groups such as Programme Management Boards, UK Strategy Group, Advisory Board and others. These are supported by progress or status reports which are of good quality. They are required in different formats but the project team has a process to manage this.

#### **4: Management of intended outcomes**

The scope of the programme has been sharpened as compared with the previous healthcheck and concentrates on getting the new training and development regime defined and delivered.

Stakeholders gave a consistent view that the programme is important in principle. The predominant view is that “we should get on with it” and that seeking perfection is a recipe for doing nothing. Delaying the programme - rollout of the specialty training – is unacceptable to most stakeholders.

Specific testable or measurable benefits and a benefit delivery plan have yet to be set out. Measures should be identified to show that the real benefits of the programme are being delivered. Professional expertise should be sought to assist in this.

The MMC programme team as such is planned to stand down in a year or so and it is essential that the arrangements for benefit realisation and tracking are in place before the transfer of responsibility to other organisations. The new arrangements should include clarity of respective responsibilities, the means to deal with issues that cut across organisational boundaries and to spot situations where corrective action is needed.

**Recommendation 3: Put in place evaluation criteria and benefit tracking arrangements by April 2007.**

#### **5: Risk management**

A risk and issue management process is in place. Major risks have been identified and are regularly reviewed. There are few contingency plans and it can be helpful to have a rule that these should be in place for risks that are red after mitigation.

Significant risks include:

- Delivery of MTAS for recruitment and selection of foundation and run-through programmes. This is the major internal risk and has already slipped. There is a contingency plan which requires reverting to a manual system, albeit with significant resource implications for which a

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- resource plan is essential. Implementation of MMC is heavily dependent on delivery of the recruitment and selection process.
- Availability of funding to sustain the programme. The bundling of SHA funding brings the risk that individual SHA decisions to secure savings could seriously undermine the programme. A well managed controlled medical training and development programme requires stability in funding for education. With the bundled funding, this stability can only be assured if the SHAs have training as a priority. This could be impressed through meetings with the CEs of the SHAs or by seeking to get such requirements into the performance management framework.
- Number of posts available for the run through phase to cope with the demand for training places. There is a major uncertainty regarding potential number of international applicants.
- International Medical Graduates. There are discussions involving Treasury and the Home Office regarding the Highly Skilled Migrant Programme which could have a major impact on the programme. With such a serious risk, contingency planning is normally called for.
- Lack of clarity of the respective roles and responsibilities for the programme once it becomes “business as usual”.
- Uncertainty over future workforce requirements. The full benefits of MMC will only be realised with effective workforce planning.

**Recommendation 4: Define and communicate the respective roles and responsibilities of the organisations managing the programme following dissolution of the MMC programme team**

**Recommendation 5: Seek ways to incorporate MMC into the NHS performance management framework.**

### **6: Readiness for next phase**

There is no doubt as to the continuing need for the programme.

A number of assumptions have been identified, but these have not been pulled together. There is a need for the assumptions of each of the four Nations to be made explicit so that any fundamental differences can be identified, acknowledged and accepted.

**Recommendation 6: Set out and agree key assumptions for the programme.**

The programme support team has been strengthened since the previous healthcheck. We saw no evidence that there is now any serious shortfall in capability or capacity. There is an issue regarding the joint working of the four Nations and there might be a case for introducing a Joint Programme Office (JPO) that provides the basic services - such as planning, progress tracking, or risk management. It is too late as regards the current phase of work but it might be appropriate to support any four-Nation governance deemed appropriate after the MMC programme team is disbanded.

The effect of slippage in a number of areas has led to a bunching of programme milestones. The management tools in use do not include standard Gantt chart packages such as Microsoft Project or Primavera, but

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instead depend on manual tracking of dependencies and of the impact of any slippage. We were assured that this works sufficiently well, but it will not automatically show the state of the critical path or of any resource crunch resulting from the bunching of milestones. Although we would normally expect to see such tools in use, it is too late for these to be applied to the programme unless the programme is to be slipped.

The schedule is seen as very tight but achievable. In a number of areas, such as curriculum development, failure to deliver (which appears unlikely) should not be a major problem since existing curricula can be used.

There is no formal system in place to define how to handle any proposed changes to programme requirements or deliverables. Such a change control system should specify who approves changes depending on the assessed impact, together with assignment of responsibility for carrying out impact assessment.

**Recommendation 7: Put in place a formal change control system with defined responsibility for approval of changes and for carrying out impact assessment of prospective changes.**

**The next Health Gateway Programme Review is expected in July 2007**

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## **APPENDIX A**

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### **Purpose of Health Gateway Programme Review 0: Strategic assessment**

- Review the outcomes and objectives for the programme (and the way they fit together) and confirm that they make the necessary contribution to Ministers' or the department's overall strategy.
- Ensure that the programme is supported by key stakeholders.
- Confirm that the programme's potential to succeed has been considered in the wider context of the department's delivery plans and change programmes.
- Review the arrangements for leading, managing and monitoring the programme as a whole and the links to individual parts of it (e.g. to any existing projects in the programme's portfolio).
- Review the arrangements for identifying and managing the main programme risks (and individual project risks), including external risks such as changing business priorities.
- Check that financial provision has been made for the programme (initially identified at programme initiation and committed later) and that plans for the work to be done through to the next stage are realistic, properly resourced with sufficient people of appropriate experience, and authorised.
- After the initial review, check progress against plans and the expected achievement of outcomes.
- Check that there is engagement with the market on the feasibility of achieving the required outcome.

**APPENDIX B**

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**Interviewees**

	<b>Title</b>	<b>Organisation</b>
	DCMO	Department of Health
	Senior Responsible Officer	Education, Regulation & Pay, Department of Health
	Head of Education, Training & Development	Workforce Directorate, Department of Health
	National Director	Modernising Medical Careers
	Chief Medical Officer	Scotland
	Chief Executive SHA	NHS South Central Strategic Health Authority (SHA)
	Chief Executive	Chelsea & Westminster Hospital, London
	Chair	Central Consultants & Specialists Committee of the BMA
	Assistant Director Commissioning & Primary Care	Huntingdonshire Primary Care Trust
	Chair	Academy of Medical Royal Colleges Health & Work Department of Work and Pensions
	Programme Lead	Modernising Medical Careers
	Head of Communications	Modernising Medical Careers
	Medical Director	Joint Committee of Higher Medical Training of the Royal College of Physicians
	Chair	UK Conference of Post Graduate Medical Deans (COPMeD)
	National Clinical Advisor	Modernising Medical Careers
	Chairman of Council	Royal College of General Practitioners
	President	Royal College of Surgeons
	Chair	Post Graduate Medical Education & Training Board (PMETB) Education Committee General Medical Council (GMC)
	Chief Executive	Wrightington, Wigan & Leigh NHS Trust
	Senior Project Manager Medical Training Application Service (MTAS)	Department of Health International Workforce Supply

## APPENDIX C

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### Summary of Recommendations

**Red** – Take action immediately.

**Amber** – Take action before further key decisions are taken.

**Green** – Take action as required.

		<b>Status</b>
<b>Ref.</b>	<b>Recommendation</b>	<b>R/A/G</b>
<b>2</b>	<b>Identify a clear breakpoint for the MTAS project beyond which the contingency arrangement should be activated.</b>	<b>R</b>
<b>3</b>	<b>Put in place evaluation criteria and benefit tracking arrangements by April 2007.</b>	<b>A</b>
<b>4</b>	<b>Define and communicate the respective roles and responsibilities of the organisations managing the programme following dissolution of the MMC programme team</b>	<b>A</b>
<b>5</b>	<b>Seek ways to incorporate MMC into the NHS performance management framework.</b>	<b>A</b>
<b>1</b>	<b>Set out the roles and responsibilities of the SRO and the DCMO.</b>	<b>G</b>
<b>6</b>	<b>Set out and agree key assumptions for the programme.</b>	<b>G</b>
<b>7</b>	<b>Put in place a formal change control system with defined responsibility for approval of changes and for carrying out impact assessment of prospective changes.</b>	<b>G</b>

**NB: Full R/A/G definitions can be found in the status section.**

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