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Modernising Medical Careers

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Memorandum by the Department of Health (MMC 01)

MODERNISING MEDICAL CAREERS (MMC)

EXECUTIVE SUMMARY

Modernising Medical Careers is a collection of policies to improve the way in which junior doctors are trained and to modernise the Senior House Officer grade. The original principles as set out in *Unfinished Business* and *Modernising Medical Careers* aim to do just that and are still valid.

In the main, the implementation of MMC was in line with the original principles. However, the introduction of run-through training, thought by many stakeholders to be a good thing, limited the flexibility inherent in the original principles. The Department is re-introducing flexibility for 2008 and beyond.

The introduction of the Foundation Programme and the changes to GP training and their respective selection processes worked well.

The implementation of MMC for hospital specialties has run into difficulties this year mainly because the number of applications, particularly from international medical graduates, was very high. As a result, some UK graduates have been unsuccessful at obtaining a training post.

The Department had planned for the high numbers of international medical graduates applicants and issued guidance to consider UK and EEA graduates before those without indefinite leave to remain in the UK. This guidance was taken to a judicial review. The judgment that the guidance was lawful was handed down after recruitment had started and was too late for the guidance to be implemented in 2007.

This year's problems in recruitment were exposed because we changed the training structure, the selection procedure and introduced a national recruitment process all in the same year. The introduction of run-through training and the fact that there would be very few second and third year places in later years meant that this year was seen as the only chance to get into training. The national shortlisting system was criticised because it gave insufficient weight to academic achievements. This happened despite considerable consultation and evidence that now suggests the shortlisting process did work. Junior doctors and consultants did not understand that many applicants would miss out on interviews in the first round. This suggests that more could have been done to manage their expectations.

The IT system lost the confidence of the profession following two security breaches and two times when it ran slowly.

The recommendations of the Douglas Review were accepted by the Department. All applicants had at least one interview and the second round of recruitment was managed locally, within a national framework and timetable.

The governance structures for MMC evolved over time and were too complex with a lack of clarity about which group would take which decision. There were weaknesses in the project management of recruitment to specialty training. There was a very ambitious timescale for developing and implementing the new selection and recruitment system, leaving insufficient time for piloting and full testing.

The Department has taken onboard the lessons learnt and a new MMC Programme Board with greater professional input has been established. For 2008, recruitment will be locally run with a national timetable.

The number of applicants to posts is likely to be higher in 2008. The Department is consulting on proposals for managing applications from medical graduates from outside the European Economic Area. The Department's preferred option is that doctors from outside the EEA with limited leave to remain in or enter the UK should be considered for post-graduate medical training places in the NHS, only if there is no suitable UK or EEA applicant.

For 2009, the Department has welcomed the independent Tooke Inquiry interim report and will consider its recommendations carefully.

1. *Overview*

1.1 We will start our evidence with a short overview of what went wrong followed by answering each of the questions raised by the committee.

1.2 The IT system Medical Training Application Service (MTAS) was blamed for the difficulties surrounding recruitment to specialist junior doctor training. In fact there were four other issues that were the main causes of the problems experienced this year:

— There were a very large number of applicants to posts (roughly two to one). Over 10,000 of these were international medical graduates. This meant that some UK graduates were going to be displaced. This displacement led to an outcry from the displaced UK graduates, their parents and the consultants for whom they worked.

— The changeover to the new specialty training scheme happened this year at all Specialty Training (ST) levels (ST1–4). Most posts were for run-through training which meant that a successful applicant at entry level (ST1) would progress through specialty training without further competition (provided they successfully passed their annual assessments). The result would be that, in future years, there would be very few training places open for applications above the first year of training. As a result, applicants felt that 2007 would be their one and only chance to get into training to be a consultant. This increased the anxiety and stress levels in applicants and families.

— It is very difficult to shortlist from an application form for the first level of specialist training (ST1) because the applicants have relatively little experience. It is difficult to use academic achievement and prizes because schools have varying standards and this may not indicate suitability to become a consultant. The solution used in 2007 was to use white boxes where the candidates could demonstrate the extent to which they met particular competencies. Since they were unused to this method, it proved unpopular with candidates and selectors. In addition, it was felt that insufficient weight was given to academic achievement in the shortlisting scoring.

— Modelling shows that the decision to allow four preferences when applying for posts inevitably means a significant proportion will not receive an interview in the first round because the best candidates are shortlisted for more than one interview slot. This factor, combined with the previous three points, led to an outcry from the medical profession in early March that good candidates were not being shortlisted for interview because the computer system and application form were considered to be flawed. In practice, many would have got a post in Round 2 because only about 50% of posts would have been filled in Round 1. It appears applicants and their colleagues did not appreciate this, suggesting that it could have been communicated more effectively.

— In the light of these factors, more should have been done to manage the expectations of junior doctors and consultants.

1.3 As a result of the above, even if the computer system had worked perfectly it is likely that there would have still been an outcry. In fact, the computer system did work slowly at times particularly in the run-up to the deadline. It was not seen as user-friendly and there were two security breaches.

1.4 The governance structures that evolved over time were complex with too many groups and tiers, and a lack of clarity about which group would take which decision.

1.5 There were weaknesses in project management of recruitment to specialty training. There was a very ambitious timescale for developing and implementing MTAS, leaving insufficient time for piloting and full testing.

1.6 All of these factors combined to result in considerable loss of confidence in the process of recruitment to specialty training as part of Modernising Medical Careers.

2. *What are the principles underlying MMC and are they sound?*

2.1 The needs of patients and demands on doctors are constantly evolving. As communication and patient-led care become more important and specialist treatment more effective, patients rightly seek more from the medical profession. Reform of training for doctors is required to deliver the high standards of professional care and treatment patients expect in the modern NHS.

2.2 Ministers made a commitment in the NHS Plan (2000) to consultant expansion, to more service being delivered by trained doctors and to modernise the Senior House Officer grade. Medical training in the UK is rightly regarded as of a high standard, but there is still room for improvement.

2.3 There was a widely held view that there were problems with medical training at Senior House Officer level—they had become known as "the lost tribe". There were:

— no clear educational or career pathways;

— no defined educational goals;

— no limit to time spent in the grade; and

— a lack of distinction between service and training.

2.4 (See Annex A for a description of training before and after MMC) There had been significant reforms of pre-registration and higher specialist training and improvements to vocational training for general practice, but there remained long-standing problems with the job structure, working conditions and training opportunities of Senior House Officers. The recruitment of Senior House Officers was done by individual hospital trusts in an inconsistent manner. Many posts lasted for only six months with no assurance of a long-term career. There was disparity between numbers of Senior House Officers and Registrar posts, with some specialties (eg surgery) developing a pyramid where there were many Senior House Officer posts and few Registrar posts. There was a wide variation in training content and standards between individual posts. This meant that patients may not have been receiving the best possible treatment, employers had a constant turnover of doctors, and the junior doctors were not receiving consistent training or progression.

2.5 The case for change was confirmed in January 2006 when the GMC undertook a survey of 1,000 UK graduates who graduated in each of 2003, 2004 and 2005. The results highlighted some of the problems with the previous system, namely:

- 19% of respondents reported a gap of between 7 and 11 months between starting the process of seeking a new training post and starting work.
- 36% of respondents reported that this process took longer than one year.
- Almost a quarter of the respondents made more than 10 job applications and 10% had submitted 25 or more.
- 14% of respondents said their current contract was under five months in duration and 28% said their contract was for five to six months.

2.6 The Chief Medical Officer published his report into the Senior House Officer grade *Unfinished Business*[1] in 2002. Building on a proposal of the British Medical Association made in 2001 that there should be a unified training grade for junior doctors, *Unfinished Business* proposed:

- a two year Foundation Programme, for doctors graduating from medical schools to include the pre-registration year;
- [followed by] a specialist training programme for the acquisition of specialist skills and competencies; and
- a single training grade;
- rigorous, competency-based assessment throughout the training programmes;
- that work be done to assess the potential for developing "run through" training grades in the specialty training programme;
- postgraduate medical Deans would be responsible for the management of training programmes, for the support and training of trainers and for appointments to all programmes; and
- selection processes should be transparent and meet nationally agreed standards and practice.

2.7 The principles outlined in *Unfinished Business* were that medical training:

- be programme-based;
- be broadly-based to begin with for all trainees;
- provide individually-tailored programmes to meet specific needs;
- be time-capped; and
- support movement of doctors into and out of training and between training programmes.

2.8 *Unfinished Business: A summary of responses to consultation*[2] shows 254 responses from 29 key stakeholders demonstrating wide consultation with stakeholders and general agreement that the principles underlying MMC were soundly based.

2.9 The consultation found that:

> "Most respondents supported the five key principles".
>
> "The vast majority welcomed the broad thrust of the proposed changes".

2.10 In light of the consultation and stakeholder engagement, these principles were refined and are set out in *Modernising Medical Careers: the response of the four UK Health Ministers to the consultation on Unfinished business—proposals for reform of the senior house officer grade.*[3] This document was launched by all four UK health Departments in February 2003.

2.11 The resulting principles are as follows:

- the end product of the training process, whether a hospital doctor or a general practitioner, should be a high-quality, well-trained and accredited doctor who can deliver the care and treatment patients need in the modern NHS;
- medical training will take account of the training and development of other health service staff. It will prepare doctors to work in multi-profession settings and employ shared learning and cross-professional training where necessary;
- all postgraduate medical training should be organised in structured programmes (usually a series of co-ordinated placements) with progress monitored against clear curricula. In general, assessment should be competency-based and should be focused on outcomes with the ability to perform as the underpinning competence;
- training should be applied to clear, consistent UK-wide standards;

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[1] *Unfinished Business (August 2002)*—http://www.mmc.nhs.uk/download_files/Unfinished-Business.pdf

[2] *Unfinished Business: A summary of responses to consultation (February 2003):* http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_4071823

[3] *Modernising Medical Careers: the response of the four UK Health Ministers to the consultation on Unfinished business—proposals for reform of the senior house officer grade (February 2003):* http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4010460

— programmes should be designed and managed to ensure that trainees complete them in the minimum necessary time. There should be explicit career pathways and explicit career goals;

— individual programmes should be available to meet individual needs;

— training should as far as possible be seamless and conducted within a grading structure which supports this process;

— training must be supported by strong educational management and underpinned by skilled trainers;

— a clear structure is necessary to encourage and support the development of academic, research and teaching skills and to support those who opt for an academic career;

— programmes should be broadly-based at first and lead on to greater specialisation where appropriate;

— the responsibilities given to doctors completing training should match their skills and competencies. Similarly, doctors in training should be able to take on progressively more responsibility as they are assessed as acquiring the competencies needed;

— training should be trainee-centred and programmes should reflect a variety of career choices, from those who decide on a particular career early on to those who need more time to do so and to those who want to train part-time. Individual programmes should be available to reflect individual needs;

— rigorous counselling and career advice should be available throughout training;

— new training structures must allow trainees to change training programmes according to service need with the minimum duplication or retraining;

— programmes should be designed to suit the needs of overseas doctors who may enter training at a number of different levels and in a number of different ways; and

— the development of new training structures, programmes and the delivery of training itself must be effectively quality assured.

2.12 The overall intention of MMC was to provide consistent national standards for training through better structured and well managed programmes of training. Training programmes would be based on new competency-based curricula approved by the newly established Postgraduate Medical Education and Training Board (PMETB).

2.13 This would improve the quality and safety of patient care. A higher proportion of care would be delivered by an appropriately-skilled workforce. There would be less reliance for service delivery on those still in training.

2.14 A more detailed formulation of proposals was published in *MMC Next Steps*[4] in April 2004.

2.15 *Unfinished Business* proposed that work be done to assess the potential for developing "'run through' training grades in the specialty training programme". *The Modernising Medical Careers: response to the consulation* document, as a result of the consultation, took this further stating that "[competency-based training and assessment] will aim to provide seamless specialist training programmes leading to a CCT".

2.16 *Next Steps* built on this saying that the consultation leading to the MMC document:

> "signalled that thinking had moved beyond the Basic Specialist Programmes foreseen in *Unfinished Business* and reflected the growing view that a single, run-through approach was not only desirable but also achievable . . . We have moved, therefore, from initial proposals which accepted a separation of basic and higher specialist programmes to a system which sees the progressive acquisition of basic and higher specialist competencies in a single programme".

2.17 This was a move from the three-phase training programme (ie foundation programmes, basic specialist training and higher specialist trainging) suggested by *Unfinished Business* to a two-phase programme removing basic specialist training. (see Annex A and below para 4.2)

[4] *MMC The next steps (April 2004):* http://www.mmc.nhs.uk/download_files/The-next-steps.pdf

2.18 In June 2005, The MMC Team set up by the Department published the Foundation Programme curriculum and Operational Framework. The new Foundation Programmes were launched in August 2005.

2.19 Since the first graduates from the Foundation Programme were due in August 2007, the PMETB approved the curricula for specialist training programmes and they were launched in August 2007.

2.20 MMC has drawn widespread support at all stages of its development.

> "Like the best common sense moves, the principle of Competency Based Assessment (CBA) is patently 'A Good Thing'".
> Simon Eccles, former Chair of the junior doctors committee, (*British Medical Journal Careers* 27 November 2004)

> "We have never before had a set of standards that doctors had to adhere to. This is a good thing for patients and a good thing for medicine".
> Dr Laurence Gant, Accident & Emergency Consultant, Homerton Hospital, London (MMC Website August 2005)

> "Employers see great merit in having trainee doctors enter 'run through programmes' and become accredited on completion".
> Mark Britnell, then Chief Executive of University Hospital Birmingham (MMC Website February 2006)

> "However, the principles that underly (sic) the new [foundation] process are sound. The old system for appointing new doctors may have had its benefits but was not sufficiently transparent. It is entirely right that we aim to create a new system that is equitable and meritocratic".
> Kirsty Lloyd Former Chair, Medical Students Committee, British Medical Association (*Times* March 2006)

> "The [foundation selection] process was equitable and transparent, which cannot be said for an interview system that has historically been paternalistic and biased . . . Some [applicants] that were not placed through the first round either failed to appreciate the importance of clarity on the application form or limited themselves to a small number of posts".
> Dr Andrew Long Chairman, National Association of Clinical Tutors (*Times* March 2006)

2.12 Finally, the principles provided a sensible and measured response to the issues of the "lost tribe" of Senior House Officers outlined in the introduction. The Department will be reviewing and updating these principles in the light of the Tooke Review.

3. *The roles of the Department of Health, Strategic Health Authorities, The Deaneries, The Royal Colleges and The Postgraduate Medical Education and Training Board in designing and implementing MMC*

3.1 In this section, firstly, we outline what the key stakeholders did in each of the three parts of MMC—education and training restructuring, recruitment and selection and use of IT. Secondly, we summarise the relationships between the groups in a diagram (Figure 1). Finally we describe the role and membership of the key bodies involved in designing and implementing MMC.

Restructuring of education and training

3.2 In August 2002, *Unfinished Business* was published by the CMO and went out for consultation.

3.3 In February 2003, the four Departments of Health published their response to the consultation in the document called *Modernising Medical Careers*.

3.4 In October 2003, the UK Strategy Group with the four CMOs was set up to develop policy for Ministerial approval. The Department set up an MMC England Team to run the implementation of the MMC policy (not including recruitment) in England.

3.5 The UK Strategy Group published *Next Steps* in April 2004.

3.6 In September 2005, PMETB was set up to approve all specialty training, curricula and related assessments.

3.7 In October 2005, The MMC England Programme Delivery Board was set up to which the MMC England Team reported. The board reported to the Director of Workforce and the Chief Medical Officer who both had joint accountability for MMC policy and implementation in England.

3.8 In November 2005 the UK strategy group commissioned the Joint Specialist Training Action Group of the Academy and Conference of Post Graduate Medical Deans of the UK (JACSTAG) to work on entry criteria, patterns of training and curricula for each specialty.

3.9 The new curricula were developed for specialty training by the relevant Royal Colleges/Faculties and for the Foundation Programme by the Foundation Programme Committee of the Academy of Medical Royal Colleges. The Foundation curriculum and related assessment system is jointly approved by PMETB and the General Medical Council. PMETB also approves the curricula and assessment system for specialty training.

Recruitment and selection

3.10 In keeping with the policy of competency-based training and to improve efficiency in recruitment, the Department decided to implement a nationwide competency-based selection process.

3.11 In December 2005, the Department established the Medical Recruitment Board with its own Senior Responsible Officer reporting to the MMC England Programme Board. The Medical Recruitment Board's role was to develop and deliver recruitment and selection including the UK-wide IT system. The MMC England team were represented on the working groups.

3.12 Implementation of recruitment and selection was and is the responsibility of Strategic Health Authorities through the Deaneries.

3.13 In August 2005, the Conference of Postgraduate Medical Deans (COPMED) established a UK Recruitment and Selection Steering Group to develop person specifications, selection criteria and the application form for the specialty selection and recruitment process. The Recruitment and Selection Steering Group also reported to the UK Strategy Group on some occasions.

3.14 JACSTAG contributed to these groups as it was responsible for working on entry criteria for each specialty.

3.15 PMETB was responsible for making sure that the selection process could identify those who are eligible to undertake training. The Board's powers do not encompass those aspects of selection which seek to choose between eligible candidates.

3.16 After public consultation in summer 2005, PMETB published the *Principles for entry to specialist training* (January 2006) and then in April 2006 published *Generic Standards for Training* which include standards and requirements for selection into specialty training. In September 2006, PMETB agreed that the arrangements for selection proposed by COPMED, so far as they had been developed at that time, broadly reflected the relevant sections of the *Generic Standards for Training* (see letter at Annex B). However, PMETB has emphasised to the Department that it is not responsible for approving such processes.

Use of IT

3.17 In order to be transparent and meet national agreed standards and practice, the Department decided that introducing a national computer-based system of recruitment (similar to the Universities and Colleges Admissions Service for undergraduate entry for University) would save considerable costs and provide a better service.

3.18 The Medical Recruitment Board reporting to the MMC England Programme Board was responsible for developing and delivering the UK-wide IT system of recruitment and selection. An MTAS Project Board was set up to commission the computer system and was responsible to the Medical Recruitment Board.

3.19 In March 2006, the Recruitment and Selection Steering Group of COPMED set up a sub-group called the Rules Group to draw up the detailed rules for the handling of applications including number of preferences and how the preferences should be handled.

3.20 The Recruitment and Selection Steering Group and the Rules Group of COPMED reported to the UK Strategy Group on policy issues (eg the number of preferences) but otherwise fed their work into the Medical Recruitment Board and into the MTAS Project Board.

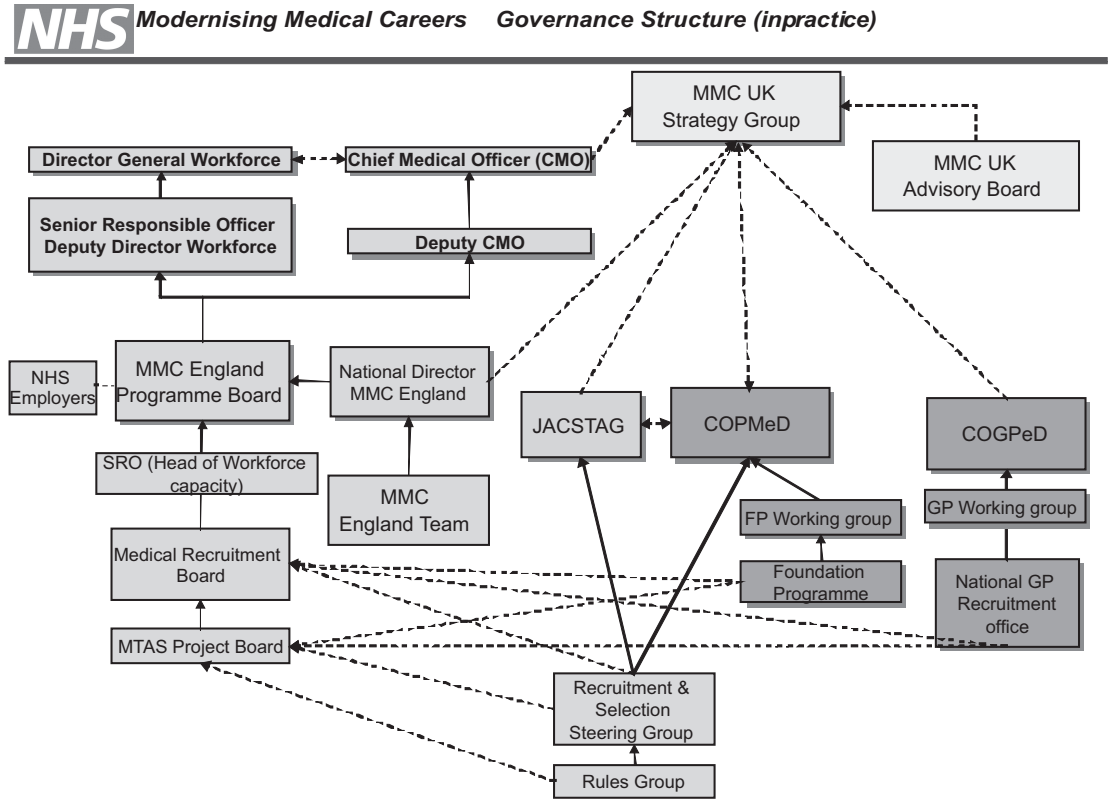
3.21 The business case for Medical Training Application Service (MTAS) was approved by the Department's Head of Capital and Programme Investment on 12 May 2006.

Relationships between the bodies

3.22 The diagram below (Figure 1) indicates the major relationships between the key stakeholders.

Figure 1

MMC GOVERNANCE STRUCTURE (IN PRACTICE)



Roles and Membership of the key bodies

3.23 Table 1 below shows the roles and responsibilities of the major groups involved in MMC.

Table 1

THE BODIES AND GROUPS INVOLVED IN MMC

THE DEPARTMENT OF HEALTH

The Chief Medical Officer proposed changes. The Department consulted on his proposals and Ministers decided policy. The four Health Departments set up the UK Strategy Group and the UK Advisory Board to develop policy further and give advice. The department also created the MMC England Programme Board and the MMC Team to lead the implementation for England. The Department set the policy for and created the Medical Recruitment Board to run the implementation of recruitment to specialty training.

MMC UK STRATEGY GROUP

The UK Strategy Group's role was to:

— develop MMC policy and give strategic advice to Ministers; and

— commission work required for MMC implementation from relevant bodies, eg National Director, the Conference of Post Graduate Medical Deans of the UK, National MMC Teams.

The UK Strategy Group was accountable to the four UK Ministers via Chief Medical Officers.

The UK Strategy Group was made up of the four Chief Medical Officers and representatives from PMETB, the General Medical Council, the Conference of Post Graduate Medical Deans of the UK, Committee of General Practice Education Directors, the Department for Health in England, Scotland, Wales and Northern Ireland, the Chair of the MMC UK Advisory Board, the Academy of Royal Colleges (covering primary and secondary care, and representatives from the service in each of the four countries (except Northern Ireland who declined the opportunity).

MMC UK Advisory Board

The UK Advisory Board advised the UK Strategy Group and contained representatives from the following organisations: PMETB, Academy, Joint Committee on Postgraduate Training for General Practice, General Medical Council, the Conference of Post Graduate Medical Deans of the UK, Committee of General Practice Education Directors, Royal College of Physicians, Royal College of Surgeons, Council of Heads of Medical Schools, Royal College of Ophthalmologists, Association of UK University Hospitals, Armed Forces, Workforce Development Confederation, Strategic Health Authorities, NHS Confederation, Community Trusts, Acute trusts, Primary Care Trusts, Central Consultants and Specialists Committee of the British Medical Association, Junior Doctors Committee of the British Medical Association, Joint Consultants Committee, General Practitioners Committee, Staff and Associate Specialist Grade Doctors Group, Medical Schools Council (MSC), Medical Academic Staff Committee of the BMA (MASC), Patient representatives, CPD, MMC team England, Department of Health England, Wales, Scotland and Northern Ireland.

The Conference of Post Graduate Medical Deans of the UK (COPMED)

In England the deans are individually accountable to Strategic Health Authorities, for the delivery of foundation and specialty training. The UK Strategy Group commissioned specific MMC tasks from the Conference of Post Graduate Medical Deans of the UK. Individual deans were accountable to the MMC Programme Board through their SHAs on behalf of UK Strategy Group for delivery of these tasks in England.

COPMED set up a Steering Group on Recruitment and Selection into Specialty Training which included representation from the four UK health departments, the MMC team, Deans, the Academy of Royal Colleges, NHS Employers, the British Association of Medical Managers, the Committee of General Practice Education Directors, the National Association of Medical Personnel Specialists, NHS Employers, Human Resources and from the Department of Health. In addition, representatives of junior doctors attended meetings as appropriate junior doctors were members of this group both from the British Medical Association and the Academy.

The UK Recruitment and Selection Steering Group was responsible for overseeing the development of person specifications produced for each level of appointment in each specialty, and the development of the single application form used in the 2007 recruitment round. The Recruitment and Selection Steering Group set up a sub-group called the Rules Group to draw up the detailed rules for the handling of applications including number of preferences and how the preferences should be handled.

Joint Specialty Training Advisory Group of the Academy of Royal Colleges and The Conference of Post Graduate Medical Deans of the UK (JACSTAG)

The Group was commissioned by the UK Strategy Group to undertake specific MMC tasks to pursue and report on entry criteria, curriculum development and the transition proposals of Royal Colleges.

MMC England Programme Delivery Board

In England MMC implementation was taken forward as the joint accountability of the Chief Medical Officer and the Director General of Workforce. The programme delivery board's role was to deliver the implementation of MMC in England. It had the following representation: Deputy Chief Medical Officer, Department of Health (Director of Workforce, (Education, Regulation and Pay Division)), NHS Employers, Workforce Review Team, MMC UK, MMC UK Advisory Board, MMC Foundation Lead, MMC Implementation Team, Department of Health (Education Policy Branch), Office of the Strategic Health Authorities, Department of Health (Workforce Capacity), National Workforce Group, Department of Health (Communications), the Conference of Post Graduate Medical Deans of the UK, Department of Health (DAT), Hospital at Night (H@N) project, PMETB.

Medical Recruitment Board

The Medical Recruitment Board was responsible for developing and delivering recruitment and selection including the IT system MTAS as a national portal for recruitment into foundation and specialty training. It brought together representations from the four UK countries, the MMC team, the Conference of Post Graduate Medical Deans of the UK, the national GP recruitment office, the Foundation Programme office, NHS Employers, and the Conference of Post Graduate Medical Deans of the UK Steering Group on Recruitment and Selection. The MTAS IT project board reported to the Medical Recruitment Board.

Contractors

The Department commissioned Work Psychology Partnerships to design the selection methodology and Methods Consulting to develop the MTAS IT system.

Strategic Health Authorities and Deaneries

Strategic Health Authorities through the Deaneries were responsible for delivering training to staff and for implementing the recruitment and selection process for foundation and specialty training locally. For specialty recruitment this included processing applications, training selectors, organising long-listing, short-listing and interviews for all post-graduate medical training vacancies.

The Royal Colleges

The Royal Colleges have been involved at all stages in the process with representatives of the Academy of Royal Colleges on the appropriate boards or consulted as key stakeholders as outlined above. The Royal Colleges individually have been instrumental in designing the individual specialty training programmes with PMETB and responsible for signing off the person specifications. JACSTAG has a key role as described above. The Academy was asked to lead the Review into the MMC 2007 recruitment process that became the Douglas Review Group.

The Postgraduate Medical Education and Training Board

PMETB is the statutory regulatory body which approves all specialty training, curricula and related assessments, including exams, together with the eligibility for entre to undertake training. PMETB requires that curricula make clear the knowledge, skills, behaviours and attitudes that must be demonstrated before a Certificate of Completion of Training can be awarded.

4. *To what extent the practical implementation of MMC has been consistent with the programme's underlying principles?*

4.1 Implementation consistent with MMC principles

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

4.1.2 The following paragraphs outline specific ways in which the Foundation Programme, GP programme and hospital speciality programme meet these principles below.

Foundation Programme

4.1.3 The Foundation Programme consists of a two-year programme with a defined nationally agreed competency based curriculum. This curriculum was developed with wide stakeholder involvement and co-ordinated via the Academy of Royal Medical Colleges. There is also an operation framework which sets out the roles and responsibilities of all those charged with delivering the programme. This also had wide consultation from all stakeholders.

4.1.4 The learning objectives for first year (F1) of the Foundation Programme are set by the General Medical Council. In order to attain full registration with the General Medical Council, doctors must achieve specific competencies by the end of this year. The second year (F2) of the Foundation Programme builds on the first year of training. The main focus is on training in the assessment and management of the acutely ill patient in a variety of specialties and healthcare settings. Training also encompasses the generic professional skills applicable to all areas of medicine—teamwork, time management, communication and IT skills.

4.1.5 The programme is trainee centred. Trainees have to demonstrate to senior clinicians that they have attained a series of skills. This is achieved by asking senior clinician assessors to utilise the four assessment tools described in the Foundation Programme curriculum (multi source feedback, clinical evaluation exercises, direct observation of procedural skills and case based discussion). In addition, at the end of each placement (usually either 4 or 6 months) the wider faculty of clinician educational supervisors are asked to reach a global decision on overall, satisfactory educational, clinical and professional development using the curriculum as a template.

4.1.6 Trainees have the opportunity to have dedicated career management support within the training programme. They can gain exposure to a wider range of clinical placements or clinical tasters than previous Senior House Officers at their level and experience.

4.1.7 All senior clinicians involved in educational supervision of Foundation trainees have been trained in the assessment tools. Each trainee follows a programme of regular meetings with their educational supervisor and receives regular appraisals.

GP Specialty Programme

4.1.8 In the past, training for general practice was made up of a patchwork of hospital posts in different specialties plus an additional year working under supervision in a practice. General practice training under MMC is an integrated three-year structured programme supported by a competency-based curriculum developed by the Royal College of General Practitioners following extensive consultation.

4.1.9 The new curriculum defines the competences of a GP working in a primary care led health service, and emphasises the principle that overall educational supervision should be provided from and based in primary care. The newly developed national exit examination (nMRCGP) includes systematic workplace-based competency assessment, as well as a knowledge-based exam and clinical skills assessment. GP trainers must be trained, approved and regularly re-evaluated by deaneries for recognition by the PMETB. Career management services are being developed by deaneries, to supplement the foundation school services.

Hospital Specialty Training Programmes

4.1.10 The delivery of specialty training is in accordance with the requirements of the PMETB Specialty Training Curricula. The curricula have been developed for all specialties by the appropriate members of the Medical Royal Colleges. Each specialty has submitted its revised curriculum to PMETB for approval. Some specialties did not receive approval until Summer 2007. In addition, the assessment methods to be used to confirm competence acquisition and professional and clinical progression have been reviewed and are in the process of being approved by PMETB.

4.1.11 The Postgraduate Deaneries work in partnership with the Specialties to ensure that the Specialty Training Programmes deliver structured, competency based training which meets with the national standard and follows the published curriculum. Deaneries have and will continue to run courses for education supervisors related to developing their training and educational knowledge and skills. In addition training programmes on the assessment methods for each specialty are either being delivered or planned for delivery shortly.

4.1.12 Colleges have developed or are in the process of developing e-learning support packages in most specialties. These will support a blended learning environment for specialty trainees.

4.1.13 Deaneries have in place career management support packages for trainees in specialty training. This includes support for trainees who decide to change specialty or to leave medicine entirely.

4.1.14 The new training programmes provide opportunities for trainees for out of programme experiences including research and less than full time training opportunities.

4.1.15 n order to meet the principle of quality assurance, deaneries have a quality management framework which maps against the PMETB Quality Assurance Framework published in 2007. PMETB holds the Postgraduate Deans responsible for ensuring that the generic standards of training are met and that suitable processes are in place to monitor and improve the quality of education across the Deanery.

4.2 Principles still to be implemented

4.2.1 One of the aims of MMC was to have flexibility for trainees to change specialties at a later stage and have a broad base to start, following Foundation training.

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

4.2.3 The advantages of run-through training are that it:

— reduced the chance of milling around in the Senior House Officer role and made training more efficient and focused;

— was educationally sound in that trainees and trainers remained together through the process and so would be able to develop the relationship and provide consistent tailored training;

— was socially sound in that trainees did not necessarily need to move around the country numerous times to complete their training;

— was supported by the junior doctors;

— led to better managed programmes of training that are more systematic, more streamlined; and

— was more efficient as less effort was wasted in seeking successive appointments.

4.2.4 The Royal Colleges were involved at every stage of the process and at the time supported the policy of run-through training following the two-year Foundation Programme.

4.2.5 However, in implementation, inflexibility has crept in. It is now clear that a considerable proportion of junior doctors are not confident about which specialty they would like to train in when they leave the Foundation Programme. The Foundation Programme, whilst broad, (including taster sessions) does not, and cannot in reality ever, give experience in every specialty. All junior doctors in foundation courses have access to career advice.

4.2.6 The principle of a broad base for the initial phase of specialty training has materialised so far only in the "Core Training" or common stem training available in the medical specialties (core medical training), the surgical specialties (generic or themed surgical training), Psychiatry and Acute Care Common Stem. The rest of the specialty curricula start at ST1. This makes it more difficult for trainees to change specialty because competences become specific to that specialty very early on. However, Colleges are continuing to work together to establish what competences are transferable, and working with Deaneries to see how this can be administered when trainees move specialty programmes. So that training in proven competencies does not need to be repeated.

4.2.7 To allow some flexibility and competition for ST2–3 posts in later years (for those wishing to change specialty or enter from a Fixed Term Specialist Training Appointment), a small percentage of places were withheld unfilled this year, however, it is recognised that these will be insignificant in comparison to the huge number of applicants.

4.2.8 The Department acknowledges that further development is needed to establish greater flexibility for junior doctors to move between specialty training programmes.

5. *The strengths and weaknesses of the MTAS process*

5.0.1 Medical training is a complex process involving many stakeholders. Changing the system inevitably posed huge challenges that had to be overcome. These challenges were greatest in specialty recruitment where in the UK 34,000 applicants applied for 19,000 posts on MTAS.

5.0.2 The timescale for implementation was overambitious, and preparation for the operational implementation in some areas could have been much better. However, it is important to make the distinction between the various parts of the overall recruitment and selection process and recognise there were both strengths and weaknesses.

5.1 The Foundation Programme

5.1.1 The Foundation Programme successfully used the MTAS IT system to manage its recruitment process.

5.1.2 There were 6,300 eligible applicants all of whom were successful. 92% of all individuals were able to obtain their first choice foundation school in the 2007 recruitment round.

5.1.3 There were more posts available than eligible applicants which helped ensure the high levels of applicant satisfaction with foundation school choice.

5.1.4 The Foundation Programme has a wide range of engaged stakeholders who continue to work to refine the curriculum, operation framework, choice of jobs and assessment methodology.

5.1.5 Full stakeholder engagement from the beginning helped bring this success. The group developing the rules for recruitment selection had representation from all four nations, medical student representatives, postgraduate deans, the council of the heads of medical schools, NHS employers, foundation school directors and managers. It also worked very closely and successfully with Methods Consulting who built the specification for selection. This level of engagement ensured "buy in" at every stage of the process.

5.2 GP Recruitment Process

5.2.1 The 2007 recruitment into GP training was successful for both applicants and for the service. Applicants went through a fair, open and competitive process. The service was able to fill all 7,300 vacancies in all parts of the country (including 3,400 outside the MTAS IT system).

5.2.2 General practice has been developing a competency based recruitment system over the last seven years. The process was incremental with each stage validated, and with deaneries converging their systems into a national process ready for MMC.

5.2.3 General practice recruitment used a machine markable test of clinical knowledge and situational judgements. The validity of the GP shortlisting method was not challenged by junior doctors nor the Douglas Review. Interviews were replaced by selection centre methods, using work place simulations to assess applicants against a competency framework. A national evaluation of MTAS GP applicants has shown overwhelming confidence in the selection centre process.

5.2.4 The selection methodology was backed up by a national recruitment office, which has co-ordinated recruitment across deaneries for several years, and was essential for the standardising of processes and quality management.

5.2.5 The national shortlisting system competition enabled applicants to be allocated in rank order to their highest available deanery of preference, ensuring an equitable distribution of applicants across the UK. Although limiting applicants to one assessment only, the system gave the maximum number of applicants the opportunity to attend selection centre. The limit of one assessment is partly compensated by a national clearing system, where the highest unplaced applicants' scores are cascaded into other deaneries where they would be prepared to train. When clearing had been completed, all posts entered for Round 1 of MTAS had been filled, without the need for a second round.

5.3 Specialty Training Recruitment and Selection Process

5.3.1 The Douglas Review found the interview process to be the strongest feature of the specialty selection and recruitment process. Anecdotal feedback from the service highlights the quality of applicants gaining posts. However, there were perceived and actual issues around the rest of the selection process.

5.3.2 The strongest criticism was about the shortlisting process. Specifically there was criticism that the application form for specialty recruitment did not allow applicants properly to reflect their experience and abilities. The application form was designed by Work Psychology Partnerships after extensive consultation (cf 5.4.2). The form consisted primarily of white boxes that applicants needed to complete to demonstrate how they met the person specification. Some applicants found it difficult to complete whilst others used standard answers. Some consultants shortlisting for interview said they found it difficult to differentiate between applicants on the basis of the form. It was also felt that insufficient weight was given to academic achievement in the national shortlisting scoring. The high volume of applications exacerbated these problems.

5.3.3 This led to serious concerns that some of the best applicants were not being shortlisted for interview.

5.3.4 These concerns arose mainly because 32% of all eligible applicants were not shortlisted in Round 1. As a result, some applicants felt that their careers had been terminated by the application form alone. About 40,000 interview slots had been prepared in the UK as a whole. However, because each applicant could make four choices, and because there was reasonable agreement across the deaneries about the high scoring applicants, 10,850 applicants had more than one interview. This left some potentially appointable trainees with none. This was an expected consequence of providing applicants with four choices in Round 1.

5.3.5 Round 1 was expected to fill only around 50% of posts leaving a similar number of posts for Round 2. However, the message that Round 2 would give applicants unsuccessful in Round 1 a similar number of opportunities, could have been conveyed more effectively.

5.3.6 As Round 1 progressed, it became apparent that confidence in the system was failing mainly a result of the concerns about effectiveness of the shortlisting process. Following representations by the Academy of Royal Colleges in early March 2007, the previous Secretary of State asked Professor Neil Douglas to undertake an immediate review, involving representation from across the medical profession and recommend changes to the specialty recruitment process for 2007 as it was happening.

The Douglas Review

5.3.7 The Douglas Review[5] assessed the Round 1 process. Its main intervention was to guarantee all eligible applicants an interview for their first preference.

5.3.8 The recommendations of the review group were accepted by the Department and implemented immediately. As a result:

[5] Douglas Review Report (August 2007): http://www.mmc.nhs.uk/download_files/final%20reportx.pdf

— all applicants were able to have at least one interview in Round 1 (this became known as Round 1b);
— 84% of vacancies were filled in Round 1 leading to a much smaller Round 2;
— 215 additional posts (in England) at ST3 level were made available in Round 2;
— Round 2 was delayed while Round 1b happened and then managed locally; and
— funding for a further 1000 training posts (in England) was made available after Round 2.

Analysis of Round 1 applications

5.3.9 Since the end of Round 1, data and analysis has become available that assesses the validity of Round 1a shortlisting. This indicates that the original shortlisting process had greater validity than may have been perceived at the time.

5.3.10 Specifically the analysis from Peninsula Deanery (Annex C) concluded:

— The shortlisting framework enabled selectors to discriminate between candidates.
— Shortlisting data is reliable:
  — Shortlisting data show a high level of reliability, considerably above the recommended minimum for high stakes assessment.
  — Correlations between the individual shortlisting sections were positive and significant. A candidate scoring well on one section of the application form was likely to score well on the other sections.
  — There is a very high level of consistency between shortlisters and thus, inter-rater reliability.

5.3.11 South Yorkshire South Humber Deanery analysis showed a high number of offers given to Round 1a applicants (Annex D).

5.3.12 Analysis of the success rates across England showed that 76% of Round 1 run-through programme posts were accepted by applicants successful at Round 1a (Annex E).

5.3.13 Further analysis of the overall process is being conducted.

5.4 Communications and Stakeholder engagement

5.4.1 The success of Foundation and GP programmes were in large measure due to considerable and effective stakeholder engagement and communications. However, specialty training presented a far greater challenge due to the number of specialties their complexity and the short timescales involved.

5.4.2 Stakeholders were involved throughout the MMC design process as indicated by the make up of the boards and steering groups above. Specifically, wide consultation took place during the development of the selection methodology development. Work Psychology Partnership retained a full contact log of their meetings and their consultations with the various stakeholders (Annex F). The selection documentation was designed with the help of three national design workshops with stakeholders using existing structured application forms provided by London and Yorkshire predominately. There were also 19 workshops across every Deanery between September and December 2006. NHS Employers initially delivered six national workshops in September 2006 to ensure that human resources representatives were appropriately informed. The MMC communications team set up the MMC website to communicate with stakeholders and provide regular updates and information. They also held national conferences attended by large numbers of applicants and representatives from the service.

5.4.3 The Department recognises that, whilst significant efforts had been made to communicate the proposed changes, more was required and specifically the message that only a proportion of applicants would get interviews and offers in the first round was not fully understood. It was also not well understood that there would have been a very sizable Round 2. This created a perception that good candidates had been missed.

5.4.4 The need for more information and advice about the selection criteria and the application process was underestimated. The helpdesk facilities were expanded for Round 1b.

5.4.5 The Department's MMC communications team has been expanded to deal with the wider demand for engagement as well as the numerous parliamentary and media queries.

5.5 MTAS database system

5.5.1 Another strength of the MTAS process was that running a national recruitment system allowed tracking of competition ratios and fill rates nationally. For the first time, this has provided applicants and deaneries with a comprehensive overview of the recruitment and selection process at all levels. As a result, high fill rates (so far 92%) have been achieved in most specialties and in most parts of the country. Applicants were given feedback about competition ratios in Round 1a so they could make evidence based choices about their options for re-preferencing in Round 1b and in Round 2.

5.6 MTAS IT functionality and performance

5.6.1 There were a number of complaints about the IT functionality of MTAS during the specialty application period, specifically that it was running slowly or crashed. The statistics do not justify claims of repeated crashing. The system was running and fully available for use above the contracted service level of 99.5% of time measured monthly by the supplier.

5.6.2 However, on two occasions (1 and 2 February), during the specialty recruitment application period, the system ran slowly, causing some users to receive "system busy" messages. This made the system difficult to use during these periods (11 hours in total). This happened just before the original deadline for close of applications of 4 February and created anxiety for applicants that their application forms might not be completed in time. Recognising these difficulties the application deadline was extended from 2.00 pm Sunday 4 February until 9.00 am Monday 5 February.

5.6.3 The Department commissioned an audit of the MTAS system to investigate concerns as part of the review group process. The report found that MTAS system was stable, performed acceptably and contained the necessary functionality to be fit for purpose. Recommendations were made which led to some technical enhancements, more help from the MTAS helpdesk and an improvement in the business processes within Deaneries. The report also recognised the problems created by short development timescales and the need for greater stakeholder engagement.

5.7 MTAS IT security

5.7.1 There was a security breach when data was wrongly made available to Deaneries through an unsecured website. This was not an IT system failure. This breach happened as a result of the actions of the IT contractor who made information about the Foundation Programme applicants available to Deaneries without the required security and password protection. This breached the terms of the contract with the contractor. The problem was rectified immediately and the files withdrawn from the website within 40 minutes of the Department becoming aware of the problem.

5.7.2 There was also a feature of the system design which allowed some anonymous messages to be read by registered and logged on users other than the intended recipient, should that user choose to attempt to see them by deliberately changing their personal reference number. This was not identified as an issue during user acceptance testing. Clearly, it was not a desirable feature. Once highlighted as an issue, this design aspect was amended rapidly to resolve this.

5.7.3 The impact on user confidence that resulted from these breaches led to the Department closing the system for applicant use and the previous Secretary of State apologised to the junior doctors in the House of Commons.

6. *What lessons about project management should the Department of Health learn from the failings in the implementation of MMC?*

6.0 In answering this question, we have addressed overall programme management (covering a number of projects), as well as management of individual projects. We have divided the answer into three parts:

— governance and programme management;

— recruitment project management (including MTAS); and

— lessons.

6.1 Governance and programme management

6.1.1 As is clear from the description of the roles in section 3 above, the governance structures that evolved over time and were complex with too many groups and tiers, and a lack of clarity about which group would take which decision. The structures failed to identify clearly who had the final responsibility. The position of Senior Responsible Officer, was not clarified. In part, this confusion arose because for a time this position was considered as shared, between the DCMO and the Workforce Lead.

6.1.2 The accountability of the Medical Recruitment Board (with responsibility for the important areas of recruitment and MTAS) to the MMC Programme Delivery Board was not sufficiently robust. This extra tier of governance between the MTAS project Board and the MMC Programme Board did not facilitate transparent decision-making.

6.1.3 Many of the governance issues in the implementation of the original ideas of Unfinished Business arose because of mission creep. Whereas the original policy document was narrow in scope—solving the problem of the "Lost Tribe"; the final policies were broader and incorporated other policy decisions under development within the Department. In particular, the need to meet the public commitment to a consultant led service, in a cost efficient manner had generated a need for the reduction in training times and creation of generalists.

6.1.4 When, in early March 2007, it became clear that the MTAS process had lost the confidence of the profession, the Douglas Review Group was set up and started meeting approximately weekly. It effectively took the place of the MMC Programme Board, which stopped meeting. The Douglas Review Group made recommendations for immediate action to the Secretary of State and Minister for Health. The Review Group's membership included a number of Presidents of Royal Colleagues (nominated by the Academy), British Medical Association representatives (including the Junior Doctors Committee), Deans, a Strategic Health Authority Chief Executive and representatives from the Devolved Administrations. Senior officials of the Department of Health were on the Review Group, including the Director General of Workforce, and the Deputy Chief Medical Officer.

6.1.5 In March 2007, the scope of the project was reviewed and a new, unambiguous, Senior Responsible Owner (SRO) was established In addition, a dedicated programme office was established to assist him. In early May, an interim appointment was made to a new post of Chief Operating Officer to provide a full time, single line of accountability with responsibility for ensuring successful delivery of:

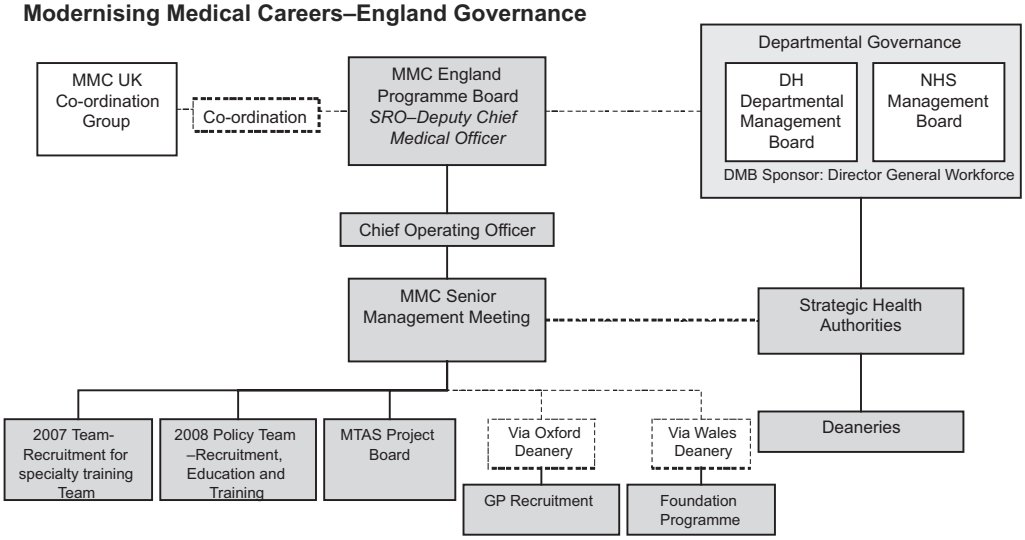
— the changeover of junior doctors on 1st August 2007;
— final implementation of the 2007 recruitment process; and
— planning for 2008 recruitment, education and training.

6.1.6 In order to achieve these outcomes, the Chief Operating Officer recommended a revised programme management which was approved by the Department in early June. It covered:

— a new simplified governance structure (see the chart below);
— a programme structure which clearly defined projects, products and project leaders, project managers and authorities for signing off products;
— a new organisational staffing structure, and a re-allocation of staff to establish a policy team to start work on 2008 and an implementation team to deliver the 1 August 2007 changeover and complete the 2007 recruitment;
— significant additional staff who were appointed to strengthen implementation leadership, project management and the communications function;
— new performance management arrangements agreed with Strategic Health Authorities; and
— improved project plans and a revised risk register, were introduced with progress reviewed at weekly meetings of the Senior Management Team.

6.1.7 The diagram below outlines the governance structure approved in early June 2007.

Modernising Medical Careers–England Governance



The new governance structure is intended to:

— provide for clearer and more direct accountability;
— bring together responsibilities for taking forward MMC itself, recruitment and any IT solutions;
— places responsibility with accountable bodies; and
— focus on responsibility for England, whilst providing a framework to ensure there is coordination of UK-wide issues across the countries.

6.1.8 The new MMC Programme Board was set up following the Douglas Review to oversee future development and implementation of MMC. It held its first meeting in July 2007. The Board draws more than half of its membership from across the medical profession as a key learning has been the need for a

deeper level of clinical engagement and clearer commitment from the medical profession in the development and design of MMC. This is in recognition of the fact that despite the strenuous efforts made to consult throughout the process, this may not always have resulted in true engagement.

6.1.9 The Programme Board also includes a wide range of other stakeholders. One of its purposes is to generate even more engagement as evidenced by its membership.[6]

6.1.10 The Programme Board is responsible for making recommendations to Ministers, ensuring that there is strong service and professional input into the development of policy and implementation plans, and overseeing effective programme management and delivery.

6.1.11 At a local level, Strategic Health Authorities have and had overall responsibility for ensuring the local implementation of the MMC reforms. However, in practical terms the Strategic Health Authorities all have Postgraduate Deaneries (some with one, others with two) to take on the day to day responsibility for planning and establishing the administrative framework, training programmes, training processes, support for trainers and educational supervisors, and quality control, improvement and management of Foundation and specialty programme training. The precise relationship between an SHA and Deanery(ies) varies but all have explicit governance arrangements to ensure the effective delivery of Foundation and Specialty Training at a local level.

6.1.12 *A guide to postgraduate specialty training in the UK* (the Gold Guide) was published in June 2007 and sets out the arrangements for the introduction of competence based specialty training in the UK. It primarily deals with operational issues to help support the transition from specialist training which has been in place since 1996 to the new arrangements for specialty training. The guide has been developed through an iterative process of reflection and discussion involving Postgraduate Deans, Medical Royal Colleges and Faculties, professional associations and the four Health Departments. It has also retained important elements of the preceding Guide to Specialty Training and the GP Registrar Scheme Vocational Training for General Medical Practice UK Guide which it replaces.

6.2 Recruitment Project Management (including MTAS)

6.2.1 The main weaknesses in recruitment project management were the very ambitious timescale for developing and implementing MTAS, national process rules developed separately from the IT project, late policy decisions leaving insufficient time for piloting and full testing, and leading to very late changes being made to the IT specification.

6.2.2 The future training structure for MMC continued to be developed until final agreement in 2005. Once it was clear what trainees were being recruited into, it was then possible to develop recruitment proposals.

6.2.3 In December 2005 the Medical Recruitment Board was established to co-ordinate the projects across the UK with the expectation that a national system would be developed for recruitment into Foundation and specialty programmes commencing August 2007.

6.2.4 Having set a very ambitious timescale, the specification for the system should have been fixed at the cut-off point in September 2006. That would have allowed time for completing the design, building and testing. However, changes to the specification were being made long after that—even after recruitment had started (the decision by London and KSS deaneries to be one Unit of Application). This meant that changes were being made and tested under enormous pressure and without sufficient time to do the work properly.

6.2.5 It would have been more prudent to plan for implementation of national specialty recruitment for 2008 rather than for 2007 recruitment. There was insufficient time to pilot the new specialty systems before using them nationwide for the 2008 recruitment. Cut-off dates were not adhered to and policy decisions, including process rules, were not defined early enough. The MMC Programme Board could have brought this to the attention of the UK Strategy Group which was responsible for policy so that a decision to stop or defer the project to 2008 could be taken on a four nations basis. However, there was a strong imperative to implement it in 2007 because that was when the first cohort of Foundation trainees completed their training, the IT system was on track to open for applications on time and Strategic Health Authorities had reported that their deaneries were ready to run the local processes for the 2007 recruitment.

6.2.6 The UK dimension and the fact that the IT system in England was run separately from the MMC programme, with a different Senior Responsible Owner for each, led to complex governance arrangements and ambiguity. This led to the lack of clear scope. For example, as late as December 2006 the Devolved Administrations were not signed up to using MTAS for a UK-wide specialist recruitment process.

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

6.2.8 The development of the MTAS computer system was subject to a formal project management approach. Initiation controls were put in place, but there were problems with the project in its scope and approach.

[6] http://www.mmc.nhs.uk/pages/programme_board

6.2.9 The scope of the MTAS project was limited to development of the IT application support service and technical helpdesk only, excluding the policy and business process decisions that underpin the requirements of that system (eg the number of applicants preferences to be considered concurrently were the responsibility of COPMED's Rules Group and the UK Strategy Group). The policy and business process decision making and the MTAS project, should have been integrated under less complex governance.

6.2.10 The Project Initiation Document specified a technical assurance role for Department Information Services. This was provided in the form of ad hoc advice to the project manager for example in technical assessment of suppliers and assurance of acceptance testing plans and scripts. However, Department of Health Information Services were not present at Project Board meetings to provide assurance.

6.2.11 The Douglas Review's report describes anecdotal problems faced by applicants using the system. However, the Department's audit of the MTAS IT system in March concluded that the system met its specification, was stable and performed acceptably except for the two periods of slow running described in para 5.6.2 above. Generally the system contained the necessary functionality to be fit for the purpose for which it was designed. After the security breaches a further review was conducted which led to a strengthened role for the Department's internal IT function in the procurement and implementation of Department of Health IT projects. In addition the necessary changes were made to the IT system to make it more secure.

6.2.12 MTAS was used successfully for the 2007 recruitment to the Foundation Programme. The MTAS service was not re-opened to applicants for Specialty Training after it had been closed due to the security breaches. However, it was re-opened for use by deaneries for recording acceptances and checking eligibility and for producing data on the pattern of acceptances by fill rate and applicant cohort.

6.2.13 The computer system is being used again for recruitment to the 2008 Foundation Programme, which starts in October. It will not be used for speciality training recruitment in England for 2008.

6.3 Lessons

6.3.1 For 2008 recruitment, the Department is planning only those changes that are very important and that it is confident can be implemented successfully in the short time available before recruitment starts in January. All policy recommendations on the changes to the recruitment process were agreed at the MMC Programme Board on 1 October 2007 and approved by Ministers shortly afterwards to allow time for implementation planning. Ministers have agreed not to use a national computer system for recruitment to hospital specialties in 2008, but work will begin on a computer system for introduction in 2009.

6.3.2 More radical changes, such as potential use of invigilated machine-markable tests (as used for GP recruitment) and selection centres are to be piloted in 2008 for possible nationwide use in 2009.

6.3.3 Future programmes should carefully consider whether the approach being undertaken amounts to a "big-bang" introduction of new systems or processes, and if so, should consider the use of pilots to establish the efficacy of what is being proposed.

6.3.4 Governance of future programmes should be clear, simple and unambiguous with appropriate stakeholder involvement in the Programme Board and project or task groups. It is imperative that an appropriate single Senior Responsible Owner be appointed to oversee the entirety of the programme's scope.

6.3.5 Future development of IT systems by the Department of Health should include, as part of the scope of the programme those policy and business processes that underpin the IT systems.

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

6.3.7 Changes to the agreed scope or approach of any future programme involving IT system development should be subject to a change control process that includes scrutiny by the assurance function, approval by the Senior Responsible Officer and Programme Board and deadlines after which approval and changes can only be given by a higher level in the management structure.

6.3.8 Assurance of the programme (management, finance, risk, IT/technical) should be undertaken through the identification at programme initiation of appropriate quality and/or review processes and deadlines . Such quality and review processes should be clearly documented. The Senior Responsible Officer should ensure that proper verification has taken place before the programme progresses beyond its previously identified review or break points.

7. *The extent to which MMC has taken account of the supply and demand of junior doctors and the number of international medical graduates eligible for training in the UK*

7.1 Context

7.1.1 The number of medical training places made available at undergraduate and postgraduate levels is based on the long-term forecast demand for trained doctors and Government policy to move towards self-sufficiency in the supply of trained doctors. Medical school intake in England increased significantly from 3,749 in 1997 to 6,451 in 2006. This will enable us to move towards a greater degree of self-sufficiency in the future. The aim is that the increase in UK supply will, over time, reduce reliance on international medical graduates to take up specialist training in order to meet the demand for trained specialists.

7.1.2 The number of doctors in specialist training has increased and will need to continue at the level required to provide the NHS with the supply of trained specialists it requires for the future. Postgraduate training demand is driven by:

— Hours trained doctors work. This will continue to decrease as the number of women entering training increases, more people work part-time, and there is a general expectation of a different work/life balance. As a consequence, more doctors need to be trained to provide the same output of trained doctors.

— Hours doctors in training work. The hours junior doctors work continues to decrease as the European Working Time Directive reduces the hours from 56 to 48 by 2009.

— Increased demand for trained doctors. Increases are driven by the changing demography, the greater needs of an ageing population, patient expectations and service improvements and the move towards more service being delivered by trained doctors and less by doctors in training. Increased demand may be offset by greater productivity and changing skill mix.

7.2 Planning for transition to MMC

7.2.1 It was inevitable that the transition from the old training system would be difficult because of the distribution of Senior House Officers, particularly in the high competition specialties where there were many more Senior House Officers than Specialist Registrars. Under the old system Senior House Officers could try for several years to get into a high competition specialty training place. Some succeeded whilst others eventually reviewed their options and sought training in either a different speciality or a different location. This meant that in the first year of MMC training would be many Senior House Officers competing for a limited number of training places. The position was exacerbated by the number of service posts that had been created at Senior House Officer level, thus widening the competition further.

7.2.2 To mitigate this and to accommodate the "bulge" of Senior House Officers in the system, the number of training posts in 2007 was maximised. A balance had to be struck across the number and type of posts made available, the experience and aspirations of junior doctors to work in particular specialties and geographies and the needs of the NHS for trained doctors; in total and in particular specialties and geographies. Providing extra training solely to meet career aspirations would be a waste of resources, leading to unemployment later.

7.2.3 The MMC website[7] shows the competition ratios for each of the deaneries and specialties as at Round 1a. This demonstrates for example that the high competition in surgery in London means that a lot of good applicants will not get training posts in that specialty in that deanery.

7.2.4 Doctors in training were encouraged to consider their options carefully in light of the competition ratios. Those pursuing popular specialties in popular locations were advised to review their career choices and be realistic.

7.2.5 The England training posts for 2007 were created out of:

— 16,500 educationally approved Senior House Officer posts.

— 2,500 Specialist Registrar and 2,500 General Practice Registrar posts.

— 2,300 service posts.

7.2.6 This total training capacity of 23,800 posts in 2007 has provided 4,900 posts for the second year of the foundation programme and the 18,900 specialty training posts, of which 3,400 GP posts were outside the MTAS system. There were more training posts than ever before because 2,300 service posts had been converted into training posts. The number of training posts made available compares with 22,500 junior doctors occupying Senior House Officer or F2 posts in 2006. Not all of these Senior House Officer posts were formally approved training posts.

[7] http://www.mmc.nhs.uk/pages/cr

7.3 The potential applicant pool

7.3.1 The planned transition of existing Senior House Officers in training into new MMC programmes was made more difficult by the potential interest in training posts from doctors working in NHS service posts (ie non-training posts), and by interest from outside the NHS. Over the last five years the number of doctors employed in service posts at Senior House Officer level had increased significantly. The number of doctors working in the NHS and the number applying for training posts in 2007 is set out below.

	England	*UK*
Number of posts	**15,554**	**19,112**[8]
Eligible Applicants:	**27,800**	**32,500**
UK Nationals	13,800	16,500
EEA applicants (not inc UK)	1,900	2,400
Non-EEA HSMPs[9]	8,900	10,000
Non-EEA non HSMPs	3,200	3,600

Of the eligible England applicants 25,500 were NHS workers (UK 29,600).

Further figures are available in Annex E.

7.3.2 The potential for doctors in service posts and doctors outside the NHS to apply for a fixed supply of training posts was recognised. In order to maximise the opportunities for UK medical graduates and doctors in NHS training, the availability of permit-free training was curtailed in 2006. The Department also issued guidance advising that doctors outside the EEA applying through the Highly Skilled Migrant Programme should be considered for run through specialty training posts only if there was no suitable UK or EEA applicant.

7.3.3 That guidance was challenged through a Judicial Review. The Court found that the guidance was lawful. The Court's judgement was received after the recruitment process had started (9 February). It would have been logistically difficult, but possible and legally justified, to implement the guidance at this late stage. However, as shortlisting and invitations to interview were already underway, it was judged that the disruption would be too much, particularly given that Round 1 was expected to fill only 50 per cent of the posts and the option still remained to apply the guidance in Round 2. There was also a serious risk of further legal challenge which would have frustrated recruitment by the required deadline of 1 August if the DH had implemented the Court ruling. The subsequent decision of the Douglas Review Group (see above 5.3.8) to extend Round 1 to guarantee all eligible applicants at least one interview (so that 85% of posts were filled in that round) considerably weakened the argument for applying the guidance in Round 2 and therefore the opportunity to implement the guidance was lost.

7.3.4 As a result the competition for specialty training posts was significantly increased.

7.3.5 In recognition of the impact of the high level of competition, an additional 215 run-through training posts at ST3 level were made available in Round 2, as recommended by the Douglas Review, and a further 1000 training posts have been be made available after the second round of the 2007 recruitment. These transitional posts aim to:

— provide extra training opportunities to doctors who are appointable but for whom there are no training posts this year, aimed at doctors applying for the over-subscribed specialties helping them to redirect their careers into other specialities;

— enable the NHS to retain talent and ensure that a cohort of appointable doctors are available to compete for specialty training where they are needed in future years; and

— provide doctors going through the recruitment process with support and careers guidance tailored to their needs.

7.3.6 The competition for places is likely to be even higher next year with a forecast competition ratio of 3:1 (rather than the 2:1 ratio of this year). Over half of applicants are likely to have trained outside the EEA.

7.3.7 The position for 2008 is currently being assessed and consulted on. The Department's preferred option is that doctors from outside the EEA with limited leave to remain in or enter the UK should be considered for post-graduate medical training places in the NHS, only if there is no suitable UK or EEA applicant.

[8] Not including 3,400 GP posts filled outside MTAS.
[9] Highly Skilled Migrant Programme workers.

8. *The degree to which current plans for MMC will help to increase the flexibility of the medical workforce*

Summary of Existing Flexibility

8.1 The design of medical training under MMC provides greater flexibility for medical workforce planning as changes to medical workforce requirements and changes in demand for different specialties can be accommodated by adding specialty training posts at ST1–4, at various entry points in the future as they are needed. As outlined above, the transition package for 2007 is designed to provide specific training to help applicants gain competencies so that doctors unsuccessful in highly competitive specialties can transfer to shortage specialties.

Flexibility in 2008 and beyond

8.2 The Department has received Tooke review recommendations for 2009 and beyond and is considering them. Possible changes to 2008 have been considered by the Programme Board in the light of feedback from the 2007 process, including the recommendations of the Douglas Review.

Timing of application process and start dates

8.3 The Department is proposing that there be more than one entry point into specialty training a year, but it should be for deaneries and specialties to determine entry dates. This will allow specialties to fill vacant posts more often during the year.

Transfer of competencies

8.4 Agreement of transferable competencies between specialties should allow trainees to change specialities and enter at a higher level or, if accepted onto another speciality, to move more quickly through the training programme. There is considerable potential here, but more work needs to be done between Colleges to agree common training and transferable competencies.

Fixed Term Specialist Training Appointment

8.5 In the context of limited resources and workforce planning, there needs to be careful modelling of numbers, and improved advice and support through the profession to support those in Fixed Term Specialist Training Appointments at this time of transition.

8.6 A number of the different models for the offer in 2008 are being considered. These include models that have the potential to provide a larger pool of core trainees, and no Fixed Terms Specialist Training Appointments, with a major competitive hurdle at entry into ST3 rather than ST1.

Run-through training

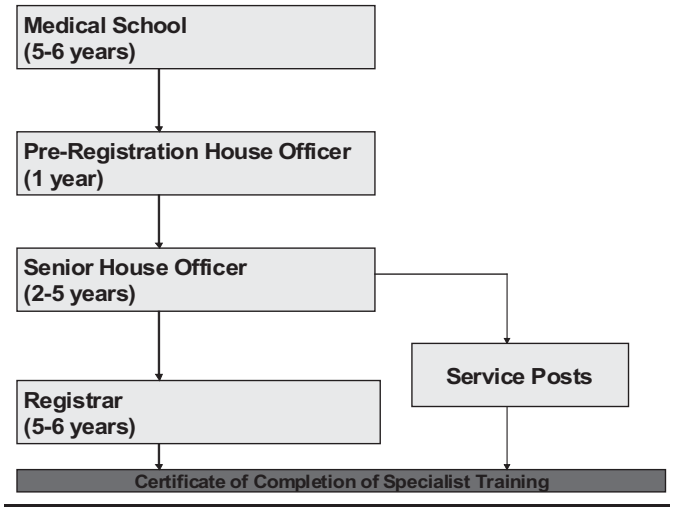
8.7 Other models being considered include the possibility of uncoupling higher speciality training (ST3 and above) from core training.

8.8 Uncoupling gives trainees more flexibility to apply to another speciality, and allows selection of final speciality to be later in a trainees career, but introduces potential geographical uncertainty and potential for displacement from progression. As different specialities have different needs, consideration needs to be given to allowing different models for different specialities (mixed economy). This will be more complex to manage, but will allow increased flexibility.

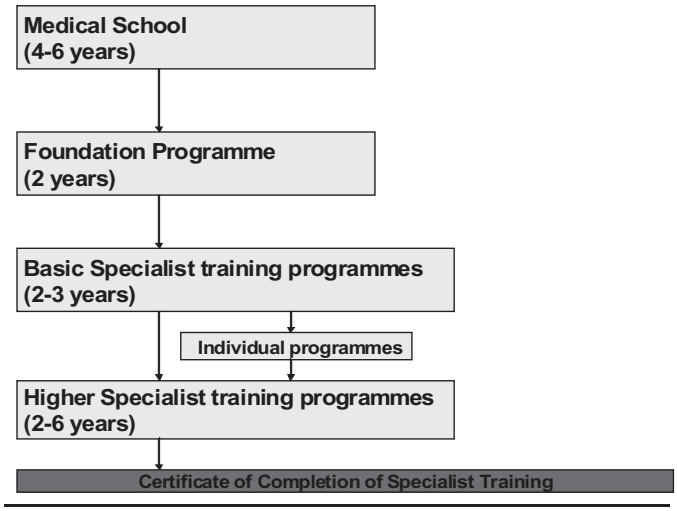
October 2007

Annex A: A description of medical training before and after MMC

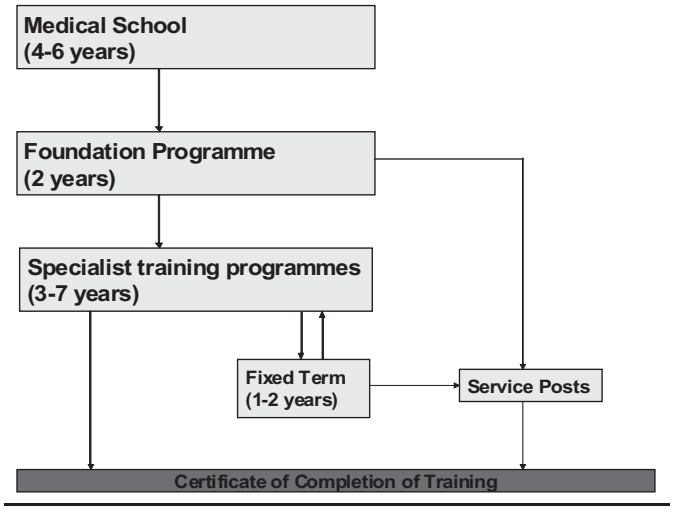
The Old System



The Unfinished Business System



The MMC System



Source: Chief Medical Officer

Annex B

LETTER FROM MARK DEXTER, HEAD OF POLICY, PMETB TO DR SARAH THOMAS, THE CONFERENCE OF POST GRADUATE MEDICAL DEANS OF THE UK (21 SEPTEMBER 2006)

National Recruitment and Selection into Specialist Training

On behalf of PMETB, I would like to thank you for your presentation on Friday 25 August 2006 summarising the proposals for selection and recruitment into specialist training on behalf of MC. Please also pass on our thanks to Professor Patterson for covering the methodology of the process so comprehensively, and to Matra Kerrin for her valuable input into the discussion.

Your helpful presentation provided the panel with a good insight to the UK-wide, overarching framework for delivery of the Medical Training Application Service (MTAS) and associated mechanisms and the developmental work underpinning the selection methodology. We would like to acknowledge, in particular, the significant steps taken to ensure wide consultation with stakeholders who are key to implementation ie deaneries, trainees, colleges/faculties and employers, and note the intention to seek endorsement from the UK MMC Strategy group for the proposals and implementation thereof.

The overarching strategy outlined broadly meets the relevant sections of PMETB *Generic Standards for Training* (Domain 4), including the *Principles for Entry to Specialist Training*, set in the context of the governing legislation and our duty to the service—covered in *The General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003*.

Clearly there are challenges in introducing such a new system, and we would be most interested to receive, for information and when available, further details on some key aspects of UK-wide implementation, including the schedule for introduction of the essential constituent parts of the process, the reliability of the proposed national computer-based system and measures to avoid unintentional discrimination against candidates. We noted your anticipation of some reluctance to embrace the new system and your intention to address this through further negotiation with key stakeholders, regarding in particular nationally consistent local quality management arrangements.

Ultimately, PMETB will wish to revisit and review the operation of the new system, once it has been established, against our Generic Standards for Training including the Principles for Entry to Specialist Training, and in the context of our statutory responsibilities.

Once again, many thanks for keeping us informed of these proposals, evaluation of which will, in due course, form a part of PMETB's quality assurance work as the regulatory body.

Annex C

NATIONAL SELECTION INTO SPECIALTY TRAINING 2007 EVALUATION OF SHORTLISTING DATA NHS EDUCATION SOUTH WEST (PENINSULA INSTITUTE), FORMERLY THE SOUTH WEST PENINSULA DEANERY

Introduction

The aim of this report is to evaluate the shortlisting data for all specialties and all levels as appropriate. All results reported are based on the 2007 shortlisting data for posts in the Peninsula Institute.

Specifically, the analysis examines the reliability (internal reliability and inter-rater reliability between shortlisters) and the validity of the shortlisting scoring process (by examining the correlation between scores at shortlisting and subsequent score at interviews).

The evaluation is focused on the following six question areas:

Question 1. *Is the data used to make shortlisting decisions normally distributed to allow differentiation between individuals?*

Question 2. *Is the shortlisting data reliable (internally consistent)?*

Question 3. *Is there inter-rater reliability (consistency) between the shortlisters?*

Question 4. *To explore internal validity, which sections of the form predict the shortlisting outcome?*

Question 5. *How was the Shortlisting Bar (pass mark) determined relative to applicant scores?*

Question 6. *Does the shortlisting have predictive validity—ie do shortlisting scores correlate with scores at interview?*

Background

The Peninsula Institute advertised 380 posts for Specialty Training in hospital-based Specialties in 2007 via the Medical Training Application Service (MTAS).

Consultants from the Specialty the applicants were applying to performed short listing. For smaller Specialties, two Consultants shortlisted the entire application. For larger Specialties, shortlisters scored one part of the application form (A, B or C/D) for a proportion of candidates applying to the Specialty consequently each application was scored by six Consultants.

Method

Participants/Data/Sample

The analysis used data from the 2007 Round 1 shortlisting and interview processes at The Peninsula Institute. Excluding almost 100 applications from applicants who did not meet the longlisting criteria, the remaining applications were shortlisted.

The data available are scores for every candidate for each shortlisting question from both shortlisters, plus total interview scores for successful candidates. For interview scores, data was limited to Specialties where the Peninsula Institute was lead deanery. In total the analysis was based on approximately 1,993 applications for posts in the Peninsula Institute (across all entry levels and specialties), approximately 1,500 of which were directly to the Peninsula Institute as Lead Deanery.

Analysis included all specialties where at least 20 candidates were considered at the shortlisting stage (so that the sample size was sufficient to run the statistical analyses). This final data set consisted of 9 ST1 specialties, 8 ST2 specialties, 9 ST3 specialties and 1 ST4 specialty.

Data Analysis

Data analysis was conducted using SPSS 12.0 for Windows. In order to examine the properties of the shortlisting framework, for most of the analyses each set of shortlisting marks was treated as a separate case (ie Shortlister 1's marks for Candidate A were treated separately from Shortlister 2's marks for Candidate A). The table gives the number of cases for each specialty when the data is treated this way (ie twice the number of candidates). However, further detail is provided below on the analyses strategy in relation to reliability and validity.

Descriptive Statistics

The table shows descriptive statistics for total shortlisting scores for each specialty (mean and standard deviation). Total shortlisting score is the final total used for decision-making (ie combined total from both shortlisters). The pass mark for each specialty is also shown, representing the lowest total shortlisting score of any candidate attending for interview.

Reliability

The reliability of shortlisting scores was examined using a several approaches. Internal consistency reliability was measured using Cronbach's alpha. Firstly, alpha coefficients for the shortlisting framework itself (14–16 item scale[10] depending on the specialty and level) were calculated. For this analysis, individual shortlisters were treated as separate cases. Secondly, as selection decisions were based on two shortlisters marking each application, alphas were calculated taking both sets of scores into account (28–32 item scale, depending on the specialty and level). Inter-rater reliability of the shortlisting process was assessed using Pearson product-moment correlations between the total scores awarded to candidates by each shortlister.

Correlations Between the Shortlisting Sections of the Application Form

The shortlisting framework consisted of four sections of questions: A = Commitment to the Specialty (3 questions), B = Clinical, Academic & Research Skills (approximately 6–8 questions depending on the specialty and level of entry), C = Personal Skills (2 questions for ST2 and above, 3 questions for ST1) and D = Probity (1 question). Sections C and D were combined for the purposes of this analysis (as there is only one question in Section D). Pearson product-moment correlations were used to examine the relationship between total score for each shortlisting section (from an individual shortlister) and overall total shortlisting score (total of both shortlisters).

[10] An item represents a question on the application form.

Correlation between Shortlisting Score and Interview Score

Where interview scores were available and the sample size was sufficient, Pearson product-moment correlations were used to examine the relationships between total interview score, total shortlisting score (both shortlisters) and total score for each shortlisting section (individual shortlisters).

Association between Shortlisting Sections and Overall Shortlisting Score

Multiple stepwise regression analysis were used to examine the extent to which each shortlisting section (marked by individual shortlisters) predicted total shortlisting score (both shortlisters). The overall shortlisting score was the dependent variable and the shortlisting sections (A–D) were the independent variables in the analysis. The intention was to examine which of the shortlisting sections contributed to predicting the overall shortlisting score (and thus, shortlisting decisions). Using a stepwise analysis, the results show the order in which the shortlisting sections contribute to the prediction of total shortlisting score for each specialty (biggest predictor first). The R squared change for each predictor is reported and this indicates the additional amount of variance in total shortlisting score that is explained by adding each shortlisting section into the regression equation.

RESULTS

Question 1. *Is the data used to make shortlisting decisions normally distributed to allow differentiation between individuals?*

Total shortlisting scores and scores for each shortlisting section were normally distributed for all specialties and entry levels; this indicates that the shortlisting framework enabled selectors to discriminate between candidates. The distribution of shortlisting totals and individual sections for every specialty was examined and all were normally distributed. Only one specialty (ST3 Ophthalmology) had a slightly skewed distribution of overall score (-1.44). On further analysis, skew is due to two very low-scoring outliers.

Question 2. *Is the shortlisting data reliable (internally consistent)?*

The average internal reliability of shortlisting decisions (using scores from both shortlisters) across the 27 specialties examined is $\alpha = .89$. This is shows a high level of reliability, considerably above the recommended minimum for high stakes assessment. If each shortlister is treated as a separate case, the average internal consistency reliability of the shortlisting framework across 27 specialties is $\alpha = .80$.

Correlations between the individual shortlisting sections were positive and significant. This shows that a candidate scoring well on one section of the application form was likely to score well on the other sections. The average correlations between shortlisting sections across the 27 specialties was $r = .48$ (Section A and Section B), $r = .37$ (Section A and Section C/D) and $r = .37$ (Section B and Section C/D).

Question 3. *Is there inter-rater reliability (consistency) between the shortlisters?*

Inter-rater consistency was assessed by correlating the total scores of each shortlister. The average correlation between shortlisters across the 27 specialties examined is $r = .82$, representing a very high level of consistency and thus, inter-rater reliability.

Question 4. *To explore internal validity, which sections of the form predict the shortlisting outcome?*

For almost all specialties at ST2 and above (the exception being ophthalmology), Clinical, Academic & Research Skills (Section B) was the largest predictor of total shortlisting score, and therefore of shortlisting decisions. At ST1, the order of predictors varied across the specialties. For almost all specialties (with only two exceptions), each shortlisting section added significantly to the prediction of shortlisting outcome.

Question 5. *How was the Shortlisting Bar (pass mark) determined relative to applicant scores?*

In the Peninsula Institute, the number of applicants shortlisted depended on the capacity of the deanery to interview applicants and was informed by competition for posts in each Specialty nationally.

In highly competitive Specialties, the shortlisting bar (pass mark) was set at an arbituary score determined by the capacity of the Deanery to interview trainees in the Specialty. In addition it was also recognised that in highly competitive specialties, there were very few Specialty Training posts in the deanery consequently interviewing many more applicants than we had posts would not result in more appointments being made.

In harder to recruit Specialties, such as Paediatrics and Psychiatry, as many trainees as possible were interviewed in the Selection Centre and the shortlisting bar were lowered. (see Graphs 1a-c). In small Specialties if there were few applicants all trainees were interviewed.

Graphs 1a–c clearly show that for most Specialties and levels the shortlisting bar had to be set well above the mean score of applicants. Consequently in the Peninsula Institute many good applicants with application scores well above the mean were excluded from interview due to lack of capacity to interview in the agreed timeframe for Round 1A.

An example of this is recruitment and selection for ST2 Orthopaedics (as shown in Graph 2). Eighty ST2 Trauma & Orthopaedics applicants applied for 5 Specialty Training Posts and 13 FTSTAs. The mean application form score for these applicants was 59.9 ± 15.2. The shortlisting Bar set at 65 so 29 applicants (36%) were interviewed in the day allocated to this Specialty and level in Round 1A.

Question 6. *Does the shortlisting have predictive validity—ie do shortlisting scores correlate with scores at interview?*

As described previously, the number of trainees interviewed for each Specialty and level was based on capacity to interview and the number of posts available for applicants rather than entirely on applicant suitability. Applicants scoring above the shortlisting bar were interviewed.

In general, this analysis shows that shortlisting scores are positively correlated with performance at interview. The average correlation between total shortlisting score and total interview score across 16 specialties (where 20 or more candidates were interviewed) is $r = .36$. There is a significant positive correlation between total shortlisting score and total interview score for all ST1 specialties. For one specialty (ST2 paediatrics) there was not a positive correlation between shortlisting and interview score.

In evaluating the predictive validity of a selection instrument, a correlation of this magnitude is more than sufficient to demonstrate predictive validity (eg for further references see BMA report on validity of selection methods, http://www.bma.org.uk/ap.nsf/Content/selectionforspecialtytraining page 29; see also Muchinsky, 1986; Smith & George, 1992; Salgado *et al*, 2001; Arnold *et al*, 2005).

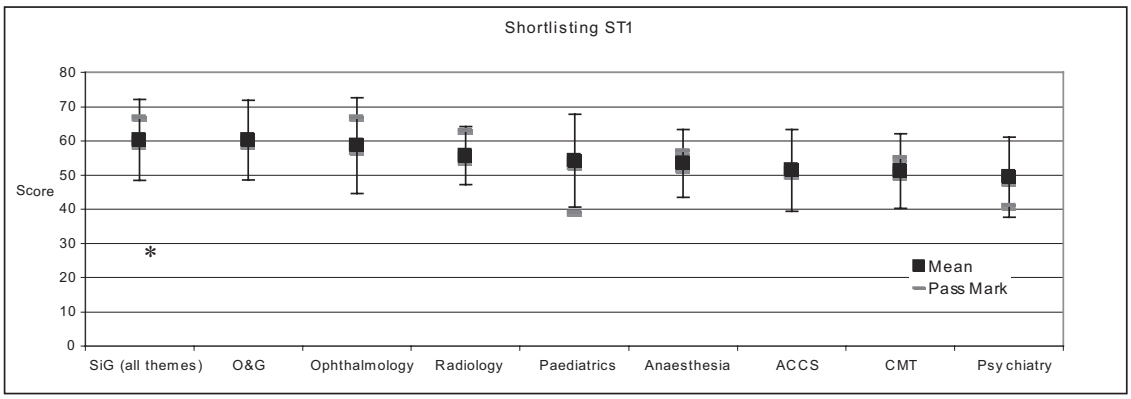
Conclusions on Shortlisting evaluation in the Peninsula Institute:

- The shortlisting framework enabled selectors to discriminate between candidates.
- Shortlisting data is reliable:
  - Shortlisting data show a high level of reliability, considerably above the recommended minimum for high stakes assessment.
  - Correlations between the individual shortlisting sections were positive and significant. A candidate scoring well on one section of the application form was likely to score well on the other sections.
  - There is a very high level of consistency between shortlisters and thus, inter-rater reliability.
- For almost all specialties at ST2 and above (the exception being ophthalmology), Clinical, Academic & Research Skills (Section B) was the largest predictor of total shortlisting score, and therefore of shortlisting decisions. At ST1, the order of predictors varied across the specialties.
- In highly competitive Specialties, the shortlisting bar (pass mark) was set at an arbituary score determined by the capacity of the Deanery to interview trainees in the Specialty and reflecting the relatively few posts available to applicants. There were consequences in Round 1A:
  - For most Specialties and levels the shortlisting bar had to be set well above the mean score of applicants.
  - Many good applicants with application scores well above the mean were excluded from interview.
- In Specialties where recruitment was expected to be less likely, the shortlisting bar was lowered so that as many applicants as possible were interviewed in Round 1A. This applied to psychiatry and paediatrics at most levels. There were consequences in Round 1A:
  - The shortlisting bar was set below the mean score of the applicants in several Specialties and levels.
  - Most applicants were interviewed.
- In general, this analysis shows shortlisting scores are positively correlated with performance at interview. The average correlation between total shortlisting score and total interview score across 16 specialties (where 20 or more candidates were interviewed) is $r = .36$. A correlation of this magnitude is more than sufficient to demonstrate predictive validity.

Report prepared on 29 April 2007 by: Dr Alison S Carr FRCA MSc PGCertMEd, Deputy Postgraduate Dean NHS Education South West (Peninsula Institute) and Prof Fiona Patterson PhD CPsychol, Work Psychology Partnership.

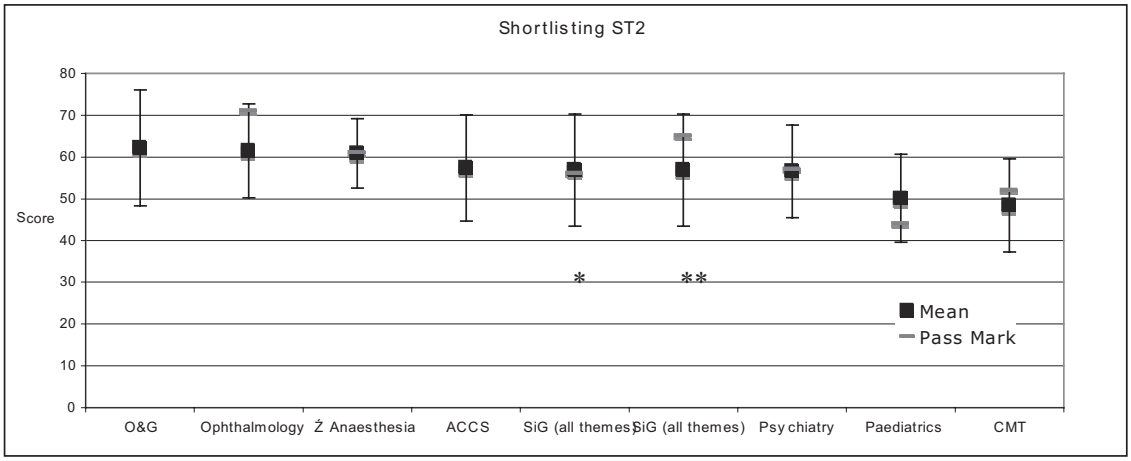
Graph 1 **Shortlisting Scores**

a. Shortlisting Scores at ST1



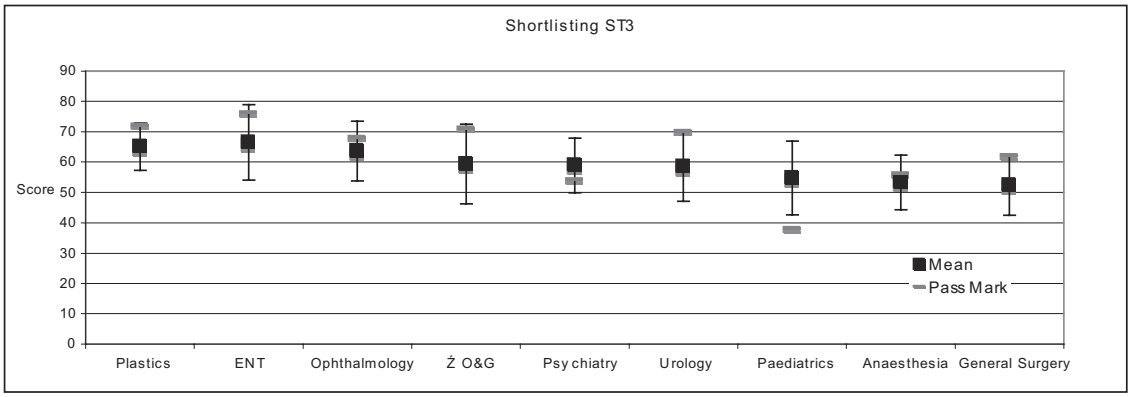
* *Shortlisting bar for SIG Generic*

b. Shortlisting Scores at ST2



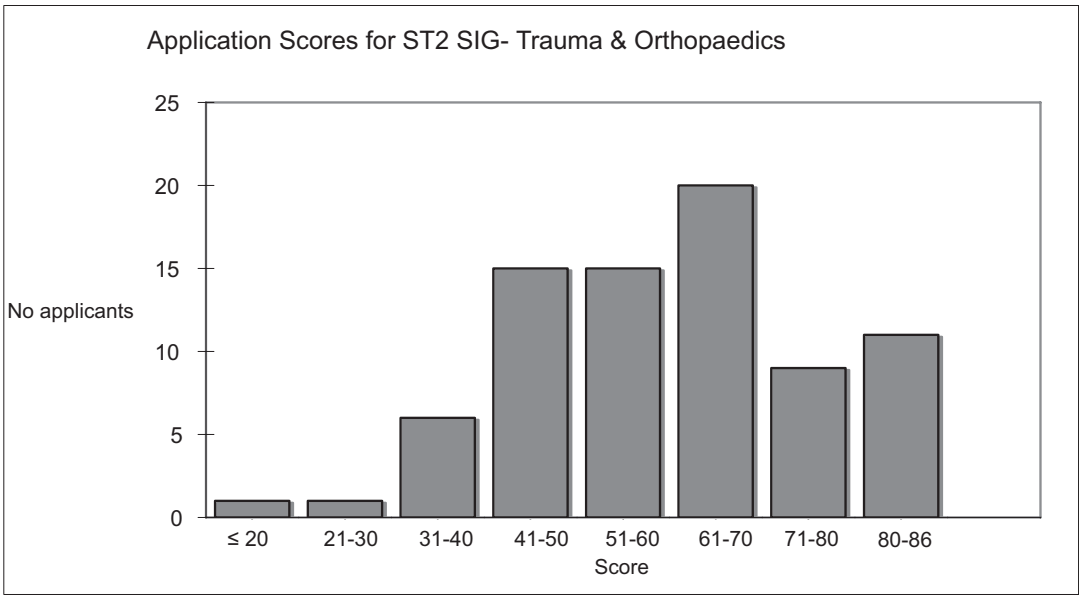
* *Shortlisting bar for SIG General Surgery,* ** *for Trauma & Orthopaedic Surgery*

c. Shortlisting Scores at ST3



Shortlisting scores are shown as mean scores (± standard deviation). The pass mark was the minimum score achieved by an applicant to be shortlisted for interview.

Graph 2



Eighty ST2 Trauma & Orthopaedics applicants applied for 5 Specialty Training Posts and 13 FTSTAs.
Average application form Score = 59.9 ± 15.2, Shortlisting Bar set at 65
29 applicants interviewed (36%).

Table 1

NATIONAL SELECTION INTO SPECIALTY TRAINING 2007: EVALUATION OF SHORTLISTING DATA

		Shortlisting Descriptives					*Correlations between the Shortlisting Sections*[11]							*Correlation Between Shortlisting & Interview Score*		*Predictors of Overall Shortlisting Score*
Level	*Specialty*	*N*	α[12]	*Mean*	*SD*	*Pass mark*[13]	*N*	*Total & A*	*Total & B*	*Total & C/D*	*A & B*	*A & C/D*	*B & C/D*	*Shortlisters 1 & 2*	*N*	*Total*	*Predictors of shortlisting total (R^2 change)*
ST1	1. ACCS	109	.88	51.4	12.0	n/k	218	.77**	.77**	.75**	.50**	.40**	.40**	.88**	n/a	n/a	A (.60), C/D (.23), B (.11)
	2. Anaesthesia	63	.85	53.4	9.9	57	126	.55**	.79**	.62**	.25**	.12	.36**	.72**	24	.51*	B (.63), A (.13), C/D (.12)
	3. SiG (all themes)	141	.91	60.2	11.8	67[14]	282	.63**	.71**	.79**	.37**	.52**	.48**	.76**	29[14]	.45*[14]	C/D (.62), B (.16), A (.04)
	4. CMT	126	.90	51.2	10.9	55	252	.76**	.78**	.68**	.51**	.33**	.52**	.78**	42	.34*	B (.61), A (.17), C/D (.08)
	5. Paediatrics	30	.93	54.2	13.6	39	60	.83**	.89**	.82**	.71**	.69**	.64**	.85**	22	.50*	B (.79), C/D (.11), A (.03)
	6. Psychiatry	28	.90	49.4	11.7	41	56	.66**	.89**	.76**	.38**	.54**	.54**	.87**	21	.62**	C/D (.78), B (.12), A (.03)
	7. O&G	30	.92	60.2	11.6	n/k	60	.64**	.75**	.84**	.61**	.48**	.50**	.86**	n/k	n/k	C/D (.70), B (.14)
	8. Radiology	151	.86	55.7	8.5	63	302	.60**	.77**	.62**	.34**	.14*	.23**	.81**	31	.46**	B (.59), C/D (.21), A (.11)
	9. Ophthalmology	23	.94	58.6	14.0	67	46	.80**	.81**	.87**	.54**	.65**	.66**	.84**	7	n/a	C/D (.76), A (.09), B (.06)
ST2	10. ACCS	142	.89	57.4	12.7	n/k	184	.61**	.83**	.72**	.40**	.18	.40**	.90**	n/a	n/a	B (.68), C/D (.18), A (.09)
	11. Anaesthesia	102	.81	60.9	8.3	61	204	.63**	.85**	.40**	.39**	.04	.19**	.81**	54	.18	B (.73), A (.11), C/D (.07)
	12. SiG (all themes)	193	.91	56.9	13.4	56 65[15]	386	.63**	.86**	.60**	.51**	.30**	.37**	.73**	28 29[15]	.44* .29[15]	B (.75), C/D (.09), A (.03)
	13. CMT	170	.90	48.4	11.2	52	340	.75**	.87**	.61**	.53**	.47**	.43**	.88**	67	.27*	B (.76), A (.11), C/D (.03)
	14. Paediatrics	34	.89	50.1	10.6	44	68	.70**	.77**	.74**	.43**	.56**	.36**	.83**	24	-.02	B (.60), C/D (.24), A (.04)
	15. Psychiatry	51	.88	56.6	11.1	57	102	.71**	.76**	.42**	.55**	.19	.04	.68**	22	.31	B (.58), C/D (.15), A (.08)
	16. O&G	25	.93	62.2	13.9	n/k	49	.73**	.87**	.85**	.52**	.79**	.65**	.89**	n/k	n/k	B (.76), C/D (.14), A (.01)
	17. Ophthalmology	25	.90	61.5	11.2	71	50	.84**	.81**	.26	.56**	.19	−.09	.85**	8	n/a	A (.72), B (.16), C/D (.04)
ST3	18. Anaesthesia	77	.85	53.3	9.0	56	154	.60**	.75**	.72**	.37**	.23**	.33**	.78**	30	.09	B (.57), C/D (.24), A (.08)
	19. General Surgery	93	.87	52.4	9.9	62	186	.66**	.68**	.58**	.57**	.43**	.44**	.72**	18	n/a	B (.47), A (.11), C/D (.06)
	20. Urology	89	.92	58.5	11.4	70	178	.72**	.90**	.39**	.55**	.09	.21**	.88**	16	n/a	B (.81), A (.07), C/D (.04)
	21. ENT	53	.90	66.4	12.4	76	106	.72**	.82**	.54**	.55**	.20*	.48**	.74**	12	n/a	B (.67), A (.11), C/D (.04)
	22. Plastics	57	.80	65.1	7.8	72	114	.54**	.79**	.43**	.29**	.12	.15	.69**	12	n/a	B (.63), A (.10), C/D (.08)
	23. Paediatrics	30	.93	54.8	12.1	38	60	.81**	.85**	.76**	.63**	.52**	.41**	.94**	23	.60**	B (.72), C/D (.20), A (.04)
	24. Psychiatry	35	.87	58.9	9.0	54	70	.75**	.81**	.41**	.39**	.32**	.33**	.85**	20	.49*	B (.66), A (.23)
	25. O&G	30	.93	59.4	13.1	71	60	.85**	.85**	.67**	.72**	.56**	.50**	.92**	8	n/a	B (.73), A (.11), C/D (.03)
	26. Ophthalmology	36	.87	63.6	9.8	68	72	.78**	.73**	.61**	.51**	.40**	.17	.79**	12	n/a	A (.61), B (.15), C/D (.12)
ST4	27. Paediatrics	50	.87	57.9	8.9	53	100	.75**	.80**	.62**	.39**	.42**	.27**	.87**	34	.20	B (.64), A (.22), C/D (.07)

[11] A = Commitment to the Specialty, B = Clinical, Academic & Research Skills, C/D = Personal Skills and Probity, * p = 0.05 (2-tailed), ** p = 0.01 (2-tailed)

[12] This is the internal reliability based on both shortlisters' marks for each candidate. As the shortlisting decisions are based on aggregate scores (2 shortlisters) this is the most appropriate statistic for judging the reliability of assessment as the item scores are treated as separate items in 1 overall shortlisting scale.

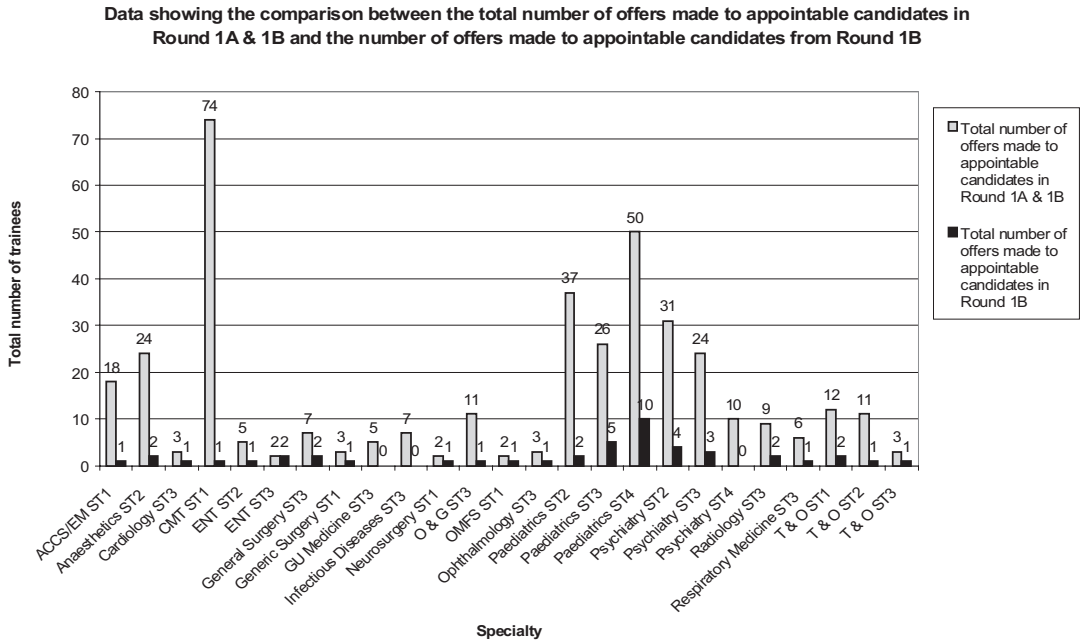
[13] this is the minimum shortlisting total of those candidates invited for interview.

[14] Figures shown is for SiG Generic only.

[15] Figures shown are for SiG General Surgery and SiG T&O Surgery respectively.

Annex D

ANALYSIS OF ROUND 1A AND 1B OFFERS GIVEN BY SOUTH YORKSHIRE SOUTH HUMBER



Annex E

NUMBERS

ROUND 1 SUMMARY

	England	*UK*
Number of posts	**15,554**	**19,112**
Not including 3,400 GP posts filled outside MTAS.		
Eligible Applicants:	**27,800**	**32,500**
UK Nationals	13,800	16,500
EEA applicants (not inc UK)	1,900	2,400
Non-EEA HSMPs*	8,900	10,000
Non-EEA non HSMPs*	3,200	3,600
UK Graduates	13,600	16,500

* Highly Skilled Migrant Programme workers

Of the eligible England applicants 25,500 were NHS workers (UK 29,600)

Acceptances (end of Round 1)	**13,168 (85% fill rate)**	**16,114 (84% fill rate)**
UK Nationals	9,112	11,043
EEA applicants (not inc UK)	705	937
Non-EEA HSMPs*	2,466	3,090
Non-EEA non HSMPs*	885	1,044
UK Graduates	9,336	11,471

* Highly Skilled Migrant Programme workers

Acceptances (end of Round 1)	**13,168 (85% fill rate)**	**16,114 (84% fill rate)**
UK Nationals	69%	69%
EEA applicants (not inc UK)	5%	6%
Non-EEA HSMPs*	19%	19%
Non-EEA non HSMPs*	7%	6%
UK Graduates	71%	71%

* Highly Skilled Migrant Programme workers

Notes on Round 1 Summary

— All data as of the end of round 1.

— Applicant classifications are to some extent uncertain. Due to issues such as the use of free-text boxes in the application form, applicant data does not lend itself to unambiguous classification. These results are based on cohorts derived as well as possible with the data available. Appropriate data is then rounded accordingly.

— Data refers to posts and applications on the MTAS system which excludes approximately 3,500 (UK) and 2,800 (GP) posts filled outside MTAS.

ROUND 1 BREAKDOWN

By Unit of Application

Summary of Round 1 Posts, Eligible Applications, Acceptances & Fill Rates By Unit of Application (UoA)

	Posts:					Acceptances:				Fill Rate:			
UoA	All	Run-Through	FTSTA	Academic	Eligible Applications	All	Run-Through	FTSTA	Academic	All	Run-Through	FTSTA	Academic
Eastern	1,167	919	242	6	9,462	984	765	216	3	84%	83%	89%	50%
England & Wales (Histopathology)	63	63	0	0	298	63	63	0	0	100%	100%		
Leicestershire, Northamptonshire and Rutland	435	342	87	6	2,482	349	302	44	3	80%	88%	51%	50%
London/KSS	4,506	3,630	809	67	21,674	4,020	3,443	524	53	89%	95%	65%	79%
Mersey	793	630	158	5	5,011	721	619	99	3	91%	98%	63%	60%
North Western	1,433	1,071	348	14	11,755	1,322	1,007	305	10	92%	94%	88%	71%
Northern	972	718	225	29	6,787	753	576	169	8	77%	80%	75%	28%
Oxford	591	489	91	11	7,103	454	425	23	6	77%	87%	25%	55%
Severn	665	539	121	5	5,524	588	516	69	3	88%	96%	57%	60%
South Yorkshire & South Humber	529	388	134	7	2,636	391	346	42	3	74%	89%	31%	43%
Southwest Peninsula	494	369	121	4	2,451	364	323	40	1	74%	88%	33%	25%
Trent	591	377	204	10	2,257	379	310	63	6	64%	82%	31%	60%
Wessex	659	468	186	5	4,591	545	439	104	2	83%	94%	56%	40%
West Midlands	1,602	1,049	544	9	11,732	1,241	937	303	1	77%	89%	56%	11%
Yorkshire	1,054	764	289	1	8,930	994	733	261	0	94%	96%	90%	0%
England Total	15,554	11,816	3,559	179	102,693	13,168	10,804	2,262	102	85%	91%	64%	57%
Northern Ireland	525	406	119	0	2,229	536	391	145	0	102%	96%	122%	
Scotland	2,004	1,623	381	0	9,292	1,636	1,503	133	0	82%	93%	35%	
Wales	1,029	622	404	3	4,232	774	538	231	5	75%	86%	57%	167%
UK Total	19,112	14,467	4,463	182	118,446	16,114	13,236	2,771	107	84%	91%	62%	59%

Notes:

- Data as of end of round 1.
- Defence Medical Services excluded.
- There are instances of post groups with fill rates in excess of 100%. Whilst apparently anomalous these are explained by lags in updating MTAS, the inclusion of deferred or part time acceptances and other issues around the way acceptances are recorded into MTAS.
- Data refers to posts and applications on the MTAS system which excludes approximately 3,500 (UK) and 2,800 (GP) posts filled outside MTAS.

By Specialty / Theme (England)

Summary of Round 1 Posts, Eligible Applications, Acceptances & Fill Rates By Specialty / Theme (England)

Specialty	Theme	Posts: All	Posts: Run-Through	Posts: FTSTA	Posts: Academic	Eligible Applications	Acceptances: All	Acceptances: Run-Through	Acceptances: FTSTA	Acceptances: Academic	Fill Rate: All	Fill Rate: Run-Through	Fill Rate: FTSTA	Fill Rate: Academic
Acute Care Common Stem (ACCS)	Acute Medicine	109	83	26	0	1,000	80	67	13	0	73%	81%	50%	
Acute Care Common Stem (ACCS)	Anaesthesia	210	174	36	0	907	159	150	9	0	76%	86%	25%	
Acute Care Common Stem (ACCS)	Emergency Medicine	370	256	111	3	3,067	328	238	89	1	89%	93%	80%	33%
Acute Care Common Stem (ACCS)	Intensive Care Medicine	23	0	23	0	45	6	1	5	0	26%		22%	
Acute Medicine		94	94	0	0	552	61	61	0	0	65%	65%		
Allergy		1	1	0	0	1	1	1	0	0	100%	100%		
Anaesthesia		1,513	1,108	401	4	8,210	1,128	1,012	115	1	75%	91%	29%	25%
Audiological Medicine		3	2	0	1	5	1	1	0	0	33%	50%		0%
Cardiology		82	80	0	2	1,297	88	86	0	2	107%	108%		100%
Cardiothoracic Surgery		5	4	0	1	252	6	5	0	1	120%	125%		100%
Chemical Pathology		8	8	0	0	61	5	5	0	0	63%	63%		
Child & Adolescent Psychiatry		37	37	0	0	311	34	34	0	0	92%	92%		
Clinical Genetics		8	5	0	3	35	6	4	0	2	75%	80%		67%
Clinical Neurophysiology		11	10	0	1	11	2	2	0	0	18%	20%		0%
Clinical Oncology		28	27	0	1	170	21	20	0	1	75%	74%		100%
Clinical Pharmacology & Therapeutics		1	0	0	1	0	0	0	0	0	0%			0%
Clinical Radiology		144	136	0	8	2,546	149	141	0	8	103%	104%		100%
Core Medical Training		2,323	1,526	757	40	13,247	2,019	1,389	605	25	87%	91%	80%	63%
Dermatology		24	24	0	0	208	24	24	0	0	100%	100%		
Emergency Medicine		204	192	11	1	932	141	141	0	0	69%	73%	0%	0%
Endocrinology & Diabetes		53	50	0	3	453	48	46	0	2	91%	92%		67%
Forensic Psychiatry		18	17	0	1	146	16	16	0	0	89%	94%		0%
Gastroenterology		45	45	0	0	541	44	44	0	0	98%	98%		
General Adult Psychiatry		161	158	0	3	1,172	154	153	0	1	96%	97%		33%
General Practice		3,062	3,050	0	12	17,872	3,016	3,006	0	10	98%	99%		83%
General Surgery		163	160	0	3	3,314	172	170	1	1	106%	106%		33%
Genito-urinary Medicine		16	16	0	0	85	16	16	0	0	100%	100%		
Geriatric Medicine		98	95	0	3	408	74	72	2	0	76%	76%		0%
Haematology		38	35	0	3	280	34	32	0	2	89%	91%		67%
Histopathology		63	63	0	0	298	63	63	0	0	100%	100%		
Immunology		5	4	0	1	3	2	2	0	0	40%	50%		0%
Infectious Diseases		12	12	0	0	134	9	9	0	0	75%	75%		
Infectious Diseases & MMV - Medical Microbiolog		13	13	0	0	38	12	12	0	0	92%	92%		
Infectious Diseases & MMV - Virology		2	1	0	1	7	2	1	0	1	100%	100%		100%
Medical Microbiology & Virology		0	0	0	0	1	0	0	0	0				
Medical Microbiology & Virology	Med Micro	20	17	3	0	321	19	15	4	0	95%	88%	133%	
Medical Microbiology & Virology	Virology	2	2	0	0	5	1	1	0	0	50%	50%		
Medical Oncology		24	17	0	7	154	19	15	0	4	79%	88%		57%
Medical Ophthalmology		0	0	0	0	0	0	0	0	0				
Neurology		19	16	0	3	355	18	14	1	3	95%	88%		100%
Neurosurgery		104	59	44	1	792	76	52	23	1	73%	88%	52%	100%
Nuclear Medicine		10	10	0	0	4	3	3	0	0	30%	30%		
Obstetrics & Gynaecology		837	716	116	5	5,930	622	576	44	2	74%	80%	38%	40%
Occupational Medicine		7	7	0	0	19	4	4	0	0	57%	57%		
Old Age Psychiatry		51	51	0	0	315	41	41	0	0	80%	80%		
Ophthalmology		279	169	109	1	2,330	227	164	62	1	81%	97%	57%	100%
Oral & Maxillofacial Surgery (OMFS)		43	36	7	0	229	29	28	1	0	67%	78%	14%	
Otolaryngology (ENT)		41	39	0	2	685	38	38	0	0	93%	97%		0%
Paediatric Cardiology		5	5	0	0	68	4	4	0	0	80%	80%		
Paediatric Surgery		16	16	0	0	207	17	17	0	0	106%	106%		
Paediatrics		1,413	1,043	359	11	7,719	1,175	948	219	8	83%	91%	61%	73%
Palliative Medicine		13	13	0	0	155	16	16	0	0	123%	123%		
Plastic Surgery		48	47	0	1	877	47	45	2	0	98%	96%		0%
Psychiatry		1,527	996	515	16	7,983	1,236	901	325	10	81%	90%	63%	63%
Psychiatry of Learning Disability		16	16	0	0	79	12	12	0	0	75%	75%		
Psychotherapy		7	7	0	0	34	6	6	0	0	86%	86%		
Public Health		57	50	0	7	807	48	43	0	5	84%	86%		71%
Rehabilitation Medicine		22	21	0	1	34	8	8	0	0	36%	38%		0%
Renal Medicine		41	39	0	2	263	36	36	0	0	88%	92%		0%
Respiratory Medicine		81	81	0	0	794	80	80	0	0	99%	99%		
Rheumatology		29	28	0	1	180	25	25	0	0	86%	89%		0%
Sports & Exercise Medicine		5	5	0	0	59	5	5	0	0	100%	100%		
Surgery in General	Cardiothoracic Surgery	25	1	24	0	88	11	2	9	0	44%	200%	38%	
Surgery in General	General Surgery	599	192	400	7	4,025	451	169	282	0	75%	88%	71%	0%
Surgery in General	Generic	179	120	55	4	1,141	183	100	80	3	102%	83%	145%	75%
Surgery in General	Otolaryngology (ENT)	155	54	97	4	805	86	34	50	2	55%	63%	52%	50%
Surgery in General	Paediatric Surgery	29	15	14	0	251	24	16	8	0	83%	107%	57%	
Surgery in General	Plastic Surgery	107	38	69	0	864	93	43	50	0	87%	113%	72%	
Surgery in General	Trauma & Orthopaedic Surgery	504	180	322	2	3,642	371	130	240	1	74%	72%	75%	50%
Surgery in General	Urology	110	47	60	3	384	42	19	23	0	38%	40%	38%	0%
Trauma & Orthopaedic Surgery		144	141	0	3	2,788	135	133	0	2	94%	94%		67%
Urology		38	36	0	2	698	39	37	0	2	103%	103%		100%
	England Total	15,554	11,816	3,559	179	102,693	13,168	10,804	2,262	102	85%	91%	64%	57%

Notes:

- Data as of end of round 1.
- Defence Medical Services excluded.
- There are instances of post groups with fill rates in excess of 100%. Whilst apparently anomalous these are explained by lags in updating MTAS, the inclusion of deferred or part time acceptances and other issues around the way acceptances are recorded into MTAS.
- Data refers to posts and applications on the MTAS system which excludes approximately 3,500 (UK) and 2,800 (GP) posts filled outside MTAS.

By Specialty / Theme (UK)

Summary of Round 1 Posts, Eligible Applications, Acceptances & Fill Rates By Specialty / Theme (UK)

		Posts:					Acceptances:				Fill Rate:			
Specialty	Theme	All	Run-Through	FTSTA	Academic	Eligible Applications	All	Run-Through	FTSTA	Academic	All	Run-Through	FTSTA	Academic
Acute Care Common Stem (ACCS)	Acute Medicine	142	116	26	0	1,242	107	94	13	0	75%	81%	50%	
Acute Care Common Stem (ACCS)	Anaesthesia	250	210	40	0	1,057	191	180	11	0	76%	86%	28%	
Acute Care Common Stem (ACCS)	Emergency Medicine	486	336	147	3	3,662	417	310	106	1	86%	92%	72%	33%
Acute Care Common Stem (ACCS)	Intensive Care Medicine	23	0	23	0	45	6	1	5	0	26%		22%	
Acute Medicine		117	117	0	0	641	85	85	0	0	73%	73%		
Allergy		1	1	0	0	1	1	1	0	0	100%	100%		
Anaesthesia		1,899	1,333	562	4	9,434	1,374	1,211	162	1	72%	91%	29%	25%
Audiological Medicine		3	2	0	1	5	1	1	0	0	33%	50%		0%
Cardiology		103	101	0	2	1,445	104	101	1	2	101%	100%		100%
Cardiothoracic Surgery		6	5	0	1	289	8	7	0	1	133%	140%		100%
Chemical Pathology		10	10	0	0	76	6	6	0	0	60%	60%		
Child & Adolescent Psychiatry		48	48	0	0	349	43	42	1	0	90%	88%		
Clinical Genetics		9	6	0	3	38	7	5	0	2	78%	83%		67%
Clinical Neurophysiology		12	11	0	1	14	3	3	0	0	25%	27%		0%
Clinical Oncology		40	39	0	1	219	32	31	0	1	80%	79%		100%
Clinical Pharmacology & Therapeutics		2	1	0	1	0	0	0	0	0	0%	0%		0%
Clinical Radiology		197	189	0	8	3,073	202	194	0	8	103%	103%		100%
Core Medical Training		2,841	1,839	962	40	15,089	2,434	1,664	744	26	86%	90%	77%	65%
Dermatology		33	33	0	0	260	36	32	4	0	109%	97%		
Emergency Medicine		254	242	11	1	1,076	186	183	3	0	73%	76%	27%	0%
Endocrinology & Diabetes		65	62	0	3	514	55	52	0	3	85%	84%		100%
Forensic Psychiatry		24	23	0	1	168	22	21	1	0	92%	91%		0%
Gastroenterology		55	55	0	0	623	53	52	1	0	96%	95%		
General Adult Psychiatry		186	183	0	3	1,293	177	174	2	1	95%	95%		33%
General Practice		3,824	3,812	0	12	21,019	3,771	3,760	0	11	99%	99%		92%
General Surgery		205	202	0	3	3,969	234	204	29	1	114%	101%		33%
Genito-urinary Medicine		21	21	0	0	94	21	21	0	0	100%	100%		
Geriatric Medicine		129	126	0	3	491	102	100	2	0	79%	79%		0%
Haematology		52	49	0	3	334	47	44	1	2	90%	90%		67%
Histopathology		84	84	0	0	535	82	82	0	0	98%	98%		
Immunology		5	4	0	1	3	2	2	0	0	40%	50%		0%
Infectious Diseases		15	15	0	0	151	11	11	0	0	73%	73%		
Infectious Diseases & MMV - Medical Microbiolog		15	15	0	0	46	12	12	0	0	80%	80%		
Infectious Diseases & MMV - Virology		2	1	0	1	7	2	1	0	1	100%	100%		100%
Medical Microbiology & Virology		0	0	0	0	1	0	0	0	0				
Medical Microbiology & Virology	Med Micro	23	20	3	0	342	24	20	4	0	104%	100%	133%	
Medical Microbiology & Virology	Virology	3	3	0	0	14	3	3	0	0	100%	100%		
Medical Oncology		29	22	0	7	186	22	18	0	4	76%	82%		57%
Medical Ophthalmology		2	2	0	0	3	1	1	0	0	50%	50%		
Neurology		30	27	0	3	419	25	21	1	3	83%	78%		100%
Neurosurgery		122	66	55	1	875	85	59	25	1	70%	89%	45%	100%
Nuclear Medicine		11	11	0	0	4	3	3	0	0	27%	27%		
Obstetrics & Gynaecology		1,031	877	148	6	6,800	812	729	81	2	79%	83%	55%	33%
Occupational Medicine		10	10	0	0	25	7	7	0	0	70%	70%		
Old Age Psychiatry		58	58	0	0	353	48	48	0	0	83%	83%		
Ophthalmology		339	200	138	1	2,628	277	195	81	1	82%	98%	59%	100%
Oral & Maxillofacial Surgery (OMFS)		50	42	8	0	258	35	34	1	0	70%	81%	13%	
Otolaryngology (ENT)		46	44	0	2	762	48	42	6	0	104%	95%		0%
Paediatric Cardiology		5	5	0	0	68	4	4	0	0	80%	80%		
Paediatric Surgery		17	17	0	0	229	19	18	1	0	112%	106%		
Paediatrics		1,692	1,217	464	11	8,716	1,390	1,097	285	8	82%	90%	61%	73%
Palliative Medicine		19	19	0	0	199	23	23	0	0	121%	121%		
Plastic Surgery		55	54	0	1	959	55	52	3	0	100%	96%		0%
Psychiatry		1,820	1,212	591	17	9,125	1,455	1,101	343	11	80%	91%	58%	65%
Psychiatry of Learning Disability		17	17	0	0	81	13	13	0	0	76%	76%		
Psychotherapy		7	7	0	0	34	6	6	0	0	86%	86%		
Public Health		69	62	0	7	922	59	54	0	5	86%	87%		71%
Rehabilitation Medicine		25	24	0	1	38	10	10	0	0	40%	42%		0%
Renal Medicine		53	50	0	3	312	43	42	0	1	81%	84%		33%
Respiratory Medicine		97	97	0	0	896	92	92	0	0	95%	95%		
Rheumatology		36	35	0	1	204	33	32	1	0	92%	91%		0%
Sports & Exercise Medicine		5	5	0	0	59	5	5	0	0	100%	100%		
Surgery in General	Cardiothoracic Surgery	37	1	36	0	124	11	2	9	0	30%	200%	25%	
Surgery in General	General Surgery	724	232	485	7	4,591	545	206	339	0	75%	89%	70%	0%
Surgery in General	Generic	253	140	109	4	1,254	209	110	96	3	83%	79%	88%	75%
Surgery in General	Otolaryngology (ENT)	183	60	119	4	900	103	38	63	2	56%	63%	53%	50%
Surgery in General	Paediatric Surgery	39	17	22	0	276	29	18	11	0	74%	106%	50%	
Surgery in General	Plastic Surgery	122	42	80	0	938	101	46	55	0	83%	110%	69%	
Surgery in General	Trauma & Orthopaedic Surgery	581	222	357	2	4,167	426	176	249	1	73%	79%	70%	50%
Surgery in General	Urology	129	49	77	3	429	46	20	26	0	36%	41%	34%	0%
Trauma & Orthopaedic Surgery		173	170	0	3	3,233	165	163	0	2	95%	96%		67%
Urology		42	40	0	2	760	48	41	5	2	114%	103%		100%
	UK Total	19,112	14,467	4,463	182	118,446	16,114	13,236	2,771	107	84%	91%	62%	59%

Notes:

- Data as of end of round 1.
- Defence Medical Services excluded.
- There are instances of post groups with fill rates in excess of 100%. Whilst apparently anomalous these are explained by lags in updating MTAS, the inclusion of deferred or part time acceptances and other issues around the way acceptances are recorded into MTAS.
- Data refers to posts and applications on the MTAS system which excludes approximately 3,500 (UK) and 2,800 (GP) posts filled outside MTAS.

By Applicant Cohort (England)

Summary of Round 1 Eligible Applicant, Acceptances & Succes Rates By Applicant Cohort* (England)

Country of Training Group	Nationality Group	Statistic	Employment Status NHS F2	NHS SHO	NHS Other	NHS Total	Non-NHS	England Total
UK Graduates:								
	UK	Eligible Applicants	3,423	5,834	2,026	11,283	711	11,994
		Acceptances	2,784	4,353	1,116	8,253	380	8,633
		Success Rate	81%	75%	55%	73%	53%	72%
	Other EEA	Eligible Applicants	111	162	77	350	39	389
		Acceptances	76	109	26	211	17	228
		Success Rate	68%	67%	34%	60%	44%	59%
	HSMP	Eligible Applicants	89	222	238	549	24	573
		Acceptances	50	100	43	193	8	201
		Success Rate	56%	45%	18%	35%	33%	35%
	Other Overseas	Eligible Applicants	185	283	162	630	38	668
		Acceptances	99	126	42	267	7	274
		Success Rate	54%	45%	26%	42%	18%	41%
	All Nationality Total	*Eligible Applicants*	*3,808*	*6,501*	*2,503*	*12,812*	*812*	*13,624*
		Acceptances	*3,009*	*4,688*	*1,227*	*8,924*	*412*	*9,336*
		Success Rate	*79%*	*72%*	*49%*	*70%*	*51%*	*69%*
Non-UK Graduates:								
	UK	Eligible Applicants	223	255	1,131	1,609	202	1,811
		Acceptances	91	104	254	449	30	479
		Success Rate	41%	41%	22%	28%	15%	26%
	Other EEA	Eligible Applicants	163	393	573	1,129	416	1,545
		Acceptances	69	183	163	415	62	477
		Success Rate	42%	47%	28%	37%	15%	31%
	HSMP	Eligible Applicants	514	2,087	5,194	7,795	557	8,352
		Acceptances	216	776	1,186	2,178	87	2,265
		Success Rate	42%	37%	23%	28%	16%	27%
	Other Overseas	Eligible Applicants	268	492	1,363	2,123	394	2,517
		Acceptances	94	179	291	564	47	611
		Success Rate	35%	36%	21%	27%	12%	24%
	All Nationality Total	*Eligible Applicants*	*1,168*	*3,227*	*8,261*	*12,656*	*1,569*	*14,225*
		Acceptances	*470*	*1,242*	*1,894*	*3,606*	*226*	*3,832*
		Success Rate	*40%*	*38%*	*23%*	*28%*	*14%*	*27%*
All Applicants:								
	UK	Eligible Applicants	3,646	6,089	3,157	12,892	913	13,805
		Acceptances	2,875	4,457	1,370	8,702	410	9,112
		Success Rate	79%	73%	43%	67%	45%	66%
	EEA	Eligible Applicants	274	555	650	1,479	455	1,934
		Acceptances	145	292	189	626	79	705
		Success Rate	53%	53%	29%	42%	17%	36%
	HSMP	Eligible Applicants	603	2,309	5,432	8,344	581	8,925
		Acceptances	266	876	1,229	2,371	95	2,466
		Success Rate	44%	38%	23%	28%	16%	28%
	Other Overseas	Eligible Applicants	453	775	1,525	2,753	432	3,185
		Acceptances	193	305	333	831	54	885
		Success Rate	43%	39%	22%	30%	13%	28%
	All Nationality Total	*Eligible Applicants*	*4,976*	*9,728*	*10,764*	*25,468*	*2,381*	*27,849*
		Acceptances	*3,479*	*5,930*	*3,121*	*12,530*	*638*	*13,168*
		Success Rate	*70%*	*61%*	*29%*	*49%*	*27%*	*47%*

Notes:

— Data as of end of round.

— "SHO" means in educationally approved SHO post. Other SHOs are picked up by the "Other" category.

— Applicants are categorised as England Applicants according to their first choice round 1 application.

— *Applicant classifications are to some extent uncertain. Due to issues such as the use of free-text boxes in the application form, applicant data does not lend itself to unambiguous classification. These results are based on cohorts derived as well as possible with the data available.

— Data refers to posts and applications on the MTAS system which excludes approximately 3,500 (UK) and 2,800 (GP) posts filled outside MTAS.

By Applicant Cohort (UK)

Summary of Round 1 Eligible Applicant, Acceptances & Succes Rates By Applicant Cohort* (UK)

Country of Training Group	Nationality Group	Statistic	Employment Status NHS F2	SHO	Other	*NHS Total*	*Non-NHS*	UK Total
UK Graduates:								
	UK	Eligible Applicants	4,142	7,069	2,389	*13,600*	*897*	**14,497**
		Acceptances	3,342	5,309	1,363	*10,014*	*485*	**10,499**
		Success Rate	81%	75%	57%	*74%*	*54%*	**72%**
	Other EEA	Eligible Applicants	182	258	104	*544*	*61*	**605**
		Acceptances	136	186	41	*363*	*29*	**392**
		Success Rate	75%	72%	39%	*67%*	*48%*	**65%**
	HSMP	Eligible Applicants	100	261	273	*634*	*29*	**663**
		Acceptances	56	126	64	*246*	*8*	**254**
		Success Rate	56%	48%	23%	*39%*	*28%*	**38%**
	Other Overseas	Eligible Applicants	211	309	182	*702*	*50*	**752**
		Acceptances	123	141	50	*314*	*12*	**326**
		Success Rate	58%	46%	27%	*45%*	*24%*	**43%**
	All Nationality Total	*Eligible Applicants*	*4,635*	*7,897*	*2,948*	*15,480*	*1,037*	***16,517***
		Acceptances	*3,657*	*5,762*	*1,518*	*10,937*	*534*	***11,471***
		Success Rate	*79%*	*73%*	*51%*	*71%*	*51%*	***69%***
Non-UK Graduates:								
	UK	Eligible Applicants	237	277	1,257	*1,771*	*226*	**1,997**
		Acceptances	97	125	291	*513*	*31*	**544**
		Success Rate	41%	45%	23%	*29%*	*14%*	**27%**
	Other EEA	Eligible Applicants	173	452	635	*1,260*	*543*	**1,803**
		Acceptances	74	212	188	*474*	*71*	**545**
		Success Rate	43%	47%	30%	*38%*	*13%*	**30%**
	HSMP	Eligible Applicants	574	2,324	5,803	*8,701*	*649*	**9,350**
		Acceptances	265	962	1,492	*2,719*	*117*	**2,836**
		Success Rate	46%	41%	26%	*31%*	*18%*	**30%**
	Other Overseas	Eligible Applicants	292	540	1,522	*2,354*	*472*	**2,826**
		Acceptances	111	205	346	*662*	*56*	**718**
		Success Rate	38%	38%	23%	*28%*	*12%*	**25%**
	All Nationality Total	*Eligible Applicants*	*1,276*	*3,593*	*9,217*	*14,086*	*1,890*	***15,976***
		Acceptances	*547*	*1,504*	*2,317*	*4,368*	*275*	***4,643***
		Success Rate	*43%*	*42%*	*25%*	*31%*	*15%*	***29%***
All Applicants:								
	UK	Eligible Applicants	4,379	7,346	3,646	*15,371*	*1,123*	**16,494**
		Acceptances	3,439	5,434	1,654	*10,527*	*516*	**11,043**
		Success Rate	79%	74%	45%	*68%*	*46%*	**67%**
	EEA	Eligible Applicants	355	710	739	*1,804*	*604*	**2,408**
		Acceptances	210	398	229	*837*	*100*	**937**
		Success Rate	59%	56%	31%	*46%*	*17%*	**39%**
	HSMP	Eligible Applicants	674	2,585	6,076	*9,335*	*678*	**10,013**
		Acceptances	321	1,088	1,556	*2,965*	*125*	**3,090**
		Success Rate	48%	42%	26%	*32%*	*18%*	**31%**
	Other Overseas	Eligible Applicants	503	849	1,704	*3,056*	*522*	**3,578**
		Acceptances	234	346	396	*976*	*68*	**1,044**
		Success Rate	47%	41%	23%	*32%*	*13%*	**29%**
	All Nationality Total	*Eligible Applicants*	*5,911*	*11,490*	*12,165*	*29,566*	*2,927*	***32,493***
		Acceptances	*4,204*	*7,266*	*3,835*	*15,305*	*809*	***16,114***
		Success Rate	*71%*	*63%*	*32%*	*52%*	*28%*	***50%***

Notes:

- Data as of end of round 1.
- Excludes Defence Medical Services.
- 'SHO' means in educationally approved SHO post. Other SHOs are picked up by the 'Other' category.
- Applicants are categorised as Defence Medical Services Applicants according to their first choice round 1 application.
- * Applicant classifications are to some extent uncertain. Due to issues such as the use of free-text boxes in the application form, applicant data does not lend itself to unambiguous classification. These results are based on cohorts derived as well as possible with the data available.
- Data refers to posts and applications on the MTAS system which excludes approximately 3,500 (UK) and 2,800 (GP) posts filled outside MTAS.

Further Details on Posts Available

ROUND 1 POST NUMBERS BY TYPE AND LEVEL

Level	*Type*	*UK*	*England*
ST1	Total	7,649	6,317
	Run-Through	6,050	4,990
	FTSTA	1,503	1,232
	Academic	96	95
ST2	Total	6,599	5,289
	Run-Through	4,068	3,325
	FTSTA	2,516	1,949
	Academic	15	15
ST3	Total	4,145	3,344
	Run-Through	3,640	2,907
	FTSTA	441	375
	Academic	64	62
ST4	Total	719	604
	Run-Through	709	594
	FTSTA	3	3
	Academic	7	7
	Totals	**19,112**	**15,554**

Notes:

— Data refers to posts on the MTAS system which excludes approximately 3,500 (UK) and 2,800 (GP) posts filled outside MTAS.

— England figures exclude the Devolved Administration deaneries and Defence Medical Services.

— Data relates to the end of round 1.

Progress to Date including Round 2

Since the end of June, recruitment to specialty training posts has continued to build on the high fill rate of round 1 of around 85%. As at 01 October, the overall number of recorded acceptances is now over 14,440 for England (equivalent to over 92% of the round 1 posts).

In addition to the posts remaining from round 1, in round 2 there are an additional 215 posts added after the Douglas Review and an expectation of 300 further posts held back from round 1.

Short-listings for Round 1a

For All Eligible Applicants

— Of the 32,600 eligible applicants, 10,300 (32%) applicants received no short-listings. 9,000 (87%) of these are currently employed in the NHS.

— Of these 9,000 NHS eligible applicants who received no short-listings, 3,000 (33%) are UKGs, 900 (10%) are F2, 2,900 (32%) are SHOs in educationally approved training posts and 5,200 (57%) are in service posts.

— 20,600 applicants currently employed in the NHS received at least 1 interview. Of these, 12,600 (61%) were trained in the UK, 5,000 (24%) are F2s, 8,600 (42%) are SHOs and 7,000 (34%) are in service grades.

NUMBER OF SHORT-LISTINGS PER ELIGIBLE APPLICANT; SPLIT BY EMPLOYMENT GRADE AND COUNTRY OF TRAINING STATUS
ALL ELIGIBLE APPLICANTS

	NHS						*non-NHS*						*Grand*
	0	*1*	*2*	*3*	*4*	*Totals*	*0*	*1*	*2*	*3*	*4*	*Totals*	*Totals*
All Applicants	8,973	10,360	5,178	3,347	1,750	**29,608**	1,338	1,124	321	172	86	**3,041**	**32,649**
of which:													
UKG	2,969	5,630	3,194	2,384	1,343	**15,520**	277	520	169	122	62	**1,150**	**16,670**
IMG	6,004	4,730	1,984	963	407	**14,088**	1,061	604	152	50	24	**1,891**	**15,979**
F2	858	2,400	1,215	963	475	**5,911**	37	52	16	11	4	**120**	**6,031**

	NHS						*non-NHS*						*Grand*
	0	*1*	*2*	*3*	*4*	*Totals*	*0*	*1*	*2*	*3*	*4*	*Totals*	*Totals*
SHO	2,931	3,930	2,296	1,517	849	**11,523**	367	363	99	30	17	**876**	**12,399**
Other[1]	5,184	4,030	1,667	867	426	**12,174**	934	709	206	131	65	**2,045**	**14,219**

[1] This group is comprised of candidates working in service posts.

NUMBER OF ELIGIBLE APPLICANTS WHO RECEIVED AT LEAST 1 SHORT-LISTING ALL ELIGIBLE APPLICANTS

		NHS	*non-NHS*
All Applicants		20,635	1,703
of which:			
	UKG	12,551	873
	IMG	8,084	830
	F2	5,053	83
	SHO	8,592	509
	Other[1]	6,990	1,111

[1] This group is comprised of candidates working in service posts.

For England Applicants

Please note that there is no perfect method to identify England applicants. The approach taken here, as elsewhere in the annex, is to classify England applicants as those whose first choice applications were to an English UoA. Since an England applicant can also make applications and be short-listed from UoAs in the DAs then the number of short-listings in the tables below do not equate to the number of short-listings in England—this number is 31,600.

- Of the 27,800 eligible applicants, 9,400 (34%) applicants received no short-listings. 8,300 (88%) of these are currently employed in the NHS.
- Of these 8,300 NHS eligible applicants who received no short-listings, 2,700 (33%) are UKGs, 800 (10%) are F2, 2,700 (33%) are SHOs in educationally approved training posts and 4,800 (58%) are in service posts.
- 17,200 applicants currently employed in the NHS received at least one interview. Of these, 10,100 (59%) were trained in the UK, 4,200 (24%) are F2s, 7,000 (41%) are SHOs and 6,000 (35%) are in service grades.

NUMBER OF SHORT-LISTINGS PER ELIGIBLE APPLICANT; SPLIT BY EMPLOYMENT GRADE AND COUNTRY OF TRAINING STATUS ENGLAND APPLICANTS

	NHS						*non-NHS*						*Grand*
	0	*1*	*2*	*3*	*4*	*Totals*	*0*	*1*	*2*	*3*	*4*	*Totals*	*Totals*
All Applicants	8,290	8,655	4,256	2,785	1,482	**25,468**	1,128	796	249	135	73	**2,381**	**27,849**
of which:													
UKG	2,719	4,507	2,538	1,931	1,117	**12,812**	241	310	116	95	50	**812**	**13,624**
IMG	5,571	4,148	1,718	854	365	**12,656**	887	486	133	40	23	**1,569**	**14,225**
F2	795	2,045	984	755	397	**4,976**	24	27	10	6	3	**70**	**5,046**
SHO	2,730	3,154	1,851	1,271	722	**9,728**	308	240	75	23	14	**660**	**10,388**
Other[1]	4,765	3,456	1,421	759	363	**10,764**	796	529	164	106	56	**1,651**	**12,415**

[1] This group is comprised of candidates working in service posts.

NUMBER OF ELIGIBLE APPLICANTS WHO RECEIVED AT LEAST 1 SHORT-LISTING ENGLAND APPLICANTS

		NHS	*non-NHS*
All Applicants		17,178	1,253
of which:			
	UKG	10,093	571
	IMG	7,085	682
	F2	4,181	46
	SHO	6,998	352
	Other[1]	5,999	855

[1] This group is comprised of candidates working in service posts.

COMPARISON OF ROUND 1A AND ROUND 1B

ENGLAND—SUMMARY OF ROUND 1 INFORMATION SPLIT BY ROUNDS 1A AND 1B

Note: Round 1A acceptances are acceptances resulting from interviews gained under original shortlisting. Round 1B acceptances are acceptances resulting from guaranteed interviews after repreferencing. Some applicants may have had both 1A and 1B interviews. There are no distinct round 1A or 1B posts—all interviewed applicants compete for the same overall pool of round 1 posts.

		All	*ST1*	*ST2*	*ST3*	*ST4*
Round 1 Posts	All	15,554	6,317	5,289	3,344	604
	RT	11,816	4,990	3,325	2,907	594
	FTSTA	3,559	1,232	1,949	375	3
	Academic	179	95	15	62	7
Applicants	All	29,193	10,960	8,962	8,178	1,093
(grouped according to first choice)	Eligible	27,849	10,185	8,620	7,972	1,072
Applications	All	109,969	41,410	33,865	30,629	4,065
	Eligible	102,693	37,467	31,940	29,368	3,918
Interviews*	All	48,328	17,721	15,095	13,195	2,317
	1A	31,986	13,146	9,655	7,441	1,744
	1B	16,342	4,575	5,440	5,754	573
All Acceptances:	All	13,168	5,297	4,403	2,936	532
	RT	10,804	4,564	3,082	2,628	530
	FTSTA	2,262	669	1,319	274	0
	Academic	102	64	2	34	2
1A Acceptances	All	9,404	4,292	2,851	1,877	384
	RT	8,235	3,862	2,237	1,754	382
	FTSTA	1,078	370	612	96	0
	Academic	91	60	2	27	2
1B Acceptances	All	3,764	1,005	1,552	1,059	148
	RT	2,569	702	845	874	148
	FTSTA	1,184	299	707	178	0
	Academic	11	4	0	7	0
Fill Rate	All	85%	84%	83%	88%	88%
	RT	91%	91%	93%	90%	89%
	FTSTA	64%	54%	68%	73%	0%
	Academic	57%	67%	13%	55%	29%
1B Interviews as % of total Interviews		34%	26%	36%	44%	25%
1B Acceptances as % of	All	29%	19%	35%	36%	28%
Total Acceptances	RT	24%	15%	27%	33%	28%
	FTSTA	52%	45%	54%	65%	
	Academic	11%	6%	0%	21%	0%
Proportion of interviews converted	All	27%	30%	29%	22%	23%
to acceptancies:	1A	29%	33%	30%	25%	22%
	1B	23%	22%	29%	18%	26%
1B rate relative to 1A rate		0.78	0.67	0.97	0.73	1.17

Notes:

— Data as of end of round 1.

— Defence Medical Services excluded.

— * 1B interviews were not directly recorded on the MTAS system. This data is estimated based on applicant preferences and the rules governing guranteed interviews. 1B acceptances are those linked to applications not originally shortlisted.

— Acceptances includes any deferrals and part time acceptances.

UK—SUMMARY OF ROUND 1 INFORMATION SPLIT BY ROUNDS 1A AND 1B

		All	*ST1*	*ST2*	*ST3*	*ST4*
Round 1 Posts	All	19,112	7,649	6,599	4,145	719
	RT	14,467	6,050	4,068	3,640	709
	FTSTA	4,463	1,503	2,516	441	3
	Academic	182	96	15	64	7
Applicants	All	34,193	13,014	10,449	9,475	1,255
(grouped according to first choice)	Eligible	32,493	12,019	10,023	9,219	1,232
Applications	All	127,745	48,736	39,156	35,346	4,507
	Eligible	118,446	43,596	36,701	33,806	4,343
Interviews*	All	64,139	23,655	19,960	17,765	2,759
	1A	40,687	16,329	12,358	9,920	2,080
	1B	23,452	7,326	7,602	7,845	679
All Acceptances:	All	16,114	6,429	5,311	3,734	640
	RT	13,236	5,552	3,757	3,298	629
	FTSTA	2,771	810	1,552	400	9
	Academic	107	67	2	36	2
1A Acceptances	All	11,876	5,245	3,581	2,567	483
	RT	10,376	4,715	2,836	2,351	474
	FTSTA	1,406	469	743	187	7
	Academic	94	61	2	29	2
1B Acceptances	All	4,238	1,184	1,730	1,167	157
	RT	2,860	837	921	947	155
	FTSTA	1,365	341	809	213	2
	Academic	13	6	0	7	0
Fill Rate	All	84%	84%	80%	90%	89%
	RT	91%	92%	92%	91%	89%
	FTSTA	62%	54%	62%	91%	300%
	Academic	59%	70%	13%	56%	29%
1B Interviews as % of total Interviews		37%	31%	38%	44%	25%
1B Acceptances as % of	All	26%	18%	33%	31%	25%
Total Acceptances	RT	22%	15%	25%	29%	25%
	FTSTA	49%	42%	52%	53%	22%
	Academic	12%	9%	0%	19%	0%
Proportion of interviews converted	All	25%	27%	27%	21%	23%
to acceptancies	1A	29%	32%	29%	26%	23%
	1B	18%	16%	23%	15%	23%
1B rate relative to 1A rate		0.62	0.50	0.79	0.57	1.00

Notes:

— Data as of end of round 1.

— Defence Medical Services excluded.

— * 1B interviews were not directly recorded on the MTAS system. This data is estimated based on applicant preferences and the rules governing guranteed interviews. 1B acceptances are those linked to applications not originally shortlisted.

— Acceptances includes any deferrals and part time acceptances.

Annex F

WPP CONSULTATION WITH STAKEHOLDERS
(TAKEN FROM WPP PAPER TO THE DEPARTMENT: NATIONAL SELECTION INTO SPECIALTY TRAINING 2007 SUMMARY OF METHODOLOGY DEVELOPMENT WORK)

1. WPP were invited to tender in June 2006. In the very short time frame WPP were given (approximately 6 months to design the selection methodology), there has been extensive consultation between WPP and key

stakeholders, including COPMeD, AoMRC, MMC, other suppliers, deaneries and trainees. At the outset, WPP interviewed all Deans (26 interviews were conducted) and attended a COPMeD Residential meeting in June 2006.

2. In the time frame and resources allocated, there was extensive consultation between WPP and the specialty representatives of the Academy of Medical Royal Colleges Specialty Training Committee in the development of both the person specifications and the specialty-specific application form questions. All person specifications and specialty-specific application form questions received sign off from the relevant specialty representative. JCHMT and JCHST representatives were involved in cascading information to the medical and surgical groups of specialties. A summary is presented in Table 2.

3. The selection methodology was reviewed and presented at 19 UoA cascade workshops across the UK. A full list of these is presented in Table 3 Nineteen additional half-day workshops were delivered (with approx 30-40 delegates in each) to various stakeholders including Deans, HR and other key representatives from September 2006 to December 2006. In this time, WPP delivered a total of 23 workshops, with over 500 delegates between September and December 2006. WPP delivered this within the same time frame as originally allocated for three workshops and made significant personal efforts. We worked alongside two clinical leads, Drs Alison Carr and Roger Price. In addition, WPP consulted with every UoA in advance (via a survey with follow-up telephone interviews) to establish how the workshops would maximise effectiveness in each UoA. This was a local decision and we tailored the workshops accordingly. In addition, feedback from these workshops informed the design of the final form, questions, rating scale and scoring framework.

4. WPP is represented on the COPMED Steering Group for Selection & Recruitment. The AoMRC are also represented, along with MMC, HR and others, including trainee representatives. Specifically, WPP asked to deliver two presentations on the selection methodology to representatives at the Academy of Royal Colleges Specialty Training committee in July and December 2006. Notably, the selection methodology was approved by PMETB.

5. Outside this project, WPP has for numerous years been involved in developing selection methodologies with several specialties, for example the Royal Colleges of Surgeons, the Royal College of Obstetrics and Gynaecology and COGPED. For the Royal Colleges of Surgeons, having competed successfully for the tender, WPP has been piloting the selection methodology for ST1 validation. This work has been disseminated via the RCS both at National meetings and deanery workshops during the past 18 months. An RCS evaluation has been conducted for live selection across 11 deaneries in 2007. WPP have attended COPMeD/ RCS liaison meetings presenting this work. The RCOG has also piloted their selection methodology over the past 2 years. COGPED has developed selection methodology with WPP over the past 7 years, and in 2006 piloted the alternative to written scoreable applications, the invigilated national "test". As noted earlier, the use of such a test was discussed with other specialties and the trainees, however for 2007, there was inadequate support for its use across all specialties.

6. A series of focus groups was conducted by WPP with trainees (N = 35) at several deaneries between July and September 2006 to explore their knowledge, expectations and concerns regarding the national process. The application form was piloted with trainees, as detailed above.

7. In November 2006 WPP were asked to develop an e-learning tool to help with upskilling of shortlisters and interviews. This tool was to support the training to ensure wide reach consultation and upskilling. This tool comprises 3 hours of training and it was disseminated for use to all UoAs in January 2007 for preparation in recruitment. Several thousand users have been registered.

Table 2

BRIEF SUMMARY OF CONSULTATION WITH ACADEMY OF MEDICAL ROYAL COLLEGES

Month	*Who was consulted*	*Details*
June 2006	AoMRC (supplied Person Specs)	Received draft national person specifications for 16 specialties (where submitted) and began drafting person specifications One-to-one interviews with all deans (N = 20 +) COPMeD residential meeting
July 2006	AoMRC STC representatives Public health representatives	Draft person specifications sent to STC representatives 28/07/06. Requested comments/amendments the following week. 9 specialties responded. Telephone interviews with public health representatives re: person specification & selection methods
August 2006	AoMRC STC representatives	Correspondence with individual specialties in response to comments. Person specifications updated to incorporate amendments (where possible) as received

Month	*Who was consulted*	*Details*
		& revisions sent to specialties. Revised ST1 person specifications sent to STC representatives Request for specialty-specific application form/ interview questions and pre-application information sent to all relevant STC representatives 22/08/06, to reply by 15/09/06. 7 specialties replied within specified timeframe, including 3 who sent example questions. No response from others. Three meetings with Shelley Heard re: person specification national template (August/September)
September 2006	AoMRC STC representatives	Revised versions of all ST1 person specifications sent to STC representatives 21/09/06 for approval. 12 specialties responded with further queries or approval. Correspondence with individual specialties in response to queries, further amendments made. Amendments to person specifications from Sarah Thomas, DH lawyers, HR etc. Drafted template for national application form based on template provided by Carole Mistry *(Project manager, Specialty Selection (itself based on existing forms used by London/Yorkshire Deaneries amongst others)
October 2006	AoMRC STC representatives Deanery representatives	Draft application form and scoring framework presented at national and local workshops. National workshop 03/10/06: Informed we would need person specifications for all ST3 and ST4 specialties. Clarified requirements for ST2/ST3/ST4, further amendments to ST1 template. Received list of ST3/ST4 specialties and example person specifications 04/10/06. Proposed final versions of ST1 & ST2 person specifications sent to Sarah Thomas 06/10/06. Outstanding queries chased with individual specialties. Drafts of ST3/ST4 person specifications sent to Sarah Thomas 16/10/06. Final versions of all person specifications sent to STC representatives on or before 27/10/06; individual correspondence with specialties to finalise queries.
November 2006	AoMRC STC representatives	Final versions of all person specifications (pending legal approval) sent to STC representatives 06/11/06. Representatives advised that these could be published on College websites. Correspondence with individual specialties to address outstanding person specification queries. Regular meetings with Methods team to develop online application form. Further request to STC representatives to supply pre-application information—13/11/06 Final versions of person specifications sent to MMC Comms team 16/11/06 for publication. Development of specialty-specific application form questions. Contacted all STC representatives 28/11/06 regarding forthcoming application form consultation.
December 2006	AoMRC STC representatives	National online application form prototype made available to COPMeD steering group 01/12/06 and feedback was invited. National application form example and draft specialty-specific application form questions sent to all STC representatives on 01/12/06. **WPP presentation on application from and shortlisting process to the AoMRC STC on 6 December.** Telephone or face-to-face discussion with all STC

Month	*Who was consulted*	*Details*
		representatives (and surgery SAC chairs) to agree application form questions. All specialty-specific questions agreed and signed off. AoMRC meeting 06/12/06 to discuss selection process. Final version of all application form questions sent to core team 21/12/06. It was agreed by Sarah Thomas/ Alison Alsbury that final questions would not be circulated further due to security. Remaining person specifications finalised and published. Extensive liaison with Methods team in developing national online application form.
January 2006		MTAS application form finalised with Methods team. Shortlisting scoring indicators and reference frameworks finalised and sent securely to deaneries.

Specialty contacts:
CMT & all physicianly specialties—Chris Clough, Patrick Cadigan (plus some consultation with individual specialties)
SiG & all surgical specialties except OMFS & Neurosurgery—Gordon Williams (plus consultation with SAC chairs)
OMFS—Andrew Carton
Neurosurgery—Richard Nelson
ACCS—Griselda Cooper, Jane Fothergill, Charles Gillbe, Mike Jones
Anaesthesia—Griselda Cooper
O&G—Laurence Wood
Ophthalmology—Peter McDonnell
Paediatrics—Claire Smith, Mary McGraw
Psychiatry—Dinesh Bhugra
General Practice—Simon Plint, Simon Gregory, Gai Evans
Radiology—initially Frances Calman, later David Lindsell
Histopathology, Medical Microbiology, Chemical Pathology—Hani Zakhour
Public Health—Celia Duff, Maggie Rae

Table 3

INDIVIDUAL DEANERY VISIT DETAILS TO CASCADE AND REVIEW THE SELECTION METHODOLOGY

WPP also conducted a Planning & Development Workshop: 19th September 2006 (90+ attended); Phase 2: National Workshops 3rd October, 10th October (40+ at each)

Date	*Deanery*	*Time*	*Venue*	*Contact*	*Attending*
5 Oct	Trent		Nottingham Racecourse		Fiona Patterson, Sarah Thomas, Maura Kerrin and Roger Price
25 October	East of England			Linda Parish	Fiona Patterson, Maura Kerrin and Roger Price
30 Oct–2 Nov	Scotland, Edinburgh, Glasgow & Aberdeen		Various locations	Jean Allen	Fiona Patterson, Maura Kerrin and Alison Carr
8 Nov	West Midlands	13:30–17:30	Birmingham Research Park, 97 Vincent Drive, Edgbaston, Birmingham, B15 2AQ	Dean Bruton or Michele Gadsby	Fiona Patterson, Maura Kerrin and Roger Price
9 Nov	Severn	TBC	Severn Institute at Frenchay Hospital, Bristol It is in the Academic Block, opposite the Postgraduate Centre.	Geoff Wright	Maura Kerrin and Alison Carr

Date	*Deanery*	*Time*	*Venue*	*Contact*	*Attending*
10 Nov	East Midlands/ LNR	12:30–16:30	LNR Healthcare Workforce Deanery, Lakeside House, 4 Smith Way Grove Park, Enderby, Leicester, LE19 1SS	Mary Hoyes	Fiona Patterson, and Roger Price
14 Nov	SYSH	12:30–16:30	Howden Room, 4th Floor, Don Valley House, Savile Street East, Sheffield, S4 7UQ	Sarah Chown	Fiona Patterson, Roger Price
15 Nov	Oxford	10:00–13:00	The Oxford Centre, 333 Banbury Road, Oxford, OX2 7PL	David Dickinson and Pauline Swan	Maura Kerrin and Steve Ball
16 Nov	KSS	13:30		David Rice	Fiona Patterson, Maura Kerrin
23 Nov	Northern Ireland	9.30–4.30 two sesssions	NIMTDA, Beechhill House 42 Beechhill Road, Belfast, BT8 7R4	Gillian Diffin	Fiona Patterson, Maura Kerrin, Steve Ball
24 Nov	Yorkshire	12:45–16:30	Yorkshire Deanery, Department for NHS PGMDE, Willow Terrace Road, University of Leeds, Leeds, LS2 9JT	Julie Honsberger, Pat Kentley and Louise Buchanan	Maura Kerrin
28 Nov	London			Elizabeth Chan and David Rice	Fiona Patterson, Maura Kerrin, Alison Carr
29 Nov	Mersey	12.30–4.30	Southport Education Centre	Carolyn Munro	Maura Kerrin/ Roger Price
30 Nov	South West Peninsula	9.45–4.30 two sessions	The John Bull Building, Tamar Science Park, Plymouth, PL6 8BU	Victoria Price and Claire Old	Fiona Patterson/ Alison Carr
5 Dec	Northern	9.00–1pm		Sarah Bussell	Fiona Patterson, Maura Kerrin, Roger Price
7 Dec	North Western	11:00–15:00	Reebok Stadium, Burnden Way, Lostock, Bolton, Lancashire, BL6 6JW	Claire Grout	Fiona Patterson, Maura Kerrin
8 Dec	Wessex	10–2.00	Wessex Institute ,Highcroft, Romsey Road, Winchester	Alison Young	Maura Kerrin / Alison Carr

Memorandum by Dr Pete Jones (MMC 02)

STRENGTHS AND WEAKNESSES OF THE MTAS PROCESS

Executive Summary

— Dr Jones carried out a review of the MTAS process based upon documents provided to deaneries and assessors, along with information provided under the freedom of Information Act. His detailed review was shared with Remedyuk and various members of parliament. The review concluded that:

— There is little evidence available that the process was underpinned with valid constructs for assessment and that inadequate assessor training may well have undermined the reliability of the process.

— The process was not adequately piloted nor scrutinised to ensure compliance with best practice and legislation in terms of equality and diversity before being used with live candidates.

— The sequencing of activities within the process were not suitable for the type of selection carried out, given the selection ratios sought and the likely calibre of the candidates.

— The sequencing and weighting of the process did not emphasise clinical skills.

Evidence

1. I am a Chartered Psychologist. I have a Bachelor of Science degree with honours in psychology, a Masters degree in psychological assessment in organisations (with distinction) and a PhD in psychometric assessment in the prediction of work performance with psychometric instruments. I am a member of the British Psychological Society, a member of the Division of Occupational Psychology and an Associate Fellow of the Society. I am the research director of Shire Professional Chartered Psychologists and Organisational Researchers. I specialise in the development of large scale public sector long listing and short listing staff selection systems for recruitment and promotion, as well as the evaluation of development programmes for public and private sector high-potential staff. During April and May 2007 I sought information from the Department of Health (DOH) regarding the technical process by which MTAS was developed.

MTAS Validity

2. The DoH response suggests that the Conference of Postgraduate Medical Dean's Steering Group on Recruitment and Selection were responsible for developing the selection process and did this in consultation with a range of stakeholders. Furthermore it suggests that "Work Psychology Partnership" were appointed to provide advice and tools to support the process including the development of national recruiting standards. Other materials suggests that the selection criteria were nationally agreed and enshrined in person specifications for each speciality and each entry level, suggesting that there had been some refining and prioritising of the competencies. There is no evidence from the DoH of a job analysis being conducted nor validated beyond these statements. Other materials suggest that the competencies which underpin the selection were established by research but again no detail nor source is provided or can be identified. Importantly, the need to ensure the behavioural indicators and competencies showed no adverse impact are mentioned neither in the DoH response or in the other materials.

3. The recommended operational process was based on good practice and outlined in some detail.

4. In the assessment of the application form, the assessment materials used a behaviourally anchored rating scale where assessors are asked to make a single judgment about each competency along a verbal scale of competence. This scale appeared to be based upon some sort of opinion about what was sought and required assessors to make a professional judgment about the depth and clarity of the evidence provided. There is no evidence that this is based upon research. The risk with asking assessors to make a judgment about the clarity and depth of evidence in this way is that it may give rise to subjectivity. What one person sees as "limited insight" or "identified key issues" may differ very much from how another may interpret these statements. This leads to unreliability and thus undermines the validity. However, overall this simplified scale is probably practical as long as suitable training is given to reduce subjectivity or suitable monitoring takes place. There is no evidence that this was the case.

MTAS Reliability

5. Assessors do not appear to have been given specific guidance on how to make judgments in the scoring of application forms and were left to make a single anchored judgment for each competency area. Again, the risk with asking assessors to make a judgment about the clarity and depth of evidence in this way is that it may give rise to subjectivity because how one assessor interprets responses may differ very much from how another may interpret these statements. However, the assessment materials suggest that each application would be independently scored on two occasions and the marks aggregated. This may reduce the effect of differences in interpretation and appears to be a sensible response. From the materials I have seen no guidance was given around the structure of assessment. Accordingly some applications were scored horizontally by a single assessor and some vertically with one assessor scoring the same competency for many or all candidates. Each method has its own virtues, but the key aspect is consistency and that vertical and horizontal scoring of applications should not be mixed in the same process. It may be that deaneries have made this choice as I have seen no guidance on the issue and that as such if all candidates within a deanery were treated in the same way, then this is not unfair per se. However, it could potentially lead to the same application being scored differently for different deaneries and more leadership and guidance was needed in this.

6. Based upon the materials I have seen I would estimate that training in the use of the competency based sift would take at least 4 hours with experienced assessors and 8 hours with less experienced assessors. This should have included some check of their competence in scoring before live use. The evidence I have suggests that training was left largely to deaneries and was "cascaded". An interactive assessor training computer package was also developed but this was nowhere near as rigorous as could have been achieved with the suggested 4 or 8 hours training and took around 2 hours to complete. The quality of MTAS assessor training cannot be evidenced as consistent nor sufficient based upon the evidence and material I have seen. This is retrieved somewhat by the double scoring of applications, as the effect of poor assessors is reduced. I have seen no evidence of assessor monitoring to ensure individual assessors were not being too harsh or relaxed in their scoring.

7. Nothing in the materials I have seen suggests that any inter-rater or internal consistency measures were taken prior to live use. This is not unusual, but given the importance and scale of this process it should have been possible to carry out a small study to evidence this, or carry out an analysis of data post assessment but before issuing results to ensure that consistency was achieved.

MTAS Fairness and Bias

8. The Commission for Racial Equality outline the purpose and process of developing adequate Race Equality Impact Assessments for new policies and procedures for public authorities. This requires public authorities to develop Race Equality Impact Assessments for their selection processes and to ensure their policies and practices do not adversely affect a group on the basis of racial origin..

9. Nothing I have seen suggests that the fairness of the MTAS process has been seriously considered. The Impact Assessments disclosed were very poor and the worst I have seen in a public sector organisation. Some work appeared to have gone into the impact of disability. For a profession with increasing representation from females and with a traditionally high proportion of Black and Ethnic Minority doctors in the workforce this is very worrying. The Race Equality Impact Assessment provided showed no evidence of either the First or Second stage actions required to review or to consult upon new policies and procedures, contrary to the legislation. What consideration had been given was shallow and revolved around expectations that there would be no differences and that the data source should be candidate feedback. I feel that this is inadequate. I would have expected consideration to be given to issues such as first language with the process. Issues of diversity are mentioned nowhere within the materials I have seen. Overall, and this is a damning indictment for the process; as lip service appears to have been paid to the diversity issues, even in the Impact Assessments which are specifically designed to prevent this happening.

10. It was clear that there had been significant leakage of assessment materials. Electronic and paper copies of the assessment criteria at both stages had been placed in the hands of some applicants, but not all applicants. This is clearly unfair as those with better contacts would have seen the materials and those on leave or working in areas where assessors didn't work would not.

MTAS Utility

11. The DoH report that a business case for the web based process was made. Government policy and targets on E-delivery of services support the use of web based applications. and my experience of them is that when their operation costs are examined they compare very favourably to paper based systems. They are most effective when the software itself is making the selection decision (eg in a multiple response competency based questionnaire) and this value is reduced if the assessment itself is still completed by live assessors.

12. Materials I have viewed did highlight the utility/cost issues for stakeholders to consider.

13. The key aspect of utility in MTAS is a simple sequential cost. The best value is achieved with inexpensive first line sifts when there are large numbers of poor quality applicants, when the final selection ratios are low (ie we appoint very few of the original applicants) and when the relative cost of the final selection compared to the initial sift are high. This does not appear to be the case with MTAS. Ineligible candidates should already have been removed from the process and the incompetent should be in the minority, not the majority which is where these often inexpensive sifts work best.

MTAS Competency Based Application

14. Not withstanding the earlier comments where I would like to be reassured about the basis for the person specification the structure of application form itself seemed to have been well developed. As I have seen no evidence for the weighting of competencies then awarding equal marks for each response seem reasonable. However, given the scale of this selection and the importance of clinical skills I would have hoped that some attempt would have been made to identify or even weight scoring of critical clinical competencies over desirable non clinical competencies at this stage. This has to be taken in context with the references which should provide a third party view of clinical competence.

15. Having only 150 words per competency is barely adequate and there is every chance that most of this would be taken up giving background detail and explaining their actions. However, if there is evidence that the top marks can be achieved by a range of candidates within 150 words then such limits may be justified. I have seen no such evidence and I feel a more realistic word limit would be 300 words. In more complex roles I have in the past given much larger limits (up to 1500 words) and asked candidates to evidence more than one competency area describing a complex case in more detail.

MTAS CV and Portfolio Assessment

16. The CV or portfolio appears to have appeared at the interview stage. Evidence from candidates suggests that there were very different approaches to how these were used at interview. Some were not apparently examined and when candidates viewed them being examined this examination was brief and non interactive (they were not asked about the content or cross examined on work they had carried out). These tend to be time consuming documents to develop and maintain and unless they sit within the wider professional development framework or are an integral part of current and future selection process they will always end up being developed specifically for the individual process. This can be a time consuming and difficult task for a busy doctor.

17. If portfolios are to be used as assessment there is a need to structure them, verify content either with the candidate or a third party and to source equivalence so that each candidate and assessor knows what to present and how to assess it. Assessor inter-rater reliability needs to be established if they become a major part of the process.

MTAS References

18. References are popular because often they are seen as a report on the quality of the candidate's previous behaviour and competence in a work setting by a fellow professional. As such they should be a very good measure with which to help make a selection decision. However, in studies written references have consistently been shown to be poor predictors of future success and suffer from many contaminating influences. . Even when enhanced by structuring it is difficult to prevent the personal and sometimes job unrelated preferences of the referee being the key construct that is reported back.

19. The MTAS reference form seemed to have been well developed. It addressed key areas and used an appropriate rating scale. As one reference was required from a current employer these should be seen as powerful evidence of workplace behaviour and competence. Although references can suffer from issues of score inflation in principle such structured assessments of workplace competence as judged by a senior clinician with experience of working with the candidate may be a highly valid and relatively inexpensive methodology. If MTAS could reassure itself that scores were not being distorted by referees it should be possible integrate reference scores into the final selection decision or as an eligibility check of minimum competence.

MTAS Interviews

20. The advice given to deaneries was detailed and should have equipped them well to carry out the final selection. However, it is clear that there was considerable variation in both quality and practice in these final interviews. Some involved good quality role plays, panel interviews and examination of the portfolios. Some did not. Evidence from candidates is that the questioning style varied between locations and that some questions seemed irrelevant to the role or the person specification. In particular arrangements for interview, particularly in the round "B" interviews were sometimes shambolic with candidates being sent to the wrong locations and/or arriving when they were not expected. Such disorganisation has a tendency to unsettle and disrupt candidates and assessors and leads to contamination of the assessment as all candidates are not getting similar experiences. Although two types of question were outlined; "behavioural" and "situational", evidence from candidates is that assessors added their own questions, the relevance and format of some of which is hard to classify or support.

21. Interviewing is not a skill we are born with and need to be taught and practised. In particular competency based and person specification based interviews are a skill in their own and require additional training and practice. The type and length of training assessors have received in these two areas (interviewing and competency based interviews) is unclear but I would expect an absolute minimum of 1 day face-to-face training which included practice with candidates. In particular no assessor should be interviewing without specific Equal Opportunities training. In materials I have seen it seemed that this may not have been the case as assessors were having to be told of fundamental questions they should avoid which would have been covered in an equalities training and has been in the public sector for the past 10 years or so.

MTAS Sequencing

22. In conjunction with weighting, sequencing is a key aspect of any efficient process. Sifting out candidates with a less valid method will remove competent candidates and leave subsequent assessors with less of a choice of candidates. The best candidates may not even reach interview stage. In additional to any legal eligibility tests (eg GMC registration) this first stage should include an assessment of the essential skills which one might presume are clinical. We might expect there to be a focus on competence rather than the "softer" interpersonal skills at this stage as the key element is clinical competence. Although we may desire candidates with enhanced interpersonal skills the first assessment should focus on technical competence to ensure that the best clinicians are selected for final interview. To focus on none clinical skills at this stage

runs the risk of accepting the less competent clinicians and the most clinically gifted being deselected because the "softer" skills are not as strong. As there have been assessments of both in the reference stage this suggests that the references should be assessed before a decision to reject is made.

MTAS Weighting

23. I have no evidence that MTAS has weighted competencies, although this would have been preferable had some evidence existing for the prominence of clinical skills over "softer" skills, it has inadvertently weighted certain types of skills by the sequencing of assessment. In the analysis of performance data three factors tend to emerge: good with task, good with people and good on paper. Any comprehensive assessment must therefore seek to measure all three if all three at some point in the process if all three are important to the role. To use a single measure as sift (eg a paper application) tends to favour those who are good on paper. Those with the strongest written evidence do not always go on to be the best candidates when more interactive and challenging assessments are used, where their technical competence (good on task) and people skills are tested. Indeed my experience is of a curvilinear relationship between high written scores and subsequent assessment or work performance. A written application of the nature of MTAS, where written skills may be important but are not the critical skills is therefore likely to progress candidates with better written skills rather than task or people based skills. Although the MTAS application does test the people and clinical skills these are best achieved through the references, interview or portfolio assessment approaches. Without integrating some assessment of these skills through, for example references, there is no guarantee that the most competent doctors will reach final assessment. Such written assessments tend to be used where the selection ratio is very low and where the drive is to reduce cost by taking out many poorer quality candidates. This is clearly not the case with MTAS.

MTAS Evaluation

24. Materials I have seen show that evaluation was built into the package for deaneries to complete. How many of them did so is unclear.

September 2007

Memorandum by Richard Cove (MMC 03)

This is a submission from an individual doctor.

The entire MMC and MTAS debacle has come about because British politics and indeed medical politics is rotten to the core.

The pain and suffering to our brightest and best. The long term damage to moral and quality training. All unforgivable.

Make those responsible for this mess accountable—and sack them from office.

I bet you do nothing of the sort, I bet you will say there were many to blame so it wasn't just PMETB or Donaldsons or anyone elses fault. Well, lives have been ruined, they deserve justice. Do you have teeth or not?

Richard Cove

2 September 2007

Memorandum by Graham Robertson (MMC 04)

1. In anticipation of the Health Select Committee inquiry into the shambolic implementation of the new medical training system, I would like to add my personal account of how MMC has effectively ended my medical career in the UK.

2. I have worked as a doctor for several years, initially training in surgery and gaining postgraduate qualifications in this field. Then, following much contemplation and discussion, my career path changed towards general practice. Due to my years of practice I was unable to enter a GP training scheme with other Dr's at FY2 level and had to construct my own training program. Having completed the appropriate training and only requiring one year in a training practice to qualify as a fully-fledged GP, I applied at ST3 in the 4 UoA (Scotland, Mersey, Wessex and West Midlands).

3. The knowledge test result allowed me to progress into the assessment stage in my 1st choice UoA Scotland. This comprised a half hour written prioritisation test and two 10 minute simulated consultations. Unfortunately as I was applying for ST3 GP in Scotland there were only 50 available positions (300 training

positions available but 250 taken up by Dr's from training programs I was not eligible for) and my other UoA's didn't count for an undefined reason. This short and worryingly subjective assessment deemed me unsuccessful for one of the posts available.

4. As there were no FTSTA positions at all for ST3 in General Practice, this effectively made me redundant and anyone else in the same position, out of work.

5. I therefore attended a careers evening in Glasgow for unemployed Dr's where the neither the professor of GP nor anyone else in the HR could find the time to attend. We were spoken to by an upbeat GP who seemed blissfully unaware of the mess MMC has caused. His only constructive advice for people in my position was "try Tasmania".

6. My current job only exists for me because the doctor in post is off on long term sick leave, otherwise I would be earning £59 a week Job Seekers allowance. Patricia Hewitt's promise that no doctor would be unemployed has proven to be as empty as her other guarantees on this country's health system.

7. The Government/DoH have been disingenuous to the point of deceitful regarding this appalling situation and the level of spin put out to the media is atrocious. MMC will undoubtedly have a detrimental effect on the future of medical training in the UK and a subsequent negative impact on patient care. The flaws in its design and implementation will make training punitively inflexible, hastily churning out a production line of disillusioned, poorly trained "sub-consultant" grade doctors. The reason this system has been slavishly pursued is so politicians can tell the public that their medical treatment is being delivered by fully trained specialists and not junior doctors. The fact that these specialists will be less experienced than many current juniors seems an irrelevance to both politicians and the professional medical bodies involved. If MMC had been designed to increase experience, skill and competence it would be laudable. Sadly it will achieve none of this.

8. I urge to Health Select Committee to demand firm answers to indepth questions, and hold those behind this mess accountable. It is the NHS that will suffer as this country's brightest assets either leave the UK or the health service altogether.

Graham Robertson
(a junior doctor with no future in UK medicine)

September 2007

Memorandum by Professor David Curtis (MMC 05)

MODERNISING MEDICAL CAREERS

Introduction

1. I am writing this submission in my capacity as a consultant psychiatrist, educational supervisor and clinical director. This has given me opportunity to witness at first hand numerous problems which have occurred with the MTAS process and which remain unresolved with regard to MMC. I work for the East London and City University Mental Health NHS Trust as a consultant in general adult psychiatry and I am clinical director for adult psychiatry in Tower Hamlets. I have been appalled by the effects this process has had on junior doctors, the medical profession and the NHS in general and I welcome the opportunity to present my account to the Committee.

Communication Regarding the Process

2. A theme running throughout the problems which have occurred has been failure of communication. I will mention this in various contexts but I feel it is important to highlight it as a general issue. Processes have been poorly explained, information has been difficult to come by and has often proven to be inaccurate. As a consultant and a clinical director there is much which I should have been told but was not and to this day much remains obscure to me. To summarise, I had little or no or inaccurate information about all of the following matters:

- Process to appoint through MTAS
- Whether trainers could assist in preparation of applications
- Implementation of rounds 1A, 1B and 2
- What jobs would be available in round 2
- Job descriptions for ST4 posts
- Process of assessment within MMC
- Procedures to move into specialist training at ST4 level
- Procedures for creating new ST4 posts

3. It is difficult to convey how problematic it has been to discover what is supposed to be going on. As an educational supervisor I need to know about these issues in order to appropriately advise my trainee. As clinical director I need to know in order to keep medical posts filled to provide a service and in order to plan service developments. I am now supposed to be engaging in the process of ongoing assessment but I do not know how this is supposed to work. The forms provided make no sense and there is no gudiance available. Over the last few months the dearth of information from the centre has been a repeated source of aggravation for me. Not infrequently, the information we have been provided with subsequently proves to be incorrect.

4. Hopefully specific examples of poor communication will appear throughout the rest of my submission. Overall, I would say that the general standard has been dreadful. We do not get told anything and the impression I have formed is that this because nobody knows what is going on because the process has been implemented without having been thought through.

MTAS 1A Short-Listing

5. I had no prior knowledge about what process was to be used to recrut junior doctors via MTAS and received no guidance regarding this.

6. I assisted two SHOs I knew in filling out their applications. Apparently some people were informed that consultants should not assist juniors. Obviously if some were assisted and some not this woul introduce unfairness. I also heard plausible reports that trainees attending courses were provided information about the assessment process, such as marking schemes, which should have been confidential. Yet again this would introduce unfairness.

7. I first became aware of problems with MTAS when large numbers of SHOs failed to be offered interviews. At this time the clear implication of this was that they would not be accepted on any training scheme and this was emotionally devastating for many. As the Committee will now be aware, many extremely competent doctors were not offered interviews at this point. It quickly became apparent that the short-listing process was essentially random. The questions asked were completely inappropriate and in fact addressed issues which should have been taken up at interview and in references.

8. The initial short-listing process had a dreadful impact on morale. Some doctors were off sick for what I assume were mental health-related reasons. Very many performed at below their normal level through a mixture of disappointment and resentment. Real uncertainties about the future prevented people taking on long-term commitments and the junior doctors in my service have in general been demotivated and bitter over the last few months, in my opinion with very good reason.

MTAS 1A Interviews

9. People were allocated interviews essentially as a result of a lottery. Some people were offered interviews on schemes which were not their first choice. However given the appalling situation which was unfolding some felt desperate to accept whatever was offered rather than end up with nothing. There was no clarity at this time around what else might be available and as a result of a failure to make this clear some doctors ended up stuck in jobs which they did not want.

10. I have heard plausible accounts of very different interview procedures being followed by different interview panels appointing to the same scheme. Some used a more traditional approach whereas others used the MTAS style which many people feel fails to assess competence and potential. Obviously this would again introduce inequity.

11. Most people would agree that any form of job interview is likely to be unreliable as a sole means of assessment. There will be a large element of subjectivity and people's performance may vary dramatically on the day contingent on a host of essentially random factors. The situation with regard to MTAS 1A was that people were short-listed according to a process which had no chance of effectively assessing their suitability for training and then were offered posts on the basis of interviews which were exceptionally unreliable and unfair. I would claim that by the end of MTAS 1A jobs had been offered to essentially a random sample of applicants.

MTAS 1B

12. This round offered interviews at their first choice to candidates who had not been given an interview in round 1A. The proposal was to use a more traditional interview procedure which might stand a better chance of assessing suitability. In the event, its implementation was grossly unfair to two groups of candidates: those who had already accepted an offer at somewhere they did not want to go to and those who had had a 1A interview at their first choice but had been unsuccessful. These two groups should both have been offered a 1B interview but were not.

13. Although offering new opportunities to some trainees, the overall effect of MTAS 1B was not at desirable as an appointments process. Excluding the two groups noted above, an interview was offered to everybody without any short-listing procedure at all. Since there is almost universal agreement that any

interview process will be unreliable and idiosyncratic it was ludicrous to appoint people to long-term training posts without short-listing and only dependent on their assessment at interview. I will note at this point that no use of references was made except to determine that the candidate was not actively unsuitable. I believe that this was a grave mistake and that references can often convey valuable information which should feed in to the appoinments process.

14. Both MTAS 1A and 1B were obviously flawed and we were given the impression that because of this only a relatively small number of appointments would be made of candidates who were clearly excellent. This would leave a large number of vacancies available candidates who would go through what was hoped would be a fairer and more effective process in MTAS 2. However we have yet again been betrayed. In my speciality there are no vacancies at ST2 or ST3 level in London. This means that anybody of this grade who was not lucky (and I do mean "lucky"") enough to be offered an appointment in 1A or 1B is now obliged to look for work elsewhere. This is a disgraceful situation. We had been led to believe that people would be offered a second chance with round 2 but now we discover that for many this chance simply does not exist.

Changeover

15. The few weeks leading up to the changeover were shambolic. Some people were being offered three-month ST locums and others were ineligible so I, in my capacity as clinical director, found them staff grade locum posts. One doctor eligible for ST4 was offered an unsuitable locum which she turned down and was unfairly told that she would not be offered anything else and would be unemployed from August 1st. I only discovered this by chance and was able to find a staff grade locum for her.

16. Junior doctors who had not been able to take leave previously tended to concentrate it towards the end of July. Two staff grades working in the Assertive Outreach Service, which deals with the most severely ill and dangerous patients in the community, took leave prior to starting ST jobs in August and it then proved impossible to find an agency locum to cover either of them. Thus the service, which is usually staffed by a consultant, two staff grades and a half time SHO was left for over a week with only the consultant covering.

17. Doctors were expected to relocate from one day to the next, sometimes across very large distances (one of our trainees went to Edinburgh).

18. Large numbers of new doctors arrived on a permanent or temporary basis having no knowledge of the local service. They were on induction for three days leaving only emergency cover. Bleeps disappeared and could not be found for days. Problems have occurred in handing over the duty bleep. Overall the mass changeover has made the service more chaotic and less safe than at corresponding periods in previous years.

19. There continues to be churning of doctors as we await the results of MTAS 2.

MTAS 2

20. From the evidence I have to date, the short-listing procedure for MTAS 2 again seems to be completely arbitrary. My current SHO is an MTAS 1 failure who has been given a 3 month locum post pending MTAS 2. He is an excellent psychiatrist and has previous experience in Italy and Britain prior to taking up his first SHO post. He initially appled for an ST2 post because of this experience but then was disqualified because it did not occur within an SHO training scheme and this is the only reason he failed MTAS 1. He was told that he needed to apply for ST1. This additional experience means that he has a very strong CV and I have seen his application form and believe that it should have made him very good candidate for an ST1 job. It is difficult to imagine many other ST1 candidates being able to provide a similar list of experiences. Nevertheless, he and I were shocked to learn that he has not been offered an interview. I have left phone messages for Claire Nottage, MMC Project Manager for the Kent, Surrey and Sussex Deanery and have emailed her and J Thompson but neither has responded to my communications. I am convinced that a mistake has been made, quite likely that somebody has thought he is not eligible for ST1, but nobody will reply to my enquiries about an appeals process or complaints process. In my view this typifies the contempt exemplified by those implementing MTAS.

MMC

21. The whole concept of MMC has come out of the blue to me. I do not believe that I am exceptionally ill-informed. I believe that this demonstrates a profound lack of consultation with the profession. The more I hear about it the more it seems to me there are obvious problems which will need to be addressed. I believe that one reason I know so little about it is that much remains unknown and that it has been implemented long before being thought through properly.

22. I have never received any useful information about the proposed MMC assessment procedures. Last month my colleagues attended an afternoon of training put on by the Royal College of Pscyhiatrists. They told me that the presenter was self-indulgent and that the information could have been communicated in forty minutes. I explained some difficulties I had regarding understanding how the process was to be applied and they said that attending the training would not have helped.

23. My SHO downloaded the documents which are intended to be used for MMC assessment from the Royal College of Psychiatrists. They do not make any sense. There are forms which look as though they are for appraisals but with no space to sign or note who the appraiser is. There is no consistency between the documents and there are frank contradictions. No guidance is provided. A month after the beginning of MMC these forms, which are supposed to support a continuous assessment process, are unusable.

24. I do not believe that the assessment process can reliably substitute for the clinical parts of the MRCPsych examination. I do not think asssessors will effectively and reliably assess competence, especially if this might involved declaring somebody not ready to proceed to training at a higher level.

25. The role of assessment in progression through MMC levels is not clear. There seems to be some notion that everybody will sail through all six ST years but I have no idea what happens if somebody is deemed not ready to progress.

26. In particular, I have no idea how the transition into ST4 is supposed to be managed, when I would expect that people would commit to a specialist training such as child, forensic or psychotherapy. People are guaranteed a run through training but we do not know how they are to compete within this for specialist trainings.

27. We have no idea what the ST4 job description is supposed to consist of. We heard it would differ from that for SpRs in that there would be more commitment to service. However we have received no formal guidance regarding this at all. Nevertheless we have had to submit job descriptions for new posts in order to get them approved by the College and we have had to make an educated guess as to how they should appear. Once again, I suspect that this information has not been deliberately witheld from us but that nobody has yet reached agreement on this matter. This is in spite of the fact that we now have people in these jobs.

28. I have no idea how we are supposed to deal with ST4 vacancies when people leave to take up consultant appointments. I have an SpR leaving next month which will leave a big gap in the service. As clinical director, I have not been informed whether there will be any prospect of filling this post with an ST4 and if so how this might happen.

29. I do not know how MMC is supposed to cope with people dropping off the scheme or whose progress will be delayed. This will inevitably happen but apparently the numbers in each year are supposed to remain constant. This clearly makes no sense.

30. I think the whole concept that one can decide after FY2 who is suitable for training in what speciality is completely fallacious. There has to be far more flexibility for people to try and fail and to pursue other career options. The most ludicrous aspect of this is the notion that one can identify who will be able to pursue a successful career as a clinical academic at this stage. A moment's thought applied to this would reveal the notion as completely nonsensical.

Conclusions

31. I find it impossible to convey in words the extent to which I have been repeatedly horrified and enraged by events around MTAS and the introduction of MMC. I and my colleagues have been kept in the dark and treated with the utmost contempt. I cannot understand who is responsible for what is happening and I seem powerless to influence it. Junior doctors who have been more directly affected than I have had their lives callously damaged by an incompetent and arrogant monopoly employer.

32. Until now British doctors have generally felt a sense of duty towards the NHS and this whole fiasco has produced hidden costs which are literally immeasurable in terms of producing a new generation of doctors who will justifiably feel little but resentment and cynicism.

33. The appointments process to date has been to a large extent random. Many excellent doctors have been unfairly denied the opportunity to train in a speciality and location of their choice because of gross failings in the system, some of which have already been admitted. It would be completely unacceptable if such doctors were not given further opportunities to compete for training jobs at a later stage. Conversely, there are doubtless many doctors who have gained training positions more through luck than ability and the NHS will have to deal with the problem that over the nest few years a cohort of doctors will emerge who are allegedly fully trained but who are in fact mediocre.

David Curtis
Consultant Psychiatrist, Clinical Director and Honorary Professor of Psychiatry

September 2007

Memorandum by The Royal College of Radiologists (MMC 06)

MODERNISING MEDICAL CAREERS

1. The Royal College of Radiologists (RCR) has approximately 7,000 members and Fellows worldwide

representing the disciplines of clinical oncology and clinical radiology. All members and Fellows of the College are registered medical or dental practitioners. The role of the College is to advance the science and practice of radiology and oncology, further public education and promote study and research through setting professional standards of practice.

2. This response outlines the RCR's views on Modernising Medical Careers (MMC) and the Medical Training Application Service (MTAS). The key points we emphasise are:

- The RCR supports the general concept of Foundation Year training and would support training at ST1 and ST2 being as broad as possible and to be followed by competitive entry at ST3 level, which for an applicant then entering Clinical Radiology would mean entering at ST1 level.
- The importance of incorporating the principle of flexibility in the new systems of medical training.
- The RCR supports a central application process, but the actual selection process should be Deanery led. The application form should include specialty specific questions and essential details such as past medical experience should be a core part of the application process.
- A full medical workforce review needs to be undertaken.
- All organisations and groups involved in restructuring plans for postgraduate medical education and training need to have defined terms of reference and a clear line of accountability. All the Royal Colleges needs to be much more involved and engaged by these organisations.

What Are the Principles Underlying MMC and Are They Sound?

3. One of the main factors that triggered *Unfinished Business,*[16] and which led to the proposals to introduce run-through training, was the perception that there was a "lost tribe" of SHOs who spent many years with little prospect of getting into specialty training and that this needed to be addressed. This is undoubtedly true, but what was lost was the fact that a number of SHO rotations were of high quality and of enormous benefit to trainees prior to entering their final choice of specialty training, preparing them for independent clinical practice.

4. The RCR's view is that something needed to be done to limit the amount of time spent in SHO training, but this did not necessitate the elimination of these posts. We support the concept that Foundation Year trainees should progress into two years of core medical, core surgical or core paediatric etc training. This would equate to years ST1 and ST2 of training and following this there should then be competitive entry into specialties training at the ST3 level. We would support training at ST1 and ST2 to be as broad as possible, particularly for the major specialties, such as medicine, surgery etc.

5. For clinical radiology this would mean doing ST1 and ST2 years in medicine or surgery etc and then applying competitively to enter radiology specialty training at ST1 level. This would be the preferred mode of entry to radiology training although we would not exclude some applicants progressing directly from Foundation Year training into ST1 training in radiology when they have demonstrated a clear determination and aptitude for the specialty.

6. The criteria for entry into specialty training in clinical oncology should include the demonstration of the knowledge and skills required of a physician as evidenced by possession of an exam such as the MRCP(UK).

7. The Foundation Year element of MMC has worked reasonably well, although some of the modules have not included acute clinical specialties which means that trainees entering radiology or core medical training directly from the Foundation Years will have less acute clinical experience than is desirable.

To What Extent the Practical Implementation of MMC Has Been Consistent With the Programme

8. Continual piecemeal changes with only fragmented information meant it became impossible to keep track of what was being proposed and implemented.

9. The flawed person specifications and short listing process from generic application forms led to good applicants being overlooked in the first round and making the process inconsistent with the principles of fairness and equal opportunity that MMC supposedly advocated.

The Strengths and Weaknesses of the MTAS Process

10. The application forms used by MTAS were generic and scenario based which lent themselves to plagiarism. CVs were not allowed to be submitted which meant the application forms became useless.

11. The Royal College of Radiologists supports a central application system, but the actual selection process should be delegated to individual Deaneries. This should avoid those in ST1 and ST2 undertaking core training spending large amounts of time attending interviews in many different training schemes around

[16] Department of Health. *Unfinished Business. Proposals for reform of the Senior House Officer grade.* A report by Sir Liam Donaldson, Chief Medical Officer for England, 2002.

the country. The Deaneries would need to be capable of defining and advertising the rotations in advance. The Royal College of Radiologists, like all the other Royal Colleges and other bodies such as the BMA, had pointed out for many years that the move to run-through training in August 2007 was potentially going to lead to a large number of young doctors being unable to obtain training positions because two or three years of doctors were competing for one year of vacant posts.

12. The development of person specifications and application forms was led by MMC and an organisation called the Work Psychology Partnership. It proved difficult for the RCR to influence this process. As a result the person specification and the application form were almost totally generic. The scoring of the application form, which was centrally driven without any input from this College, did not appropriately score past medical experience or academic or research activity. In fact, past medical experience and a full curriculum vitae were not available to the selection committees. The generic questions in the application form were almost immediately the subject of "perfect answers" being made available on different web sites so that selection committees had little opportunity of discriminating between the good, average and weak candidates.

What Lessons About Project Management Should the Department of Health Learn From the Failings in the Implementation of MMC?

13. All organisations, groups and committees involved in restructuring projects for postgraduate medical education and training need to have clearly defined terms of reference and a clear line of accountability which is transparent and understood by all. It needs to be absolutely clear where the final decisions are being taken and by whom. Meaningful engagement with key stakeholders should feature throughout the project.

The Extent to Which MMC Has Taken Account of the Supply and Demand of Junior Doctors and the Number of International Medical Graduates Eligible for Training in the UK

14. In order to inform decisions made in the future, a comprehensive formal medical workforce review should be undertaken.

15. If this country is likely to be self sufficient in doctors in the near future then a clear policy and understanding need to be developed on international medical graduates, which will involve a review of processes relating to visas for training posts and skilled migrant worker status. In addition, predictions for any expansion in the consultant workforce need to be matched to the numbers entering medical school and the numbers of specialty training posts available.

The Degree to Which Current Plans for MMC Will Help to Increase the Flexibility of the Medical Workforce

16. Probably unintentionally, but unfortunately, the current implementation of MMC has made training more prescriptive and less flexible. This may have been the result of the failure of the stakeholders involved to understand fully and co-operate. It is unreasonable for a specialist trainee at the beginning of a five year programme to be able to identify whether and when he or she will want to spend time in research. Moreover, expecting young doctors, who are half way through their second foundation year, to make decisions about their future long term career aims and area of specialisation, for which many will not be adequately prepared, will greatly diminish their flexibility to make more informed decisions and choices at a later, and often more appropriate, stage of their training.

17. The decision to award out-of-programme experience has been delegated to the Postgraduate Deans, who increasingly seem to be reluctant to grant this experience. Trainees in our specialties have benefited enormously from out of programme experience in the past, often spent overseas or in small research projects, and we feel this should continue.

The Roles of the Department of Health, Strategic Health Authorities, the Deaneries, the Royal Colleges and the Postgraduate Medical Education and Training Board in Designing and Implementing MMC

18. All the Royal Colleges need to be much more involved and engaged by organisations such as MMC and PMETB in the process of specialty training, and their considerable expertise in this area should be harnessed. The Royal College of Radiologists wishes to work proactively with these organisations and with the Deans through COPMeD to modify and develop curricula, to modify and develop methods of assessment and to verify that appropriate standards of training are maintained throughout the country, ensuring high standards of patient care.

19. Dialogue between the Colleges and MMC was confused. The Colleges did not act in a co-ordinated fashion which would have given them a stronger overall voice. However, the Colleges did flag up problems continually which were ignored.

20. It is essential that this College has an integral role in shaping the future for its specialties.

The Royal College of Radiologists

August 2007

Memorandum by Diana Morgan (MMC 07)

I am writing in the hope that my voice joined to others will effect a change and an improvement to the disaster that has been MMC/MTAS this year. Something has to be done so that those who failed to get the one off opportunity for specialist training this year have an opportunity next year. The rigidity of this new system means young doctors have to choose their speciality with little experience of hospital medicine; they cannot explore different specialities nor can they go abroad or carry out research all of which contributes to give us doctors who are not just competent robots. Surely we want excellent doctors, not just competent ones and with a rapidly changing world we need doctors to be multi skilled and aware of the whole patient and inter connections not just only capable of fixing one part of the body. Many of the brightest doctors particularly those who are 2 or 3 years out of university don't have training posts because they competed in the most sought after areas or specialities. Having only one chance to try for a run through training post they may now have no job or a one year post which is seen as a dead end. Previously they could have continued to apply to a different hospital or speciality with some hope of continuing to Consultant level.

My son is a junior doctor caught up in this year's turmoil. All the options he chose which in the past would have recommended him have now conspired to negate his ambitions. He took a BSc in his third year at medical school, he spent a year teaching Anatomy while he took the first part of his MRCP and was voted "the best lecturer" by his students, he has completed his MRCP passing each section first time, and he has explored more than one speciality. He is at S3 level. If he had gone straight through his medical degree, not taught medical students, he would now be a registrar and above the maelstrom. He was offered a one-year FTST contract six months at one hospital and six months at another in a different town. So he was "lucky"" he has a job, but will it lead anywhere? More to the point will he feel that he has choice in what he wants to do next? At the moment he is just getting to grips with his new job and hasn't got the energy to do anything else although he supports Remedy UK. He found the whole MMC/MTAS fiasco totally depressing and stressful especially the formulaic and politically correct 30-minute interviews, which he could compare with previous interviews where he felt his strengths and weaknesses, were really probed.

As a family we feel helpless. We cannot give him any useful advice so this e-mail adds to others I have written to those who have the power to make changes. Please make sure that this year's cohort of ST3/ST4 are not sacrificed. If a doctor makes a mistake he can be struck off but those who organised this dreadful fiasco are still in post. Please listen to Remedy UK and Fidelio. They have the interest of the NHS at heart and they clearly state the problems and the remedies.

3 September 2007

Memorandum by The Academy of Medical Sciences (MMC 08)

MODERNISING MEDICAL CAREERS

1. Executive Summary

There is grave concern that Modernising Medical Careers (MMC), in its current form, will limit diversity, flexibility and excellence in medical training. The impact of such reforms are particularly serious for clinicians wishing to pursue an academic training route alongside their clinical development. Mainstream clinical medicine draws on discoveries, innovations and developments pioneered by clinical academics. The consequence of MMC, if not robustly remedied, will be a barrier to sustaining a first class workforce and thus compromise the country's ability to deliver quality biomedical research and excellent patient care.

2. The Academy's submission is taken from our previous response to the independent MMC Inquiry, chaired by Professor Sir John Tooke FMedSci, which is being conducted in parallel to the House of Commons Inquiry.

3. The Academy's ultimate goal is to foster the best biomedical research in the UK, and to translate this into improved outcomes for patients. Our submission therefore addresses the broad issues of MMC and MTAS on medical training and the implications for academic training during postgraduate medical training. We are committed to finding robust solutions to safeguard academic medicine and we offer a number of recommendations for consideration.

4. *Recommendations on the broad issues of MMC/MTAS*

— Carefully designed pilot schemes should be used to test and refine ideas such as MMC and MTAS prior to full implementation.

— Constructive dialogue between doctors, their professional bodies and the government needs to be activated in order for solutions to be developed.

— Practical solutions need to be delivered to current trainees immediately, followed by a longer-term strategy to re-build morale.

— The principles of competence based specialty training, where trainees automatically emerge, via a run-through system, at consultant level, must be reconsidered. The introduction of a competitive progression point, where skills and knowledge are externally assessed would allow for (i) the identification of individuals across the ability spectrum and (ii) create a natural point where individuals could adjust their choice of specialty and/or training programme.

5. *Recommendations for academic training in postgraduate medicine*

— A robust recruitment and appointment process must be implemented for clinicians wishing to pursue academic training.

— Appropriate accreditation should be allocated for academic work.

— Flexibility should be a key principle in training programmes. Academic training requires flexibility with the possibility of entry and exit at different stages. Transferring from standard clinical training programmes to academic programmes or fellowships must be straightforward for all trainees.

— Opportunities for academic exposure in mainstream medical training should be strengthened.

6. Introduction

The Academy is pleased to submit evidence to the House of Commons Health Committee Inquiry of Modernising Medical Careers. The Academy was previously invited by Professor Sir John Tooke FMedSci, Chair of the independent Modernising Medical Careers (MMC) Inquiry, to advise on the changes it would like to see in the Clinical Academic Career pathway throughout the training grades, giving particular attention to the issues of choice, flexibility and the assessment process used to select trainees for the integrated academic and clinical training programmes. The submission presented here is based on the paper submitted to Sir John's inquiry in July 2007.[17]

7. The Academy supports the development and promotion of careers for biomedical scientists and encourages good practice in training and development across all sectors. The Academy's ultimate goal is to foster the best biomedical research in the UK, and to translate this into improved outcomes for patients. The UK's world-class position in medical science is underpinned by a first class workforce. It is vital that the UK's medical training and career structures continue to be attractive to the next generation of young researchers.

8. The Academy's submission addresses the broad issues of MMC and MTAS on medical training and the implications for academic training during postgraduate medical training. We would welcome the opportunity to expand on the issues highlighted here by providing oral evidence to the committee.

9. Broad Concerns Over MMC and MTAS

The majority view from the Academy is that MMC in its current form will limit diversity, flexibility and excellence in medical training. The consequences of limiting flexibility and failing to value excellence would be particularly serious for academic training and hence for the future contribution of UK biomedicine to the health and wealth of the nation.

10. The implementation of Modernising Medical Careers (MMC), via the Medical Training Application Service (MTAS), has resulted in an unmitigated disaster. A top-down, prescriptive approach has been taken and there has been a failure to engage effectively with the medical profession. We are concerned that the country's future ability to deliver quality biomedical research and excellent patient care will be compromised.

11. In finding robust solutions for the future, frank acknowledgement that medical training was not perfect beforehand is important. A particular concern has been the decline in the number of clinical academics over recent years and significant loss of research capacity in some specialties. The National Coordinating Centre for Research Capacity Development (NCCRCD)'s "Walport" initiative is an important measure to address this.[18, 19] We strongly support this scheme which aims to provide a career pathway for clinical academics and particularly regret that evaluation of its progress is compromised by MTAS. But in considering the potential impact of MMC and MTAS on academic medicine it is important to recognise that the NCCRCD integrated academic training (IAT) scheme applies only to a small proportion of academic trainees.

[17] http://www.acmedsci.ac.uk/download.php?file=/images/project/MMC.pdf

[18] http://www.nccrcd.nhs.uk

[19] Report of the Academic Careers Sub-Committee of Modernising Medical Careers and the UK Clinical Research Collaboration (2005). *Medically—and dentally-qualified academic staff: Recommendations for training the researchers and educators of the future.* http://www.ukcrc.org/PDF/Medically_and_Dentally-qualified_Academic_Staff_Report.pdf

THE FOLLOWING ARE THE ACADEMY'S GENERAL RECOMMENDATIONS:

12. *Carefully designed pilot schemes must be used in the future.* The NHS is a large and complex organisation. Major changes in direction have often led to unintended consequences. Pilot schemes should be used to test and refine ideas before full implementation. Extensive testing and validation of any changes to training should be carried out in those grades and specialties which have most to gain from a change.

13. *Developing solutions will require a constructive dialogue.* Relations between doctors, their professional bodies, and government are at a low ebb. Many doctors are suspicious of the government's motives concerning postgraduate medical training. There is also widespread criticism by doctors of their professional bodies on the grounds that they should have prevented or refined these changes. To develop solutions professional leadership needs to be re-established and government and the profession will need to work together. Both must be guided, and be seen to be guided, by the desire to deliver the best care and the best research for patients.

14. *Low morale amongst trainees must be considered and addressed.* Many are distressed by the prospect of not having a job, and by uncertainty about where they will be working or what will happen to their career. There is an immediate need to deliver practical solutions and a longer-term requirement to rebuild morale.

15. *Automatic progression via a run-through system must be reconsidered.* Under MMC, entry into specialty training (ST1) is pivotal. Subject to adequate performance in competency-based assessments individuals will automatically emerge with at the end of the training programme with a Certificate of Completion of Training (CCT). We are gravely concerned that this is inherently inflexible and that competency-based assessment will be insufficiently robust to ensure high standards or to identify problems reliably. A "run-through" system creates the need for irrevocable career decisions at a stage when insufficient assessable evidence is available to either the applicants or their scorers. To this extent the problems of MTAS are entwined with an inherent aspect of MMC. Introducing a competitive progression point (probably at the end of the second year of specialty training (ST2)) would provide a robust external assessment of the knowledge and skills acquired to date. This would assist identification of those at both ends of the ability spectrum. It would create a natural point at which individuals could adjust their choice of specialty and/or training program. It would thus objectively benefit both the individual trainees and the quality of those entering the senior grades in all segments of the profession. However, careful planning will be essential to avoid creating another 'lost tribe' at the end of ST2.[20]

16. *General principles concerning academic training in postgraduate medicine.* Academic medicine and medicine in general are symbiotic. In order to thrive, academic medicine requires a well-organised clinical environment and well-trained clinicians. Mainstream clinical medicine draws on discoveries, innovations and developments pioneered and implemented by clinical scientists in academic medicine. There are great benefits from exposure of all trainees to academia and a key objective should be to increase this exposure. There is an inherent artificiality in regarding academic medicine as a separate discipline—even more at a time when the importance of research to the NHS as a whole is recognised. There is a risk that identification of individual trainees as "academic" implicitly regards the rest as "non-academic". Academic values and the spirit of enquiry should be pervasive throughout the NHS.

17. *Access to research training and appropriate credit.* Time spent undertaking research does not automatically provide clinical skills training. But medical science is evolving rapidly and all doctors need to be able to evaluate advances and decide how to apply them. Research experience is an excellent way of fostering this and there should be a constructive approach to recognising this as professional training. MMC should consider how it could facilitate academic exposure in mainstream training. We recommend that research for a higher degree should be considered as credit for one year of clinical training (subject to demonstrating the required clinical competencies). This approach should be adopted across all specialties, although it is recognised that a minimum duration of clinical training is required, which will vary across specialties.

18. *Flexibility.* Academic training requires flexibility with the possibility of entry (and exit) at different stages, as emphasised in the MMC/UKCRC report on academic training. The NCCRCD integrated academic training (IAT) programmes provide a useful framework for this. However, they apply to a restricted number of trainees. We are concerned that for others there will be much less flexibility. Transferring from standard training posts to academic programmes or fellowships must be straightforward for all trainees. Operational simplicity is also essential for the local training programme. To achieve this we recommend that approved out of programme experience (OOPE) for research would generally be covered by provision of additional national training number (NTNs). Training programmes which have a track record of trainees undertaking 3 year OOPEs should be provided with additional NTNs for this purpose. Control over numbers of training numbers in this way will have benefits for workforce planning at the local and national level.

19. *Allocation of academic national training numbers (NTN(A)s).* We are concerned that differentiating between clinical and academic trainees at an early stage by badging the latter with an academic training number (NTN(A)) will be inconsistent and may in some circumstances be unhelpful. Illustrating this, in the

[20] Donaldson D. (2002) Unfinished Business, Proposal for the reform of the Senior House Officer grade. NHS. http://www.mmc.nhs.uk/download/Unfinished-Business.pdf

Gold Guide, NCCRCD integrated academic trainees would have NTN(A)s, which they would retain during their out of programme experience (OOOPE), while other trainees awarded Medical Research Council (MRC) or Wellcome Training Fellowships would not have NTN(A)s.[21] We are also concerned that having two classes of NTN will make transitions between academic and standard training paths less flexible. A further issue is that NTN(A)s could be regarded as providing less effective clinical training—making IAT posts less attractive, and possibly rendering individuals less competitive for subsequent clinical appointments. There is utility in retaining NTN(A)s for more senior clinical academic trainees such as Clinical Lecturers, and Intermediate Fellows/Clinician Scientists where they are valuable in identifying a specific cohort who are most probably committed to an academic career.

20. *Entry to Consultant Grade.* Training for clinical academics takes longer than standard clinical training. It is important that seniority at appointment to Consultant grade, and eligibility for Clinical Excellence Awards, take this into account. We consider that this is essential if academic medicine is to be protected from serious attrition in future as reward differentials accumulate.

21. *Alternative route to consultant grade.* We support the system which allows individuals who have not followed a traditional training programme to apply for a Certificate of Eligibility for Specialist Registration (set out in Article 14 of the General and Specialist Medical Practice Order).[22] Although we envisage that most academic trainees will obtain a Certificate of Completion of Training (CCT), the Article 14 route provides an important route to eligibility for a sub-specialty post at Consultant level. This flexibility should be communicated more widely to the profession, providing reassurance to trainees who are considering or pursuing an academic pathway.

22. Recommendations

Taking the general principles set out above, the Academy recommends:

— *A robust recruitment and appointment process for academic training posts*
Detailed recommendations are outlined in our paper to Professor Sir John Tooke's FMedSci MMC Inquiry.[23]

— *Accreditation for academic work*
Research for a higher degree should be considered as credit for one year of clinical training (subject to clinical competency).

— *Flexibility*
Trainees would have a standard national training number (NTN) irrespective of their chosen career path which will be retained during out of programme experience (OOPE) for research training fellowships. Academic national training numbers (NTN(A)s) would be restricted to individuals at a later stage in the academic career, ie those in Clinical Lecturer posts and Clinician Scientist Fellows.

— *Competitive progression points*
Automatic progression of trainees via a "run-through system" should be replaced with a mechanism for at least one robust assessment.

— *Opportunities*
MMC should consider how it could facilitate academic exposure in mainstream training. Allowing innovative Deanery/University/Trust partnerships which would provide research exposure during clinical training would be one route. Biomedical Research Centres, and Research Council Institutes, would provide fertile environments for trainees to gain insight into biomedical research. Masters level courses designed for medical graduates can be very valuable, and should be recognised by consideration of reduction of the direct clinical training time required to attain a Certificate of Completion of Training (CCT) (subject to clinical competencies being attained).

The Academy of Medical Sciences[24]

September 2007

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[21] A Guide to Postgraduate Training in the UK, "The Gold Guide" (June 2007) http://www.mmc.nhs.uk/download—files/Gold—Guide290607.doc

[22] http://www.opsi.gov.uk/SI/si2003/20031250.htm

[23] http://www.acmedsci.ac.uk/download.php?file=/images/project/MMC.pdf

[24] The Academy of Medical Sciences promotes advances in medical science and campaigns to ensure these are converted into healthcare benefits for society. Our Fellows are the UK's leading medical scientists from hospitals and general practice, academia, industry and the public service. The Academy seeks to play a pivotal role in determining the future of medical science in the UK, and the benefits that society will enjoy in years to come. We champion the UK's strengths in medical science, promote careers and capacity building, encourage the implementation of new ideas and solutions—often through novel partnerships—and help to remove barriers to progress.

Memorandum by Dr Clive Peedell (MMC 09)

I have one simple question that I would like the Health Select Committee to investigate in it's enquiry:

"What and where is the evidence for the 'lost tribe' of SHOs?"

Much has been made of this group of doctors, but I have seen no real evidence to suggest that this was a significant problem. As far as I am concerned this was based on hearsay. In my view, I accept that the old system of recruitment and selection for specialist training of doctors had some problems. However, these were minor and being ironed out over time. Problems with "biased" selection and "patronage" had become rare. The "lost tribe" is a fabrication of reality and based on the views of senior doctors who experienced the system decades ago, yet this seemed to be a key reason for the development of Sir Liam Donaldson's "Unfinished Business" document. This lead to a perfectly good system being decimated and replaced by the debacle of MMC, which has serious and sinister political motives behind it.

Thanks for considering my comments.

Dr Clive Peedell BM MRCP FRCR
Consultant Clinical Oncologist,
James Cook University Hospital,
Middlesbrough

15 September 2007

Memorandum by Anna Peek (MMC 10)

I note with interest your terms of reference and I would like to comment on some of them in particular. I was an SHO, am now an ST2, hoping to pursue a career in Orthopaedics. I trained and live in London. I am now in the LNR deanery, working in Northampton. These views are my own, having experienced both systems of selection and training, based on my observations, and not those of any particular organisation. They reflect the state of affairs in surgical training, I cannot personally comment on other specialities.

What Are the Principles Underlying MMC and Are They Sound;

I believe the principle of run through training is reasonably sound, but ONLY if the selection to that training is sound, fair and appropriate. MTAS fundamentally undermines MMC.

The principle of formalising teaching and learning is not a bad principle, but results mainly in large amounts of box ticking exercises. Craft specialities are learnt through an apprenticeship type of process and this is what should be reserved.

To What Extent the Practical Implementation of MMC Has Been Consistent With the Programme's Underlying Principles

The assessment tools introduced by MMC are satisfactory for ensuring that doctors meet a minimum standard (this is what they were designed for) but are inadequate for selection of the top candidates and should not be used in this fashion. This was one of the problems with MTAS. I believe the same could be said of membership examinations. The ideal selection tool, in order for example to appoint to competitive training programs, would I believe be a combination of interview (motivation/personal attributes test) and a formal knowledge test the level of which should be very challenging. There are many foreign models the committee may choose to consider.

The Strengths and Weaknesses of the MTAS Process;

Strengths:

— Long term work force planning (but that does require the DoH to do just that-see below)
— Less time spent applying to many different places

Weaknesses:

— IT failures (I hope the committee will not be hood-winked by IT babble: a website that does not work is a website that does not work, whether it is officially crashed or not!)
— The UoA were far too large. I drive 60 miles to work every morning passing on the way at least five hospitals I could train in just as well. It simply makes no sense at all. Deaneries should be of different sizes depending on the speciality: for example, a deanery for orthopaedics could be one teaching hospital and two or three nearby DGHs. A deanery for neurosurgery would have to include several tertiary centres, etc . . .

— The selection criteria as above.
— The whole FTSTA situation: now what?

What Lessons About Project Management Should the Department of Health Learn From the Failings in the Implementation of MMC

The project managers should be fired immediately and the reforms implemented by the royal colleges, which have historically been independent, knowledgeable about their speciality, and accountable to those who have to undergo the training (most trainees have membership).

The Extent to Which MMC Has Taken Account of the Supply and Demand of Junior Doctors and the Number of International Medical Graduates Eligible For Training in the UK

As far as I can tell it has taken no account of either supply or demand.

As to predicting future demand, this should be a high priority for those implementing training, but this is clearly a very difficult thing to do (eg cardiothoracics) and therefore all members of the speciality should be widely consulted before a consensus is arrived at. Demographics (eg ageing population, immigration) should not be ignored.

The Degree to Which Current Plans For MMC Will Help to Increase the Flexibility of the Medical Workforce

MMC has drastically decreased the flexibility of the medical workforce. We all have fewer skills, having spent less time acquiring them (although we do have more forms to prove that we have those fewer skills).

As individuals, we are far less flexible to choose specialities of interest during our training, as posts are allocated by some higher process. There seems to be very little provision for overseas work, maternity, or any other personal circumstances.

The Roles of the Department of Health, Strategic Health Authorities, the Deaneries, the Royal Colleges and the Postgraduate Medical Education and Training Board in Designing and Implementing MMC

From where I stand:

— DoH: Chronic and long term failure to implement any effective workforce planning
— SHA: They are concerned only with meeting government targets. Training good surgeons is not a government target.
— Deaneries: Trying their best in confusing circumstances with very few resources.
— Colleges: Realising far too late that things were not going well.
— PMETB: Denying they have anything to do with it!

September 2007

Memorandum by Dr Schramm-Gajraj (MMC 11)

I am writing to you because I would like to point out the unfairness of the selection process of MTAS from my personal experience in the hope for more fairness in the selection process next time.

In principle I agree with a centralised selection system—and that can be by computer (if the system works and doesn't leak intimate information to the general public) and I do see the problems of workforce planning.

I did have 4 shortlistings during the first round and attended 4 interviews in a row (in March), which was a pretty stressful experience because it was a lot of interviewing within 2 weeks.

Three months after I had had my interviews all the people who hadn't had interviews due to not being shortlisted were also attending interviews. These people had heard all the questions from other candidates and in my hospital one consultant even provided intensive preparation for the counselling station AFTER I had had my interviews but very helpful for all the candidates who were not shortlisted and who got interviews later—I did not get an interview again. Do you think it is fair to compare the answers of somebody in March who didn't get special training from this consultant and who didn't know what would actually count as it kept changing?

In my case I don't think it was very fair. The outcome showed: the people who were finally offered jobs did not have any shortlisting but lots of time to listen to the questions asked the others.

Sadly I can't leave the country due to your visa rules.

The people who were given jobs even need a work permit. This is all given although they are less qualified than me!—But what can I do then?

Please consider the problems you are posing on families with small children—like my family.

Thank you

September 2007

Memorandum by Catherine Macdonald (MMC 12)

MMC/MTAS

Firstly, I would like to wish you success as a committee. The MMC/MTAS problem needs solving. Secondly I would like to put down my own thoughts on how such a problem occurred, and ask you to consider them.

Sloppy Development of the MMC Goals

MMC started as a wish to improve training, particularly for the SHOs. From this sensible beginning it evolved to become a series of often vacuous and at other times foolish catch phrases. "Competency based v excellence based" is an example of the first. "Run through training" and "no CVs" are examples of the second.

Successful firms in private ownership do not offer the newly qualified ten year training posts, on the basis of a single interview, and without references. Ask one of the "magic circle" firms of solicitors (Freshfields, Allan and Overy etc.) whether they would contemplate such an idea. Then ask yourselves whether you would employ a gardener, a driver or a cleaner on such terms.

Sloppy Development of the IT System

It takes rigorous thought to specify an IT system. The all important work is the development and specification of the brief. The time allowed for this was wholly inadequate, and the results inevitable.

Big Bang—a Foolish Decision

Big bangs require meticulous preparation. Those who lack either the ability or the resources should chose a different approach.

Failure to React Appropriately to the End of February Events

The end of February saw large numbers of decent and respected doctors without a job interview. It was clear the selection system had failed. Calm assessment and fast remedial action were called for. Instead we saw denial of the problem, spin, and "bad mouthing" of those who gave a realistic assessment.

End of February to Start of August—the Abandonment of Principle

The slide from an understandable series of errors to dishonesty and abuse is depressing.

The first Douglas Review was presented as independent, when this was not the case. Remedy and its supporters were characterised as wild fringe elements—also not the case. Job numbers were given incorrectly—with the numbers applying for posts consistently underestimated and the numbers of jobs available consistently overestimated.

It took a court case in May to make public that the algorithm used by MTAS to select appropriate doctors for jobs was not only defective (obvious from the February allocation of interviews) but known by the DH to be so.

Panic and bullying by the DH had its effect further down the line. Jobs offered at short notice, by e-mail and without supporting paper documentation, to be accepted by return. Such job offers to be binding on the recipients, but not on the Deaneries. Such jobs to be accepted without details of contract conditions, pay or place of work.

These are in my view the main factors in the MMC/MTAS debacle. I hope that you as a committee will be able to undo the damage done, and restore the situation for both individual doctors and the NHS.

Perhaps too you could look more widely. The mistakes and inadequacies outlined above are not unique to the Junior Doctor fiasco. Lack of rigour when setting goals, IT as a magic trick, spin, disparaging those who disagree, and bullying are common within government. A cure for these problems would be a resounding result.

September 2007

Memorandum by James Jenkin (MMC 13)

MODERNISING MEDICAL CAREERS (MMC) AND MEDICAL TRAINING APPLICATION SERVICE (MTAS)

1. Background

I have an interest in this matter which is both general and personal.

I am qualified as a Chartered Engineer and as a Barrister and I am a British Citizen.

2. The Present Position

2.1 There is widespread dissatisfaction with the MMC as it presently is and intended to be and with the recruitment process.

2.2 A great deal of the expressed dissatisfaction has been to do with the operation of MTAS. However the problems really start with the MMC.

2.3 The MMC has a particular aspect, which is the shortening of the training to become a consultant (I understand by one year)

2.4 The European Working Times Directive (EWTD) will progressively reduce (drastically) the number of hours that doctors may work and hence the experience they will gain in each year of training.

2.5 It is understood that the number of hours of training to become a consultant in much, if not most, of the European Community, and thus experience gained before becoming a consultant is generally less perhaps considerably less (and may be in a narrower field) than the corresponding amount of expertise gained by current UK consultants before qualifying.

2.6 The expertise required to be acquired before qualification in other significant parts of the world such as Australia, Canada and the US are believed to be more akin to the amount of expertise gained by current UK consultants.

2.7 A so called "big bang"" approach has been taken for the introduction of MMC. Big bang as a description is a portmanteau expression which can imply a legitimacy of approach which may be undeserved.

2.8 A result is there has been a "double cohort" of potential applicants for training posts this year.

2.9 On the assumption that the number of trainee posts is not significantly different from that in 2006 there has obviously been a multiplication of the number of rejects of trainee applicants this year as compared to previous year(s); and.

assuming that 2.8 (above) happens to correspond to a doubling of applicants then

the reject factor, being the number of times more likely to be rejected this year than last, is

(the ratio of number of applicants this year to that last year) minus (the fraction of applicants found places last year)) divided by (1 minus (fraction of applicants found places last year)).

— If percentage obtaining places last year was 50% then (2-0.5)/(1-0.5) = 3 is the factor of rejects this year compared with last year.

— If percentage obtaining places last year was 90% then the reject factor this year compared to last year is (2–0.9)/(1–0.9) = 11

These assumptions can be replaced with the correct values when available. In the meantime members can substitute into the equation what they may consider to be any more appropriate values from any specialised knowledge they may have.

Indeed, the Committee will presumably be interested in being provided with the present best estimate by the NHS of the number of applications for training posts and of refusals that will be made in 2007 and 2008 and that were made in 2006. If initially unavailable they should surely nevertheless be produced for the Committee. Perhaps this should be done both with overall figures and also figures for those doctors who first qualified as doctors in the UK.

2.10 What is clear from this analysis is that there is to be a massive and unusual wastage of excellent junior doctors. What is incidentally true is that this could neither have been anticipated by students starting their medical studies 9 or more years ago nor by those same persons now, as well qualified doctors and their families.

2.11 The NHS and the country are on the point of losing a tremendous resource produced at huge cost to the taxpayer, the teaching institutions, the doctors themselves and often their parents.

3. Important Questions as to Quality Arise

3.1 Is the MMC intended to produce a lesser quality of training than the present?

3.2 Have the implications of the negative effects of European Working Times Directive (EWTD) on medical training been properly evaluated?

3.3 Is there well based confidence that the intended quality of training will be achieved notwithstanding the effects of the reduction of the period of training and of the EWTD?

3.4 Is that level of quality of training of future consultants going to be maintained so as to produce consultants who are equivalent in their quality with the best in the world? If so how?

4. In Conclusion

Notwithstanding the detailed arguments in relation to the content and philosophy of MMC and whether it is to be changed to a lesser or greater degree, or discontinued, or the difficulties of MTAS and how they may be overcome for the future, the question I would ask the Committee to seriously consider is:

Should not the decision that was taken to shorten the training period for doctors to become consultants be reversed forthwith?

- The quality of our future consultants would be maintained or even, given the amount of thought now being applied to this matter, improved.
- At a stroke the massive wastage of excellent junior doctors would be largely prevented.
- The taxpayers' investment (and that of others) in the training of those doctors would not be wasted
- The NHS would benefit from the services of the doctors retained in training and an incidental benefit would surely accrue to the morale of the NHS generally.
- The, not to be expected, destruction of vocational aspiration of so many doctors; hardship to the doctors themselves and in many cases their families and to their other relationships could be largely avoided.

September 2007

Memorandum by Mums4Medics (MMC 14)

MMC AND MTAS

Summary of Evidence

The Committee will have received personal evidence from individual doctors and their families which illustrates the human costs of the 2007 implementation of MMC through MTAS. We urge the Committee to give adequate weight to this evidence.

Doctors are, first and foremost, people whose values have informed their choice of profession and their approach to it. In a civilised society, the values they demonstrate every day of their working lives—dedication, selflessness and a commitment to a great tradition of public service—would be celebrated and valued.

Instead, MMC through MTAS has subjected them to a brutal, unfair and inhumane selection process that has left them traumatised and demoralised. We believe this has arisen from the government's view of the doctor simply as "service provider", and therefore disposable and interchangeable.

We believe that every commitment to medicine is an individual commitment to a vocation, not simply to a job, and that a wise government would recognise and celebrate that dedication and skill.

If the government respected the medical profession and the individuals who dedicate their lives to it, what has been done could not have been done.

Our Request to the Committee

We ask the Committee to examine:

1. Whether the development of MMC and its implementation in 2007 were driven by evidence-based need or by political ideology.

2. Whether MMC as implemented in 2007 fulfilled the original principles of the MMC project.

3. Why the decision to shorten the training period for doctors to become consultants was taken, and how less experience can be better experience.

4. Why the decision was made to take a "big bang" approach to implementation.

5. Why no sensible transition between "old" and "new" systems of training was developed.

6. Why the implications of the "double cohort" were not taken into consideration.

7. What happened to humanity and common sense in the design and implementation of MTAS.

8. Whether MTAS application and selection processes were adequately tested and piloted.

9. Why the medical Royal College exams were so devalued in the MTAS selection process.

10. Why UoAs were set as huge geographical areas and not as listings of every "rotation" available to allow true choice.

11. Why the government has consistently increased medical school places when NHS workforce planning seems to indicate that the result would be an excess of doctors over posts available.

12. Whether the government has accurately assessed the implications of the European Working Times Directive on medical training and staffing.

13. What strategies are in place to manage the crisis of over supply and the expectations of those who have invested five to eight years of their lives in qualifying and securing registration.

14. Whether NHS workforce planning is fit for purpose.

15. Why the Douglas review did not call a halt to the implementation of MMC through MTAS in March/April 2007 when there would have been time to return to tried and tested methods of selection for August 2007.

16. Whether MMC should be abandoned.

17. Whether responsibility for medical training should be returned to the medical profession and PMETB abolished.

Finally, we would ask the Committee to establish who is responsible for this deeply damaging episode and to hold them to account.

Background

Mums4Medics is an ad hoc lobby of the families of doctors affected by the MMC/MTAS crisis.

We began to come together on 8 March 2007 because we understand better than most lay people the dedication and commitment of junior doctors and their fears for patient care and the future of the health service they have chosen to dedicate their working lives to. And it was no longer enough for us simply to provide a shoulder to cry on.

Mums4Medics is non-political, and sought only a fair and reasonable solution to the proven problems of the MTAS application and interview system, and sensible answers to the many questions raised by the government's intention to implement the untried Modernising Medical Careers (MMC) post-graduate training system without transitional safeguards.

It originally lobbied for:

— The MTAS application and interview system to be scrapped;

— A return to the "old" tried and tested application and interview system for August 2007 appointments, and

— An independent review of both MTAS and of Modernising Medical Careers (MMC), of which MTAS was a crucial part.

As part of such a review, it also argued that urgent consideration should be given to:

— Increasing the number of training places available in August 2007 so that good doctors were not disadvantaged, the future of the NHS was not compromised, and the implications of the European Working Time directive could be properly assessed;

— A safe and sensible transitional process into any new training system, so that its impact on doctors, other health professionals, patient care and safety and the future needs of the NHS could be properly and independently assessed.

In the months since March 2007, Mums4Medics supporters, in co-ordination with RemedyUK, have:

— marched with junior doctors in London and Glasgow on 12th March 2007;

— attended a Mass Lobby of Parliament on 24th April 2007;

— supported the RemedyUK application for judicial review with evidence and donations towards its legal costs

— written to MPs, to the Secretary of State, Patricia Hewitt, to Tony Blair, to Cherie Blair, to Gordon Brown, to the Royal Colleges of Surgeons (England) and Physicians, to the Commons Health Select Committee, to the Post Graduate Medical Training Board (PMETB), to the General Medical Council (GMC), to the Patients' Association, to the National Patient Safety Agency (NPSA), to Trusts in England expressing their concerns for patients care on August 1st, and to numerous newspapers, national, regional and local, in support of its aims, and

— made a submission to the Tooke review, set up by the Secretary of State for Health in April 2007 and due to make its first report in autumn 2007.

It is also directly supporting junior doctors by offering hospitality, a "listening ear", and Roomz4Medics—temporary "lodgings" for displaced doctors.

Mums4Medics is not simply a pressure group of the families of those unlucky in the MTAS 2007 lottery. A straw poll conducted in July 2007 indicated that Mums4Medics supporters were split roughly 50/50 between the families of those who have secured run through training and those who have not. Our continuing concern is about what has been done and how it has been done, and the future implications for the profession and the NHS.

Mums4Medics was set up and is coordinated by Lindsay Cooke, the mother of a surgical SHO who worked in a Foundation hospital in SE England until July 2007 and is leaving to make her future in New Zealand in October 2007 as a direct result of the implementation of MMC.

Submitted on behalf of Mums4Medics by Lindsay Cooke

September 2007

Memorandum by the NHS Workforce Review Team (MMC 15)

MMC INQUIRY

INTRODUCTION

The Workforce Review Team (WRT) is responsible for workforce planning for all professional groups within the NHS. It currently works through a service level agreement with the Department of Health (DH) and provides valuable workforce information to DH, strategic health authorities (SHAs) and employers.

The major part of WRT's remit is supply-based modelling and gathering information to inform demand side analysis. As part of this remit members of WRT have provided support in the modelling of workforce numbers, analysis and workforce intelligence to the Modernising Medical Careers (MMC) team. WRT's excellent links to workforce planners within the Royal Colleges meant that we were able to look at some of the implications of MMC at specialty level and also to predict some of the possible outcomes of the change.

1. *What are the principles underlying MMC and are they sound?*

We believe the original aims of MMC were to:

— produce safer doctors in a structured competency-based training programme

— produce a consultant-delivered service more quickly

— deliver the expansion of consultants promised in the NHS plan

— remove the problem of the junior doctors being "stuck" at SHO level.

However, MMC alone cannot deliver the expansion of consultants. This depends on the actions of employers who independently determine their workforce requirements.

2. *To what extent has the practical implementation of MMC been consistent with the programme's underlying principles?*

A structured competency-based training programme has been introduced, but the training is not necessarily completed more quickly.

Within the system, an increased number of trainees will get their Certificate of Completion of Training (CCT). However, whether the NHS will or can now afford to employ them at consultant/specialist level is another issue. The emphasis seems now to have moved from the initial objective of the service being delivered by "trained doctors", to how do we train all these doctors?

There has been an increase in medical school numbers without a proportionate control on the numbers of doctors from overseas. Whilst the aim of increasing self-sufficiency is sound, the handling of the transition towards this was incomplete and there is a risk of displacing UK-trained doctors.

3. *What are the strengths and weaknesses of the MTAS process?*

The key components of the "MTAS process" were:

a) a national computerised application system

b) a new system of competency-based selection

Both were introduced at the same time.

The MTAS system produced a national system of recruitment which had the potential for huge savings, in terms of cost and time, for both consultants and trainees. The computer system did not crash despite unprecedented loads, although at times it was slowed down.

When applied as intended, in many parts of the country, it was able to be used to shortlist excellent quality candidates in round one, showing that it did have power to identify the best candidates.

However, there was not enough professional "buy-in" to the new system, particularly relating to the selection methods. In addition, the whole system of recruitment had the flaw that the best candidates were offered more than one interview in round one, whilst the "average and below" candidates may not have had an interview at that stage. By restricting interviews perhaps this problem could be solved. A very similar system has worked very well for Foundation 1 trainees.

In spite of these issues, we believe it was probably the fairest system ever used for medical recruitment that reduced the potential for discrimination on unacceptable grounds.

4. *What lessons about project management should the Department of Health learn from the failings in the implementation of MMC?*

— Decisions were made to resolve "today's problems" in an attempt to avoid bad news. This had the effect of creating an even worse position for the future, eg the decision to interview everyone in round one (consequently delaying round two) resulted in excellent doctors not being offered jobs as early as they should have.

— Wholesale changes such as this need more planning time with earlier engagement from all parties, as well as a commitment from all to making the change happen.

— Merging London with Kent, Surrey and Sussex (KSS) during the recruitment stage had a knock-on effect on the MTAS reporting time.

— In the early stages more resources should have been made available at every level, to the same extent as have now been made available to deal with the aftermath.

— The IT system would have benefited from being piloted, especially to discover the possible security breaches from determined hackers.

— The governance structure needed earlier clarity with a clear process for decisions to be made. The system for gathering expert opinion and concerns needed to go hand-in-hand with the governance structure.

— The small MMC team worked hard, but it appeared this important change process was not embedded either within DH or the service and was perhaps not adequately resourced.

5. *What is the extent to which MMC has taken account of the supply and demand of junior doctors and the number of international medical graduates eligible for training in the UK?*

Although data and intelligence on workforce was included, with the support of the Workforce Review Team, we do not believe that workforce planning was given enough consideration in the process.

The decision to open the training process to all international medical graduates meant that there would be very high levels of competition. This was known and predicted at an early stage. The lack of control has meant that medical expansion is now probably producing the right number of doctors for our system, especially if more of the service is delivered by trained doctors rather than relying on partly trained trainees. However, by allowing virtually uncontrolled entry of international medical graduates, the numbers applying far outstripped the available training places with the potential to displace graduates that the UK economy had already invested in and supported through medical school.

Strenuous efforts were made to ensure that the fixes to the system did not make the situation worse, for example by increasing the numbers of training places in specialties where there was an excess of potential trainees but expansion was not needed. However, some surgical posts have been introduced temporarily and it is important that these are removed as planned.

Although some candidates switched preferences once good information about competition ratios was made available, there needed to be a much greater willingness among young doctors to choose less popular specialties in less popular geographical locations.

6. *The degree to which current plans for MMC will help to increase the flexibility of the medical workforce*

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

7. *The roles of the Department of Health, Strategic Health Authorities, the Deaneries, the Royal Colleges and the Postgraduate Medical Education and Training Board in designing and implementing MMC*

The SHAs were only engaged at a very late stage in the process, although membership of the MMC programme board included an SHA chief executive. They were also undergoing considerable re-organisation at this time.

It has become apparent that the understanding of the tenets under which the Postgraduate Medical Education and Training Board (PMETB) works was flawed. This led to decisions being made about the nature of recruitment based on what were thought to be statutory considerations which in fact were advisory. The design of the MTAS system was thought to require strict adherence to PMETB regulations, whereas it is now clearer that those regulations were more like guidance and further discussions could have ensured, and possibly altered, the design process.

The deaneries and employers worked very hard to support the process as it evolved.

The royal colleges were, in some cases, slow to engage, as they possibly felt that the change would not happen. Having been engaged, many worked hard to produce explicit curricula, in a tight time-frame—many for the first time. Once the process began to go wrong some were unwilling to share ownership of the problems.

Changes were made to deadline criteria once the process had commenced. This, along with repeated requests for information, slowed the actual process of getting the job done.

Much more weight should have been given to the employers' views in designing the processes and to a greater understanding of the workforce implications.

CONCLUSION

Although MMC was intended to produce a more flexible workforce, this is not well reflected in the final product. Also some of the "fixes" put into the system have been counter-productive in workforce planning terms.
This process was designed to support the vision of a consultant or trained doctor-delivered service, but other changes introduced simultaneously have affected the integrity and deliverability of that vision.

Workforce Review Team

September 2007

Memorandum by The Yorkshire Deanery (MMC 16)

MODERNISING MEDICAL CAREERS

Please find enclosed a submission of evidence to the Health Select Committee Inquiry on Modernising Medical Careers, which represents the views of myself and medical colleagues in the Yorkshire Deanery.

I should stress that the views of the Yorkshire Deanery do not purport to be those of the Yorkshire and Humber Strategic Health Authority. The SHA contains both the Yorkshire Deanery and the South Yorkshire and South Humber Deanery and opinions would be likely to differ between the two Deaneries. Nevertheless, individual Deanery views should be considered since Deaneries were the final common pathway for the implementation of the MMC reforms and MTAS.

1. EXECUTIVE SUMMARY

1.1 *Principles Underlying MMC*

— Are generally sound and accepted by Deaneries and the profession.
— Are reflected in the success of Foundation Programmes.

1.2 *Practical Implementation of MMC*

— Successful with Foundation Programmes (FPs), which are patient and trainee focused, competence based with an assessment framework against an explicit curriculum.

— Generic skills training has been a notable success in FPs

— Careers guidance is provided specifically for FP trainees and is successful, funded and highly valued by trainees

— FP success is largely due to the fact that implementation, and management through Foundation Schools was funded

— Foundation recruitment was successful only because vacancies exceeded the number of applicants. If there are more EEA applicants in the future they may crowd out UK trainees.

— Run through programmes may not be suitable for all specialties at the present time. Better selection and career planning might alter this in future but it should not be imposed on all specialties.

— The MMC principle of career flexibility has not been pursued and has been compromised by run-through programmes and PMETB single curricula.

— The reform of post foundation specialty training has not been funded

1.3. *Strengths and Weaknesses of MTAS*

— Changes were rushed through without adequate funding, and without inclusion of better selection methods, which would have had to be piloted.

— Communication was generally poor, especially with trainees.

— Deaneries' financial situation was threatened because of the £600,000 "hole" in the DH budget.

— The process appeared to trainees to be an impersonal electronic process which ground on for months while their careers hung in the balance.

— The actual interviews were a step change improvement compared to what had gone before.

— There was increased fairness, transparency, objectivity and robustness, with competence-based interviews using panels of trained interviewers.

1.4 *Project Management Lessons*

— Major change needs time, testing, good communication, stakeholder sign-up and resourcing.

1.5 *MMC and supply and demand for junior doctors*

— The NHS workforce is still predicated on a broad based pyramid, with acute services based on SHO-grade training and service posts. EWTD 2004 was associated with a massive increase in foreign doctors (mainly Indian) who are now HSMPs and who applied through MTAS for training posts. There is no training pathway for these large numbers unless the workforce changes and CCT-holding specialists are employed to deliver out of hours service in the middle grade rotas. In the future, StR numbers will have to fall and there is currently no solution on the table as to how the acute service will be staffed.

1.6 *MMC and workforce flexibility?*

— There has not been a concerted attempt by specialties to identify transferable competences.

— There has been no overall plan to guarantee entry points beyond ST1 for trainees wishing to transfer.

1.7 *Roles of different agencies*

— DH, SHAs, Deaneries, Colleges and PMETB share some of the responsibility for the failure to implement important aspects of MMC

2. Background

The initial driver for reform of medical training was concern about the training of Senior House Officers (SHOs), which had become known as the "lost tribe" following the Calman reforms of Registrar and Senior Registrar training. They acquired this title because of the uncertainties of their career pathways in that they had no promise of career progression into specialties; they had jobs which were not always clearly identified as training posts. They were employed by individual NHS trusts and so did not have direct Deanery contact for remedial training or health problems. Their careers were on hold while they tried to achieve College exams which were not necessarily a relevant barrier to career progression, and in popular specialties, they

would undertake additional tasks, such as research to obtain a higher degree to improve chances of specialty entry. Many spent up to 5 years in the SHO grade before entering specialty training or changing specialty having failed to progress.

The NHS depended to a large extent on this extensive pool of SHOS, augmented by service posts, such as Trust Doctors and Staff Grades to deliver the service, especially in the acute specialties and out of hours. The 58 hour EWTD target in 2004 further expanded the Trust Doctor / SHO pool with thousands of additional doctors being employed, mainly recruited from the Indian subcontinent.

As the review of medical training progressed, one of the guiding principles became the fact that the service should be delivered by trained doctors with assured competences (rather than the historical mix of SHOs, Trust Doctors, Staff Grades and Clinical Fellows etc with equally varied experience and reliability).

As the concepts of Foundation and Run Through Training developed, it was clear that more than just the SHO grade would be affected by the reforms and so the "Modernising Medical Careers" idea was developed since almost all medical trainees (and Consultants) were affected by the proposed changes.

3. Principles Underlying MMC

The key principles of the medical training reforms were set out in "Unfinished Business", and further elaborated in "Modernising Medical Careers: the response of the four UK Health Ministers to the consultation on Unfinished Business—proposals for reform of the senior house officer grade".

The initial principles are sound, and have largely been implemented in Foundation Programmes, which are the only element of MMC thus far implemented. They are that training should:

- Be programme-based
- Be broadly based to begin with for all trainees
- Provide individually tailored programmes to meet specific needs
- Be time capped
- Support (allow) movement of doctors into and out of training and between programmes

The last principle does not fully apply to Foundation Programmes, in that movement between programmes is not an issue (except geographically for which provision is made).

4. Foundation Programmes

Significant and relevant successes of Foundation programmes include:

- Sign-off with Foundation competences as a doctor fit to work in the NHS
- A professional development programme focussing on generic skills such as team-working, communication, patient safety and teaching skills
- Structured programmes with dedicated Programme Directors, clear curriculum and competency-based assessments (these are still in development, and are not yet adequately performance-based so it is possible to pass assessments and still have serious clinical deficiencies—hence the need still to take account of the opinion of experienced supervisors!)
- UK-wide standards
- Time-limited, with much improved career guidance specifically funded for Foundation trainees
- Programmes are varied and most Schools offer F2 choices to meet trainees' aspirations
- Training is seamless and graded through GMC registration into F2, where clinical skills are applied in more varied settings
- Educational management is strong, through Programme Directors, Supervisors trained in the Foundation assessments, and portfolio-based
- Academic programmes with training in research skills
- Progressive increase in clinical responsibility as competences are acquired
- Trainee-centred with programme variety to meet different career choices
- Open to overseas doctors with appropriate skills and requirements at both F1 and F2 levels

Foundation programmes are generally considered to be a major improvement, especially for the emphasis on generic skills and formal assessment and sign-off of competences. From the Deanery point of view, the success is due mainly to the fact that Foundation programmes were properly funded to provide the leadership, management and administrative functions of the Schools together with paid Directors and career advisors.

Foundation recruitment, through MTAS in 2007, is generally held to have been successful. In fact, the success is almost entirely due to the fact that there were more jobs than applicants, so that most people were happy. There are intrinsic problems in the process which will be a source of embarrassment for the DH if the scheme attracts large numbers of EEA applicants. The UK insists on a fair, open and transparent process

with no discrimination against eligible EEA applicants. It is extremely difficult to discriminate between newly-qualified UK medical graduates, and even more so when they come from a variety of European Schools about which we may know very little. We have to guarantee UK graduates an F1 placement to register their degrees, but the system could well produce large numbers of UK graduates with no Foundation placement. This is a potential embarrassment for the Government which is waiting to happen.

5. Practical Implementation of MMC and the Underlying Principles

It is fair to say that plans for MMC implementation have allowed some "principles" to dominate the agenda, at the cost sometimes of compromising other principles. The most contentious is perhaps

> "training should as far as possible be seamless and conducted within a grading structure which supports this process"

Pursuit of this led to the concept of "run through" training, which in turn came to be interpreted as meaning that doctors should be recruited from F2 posts into the specialty of their choice, and that they should progress seamlessly to a CCT in 6-8 years as long as their competencies were achieved. This "ideal"", if that is what it was, flew in the face of accepted and long-hallowed UK practice, whereby trainees in such specialties as Medicine and Surgery spent several years sampling different specialties, passing exams and acquiring skills before attempting the major hurdle of specialty entry (at the equivalent of ST3).

It is probably true that UK medical trainees have not historically focused on career choices until well-embarked into the SHO grade, whereas in North America most students in Medical School have quite developed career plans. This type of change in attitude to career planning will take time to achieve.

More contentious was the idea (also deriving from slavish application of run through) that progression from core medical or surgical training into a specialty could not be based on any sort of competitive process. Apart from the major deviation from custom and practice, this ignores the difficult reality of how selection could take place into highly popular specialties such as Cardiology or General Surgery.

Another casualty of the pursuit of run through was also an MMC principle—that of career flexibility and transferable competences. No real work was done to see how specialties could achieve this, so to all appearances a change of specialty appeared to be a process of "snakes and ladders", whereby a change would involve competing again for a place at the ST1 level in the new specialty.

One unexpected potential benefit to the Service from application of run through principles was the fact that the numbers of training posts at ST1 and 2 level had to match the available numbers of specialty training posts at ST3 and beyond. This highlighted the fact that in major acute specialties such as Medicine and Surgery there were 2 or 3 times more SHO posts than there were available ST1 and 2 slots. This was especially true in Northern Deaneries, which historically are deprived of trainees at ST3 and above (if there are more ST3 trainees, more SHOs can be converted to ST1 and 2, London Deanery for instance, has 35% of English higher trainees for only 10% of population). What this adds up to is that the Service is running on the basis of large numbers of junior trainees who have almost no chance of progression into the specialty of choice. These posts have now mostly been converted into FTSTA posts, and these will progressively come to be seen as having no real worth apart from facilitating a change of specialty. If talk of "uncoupling" core and higher training is implemented, it will be a pity if FTSTAs are once more merged with the ST posts because effectively trainees will be deluded into pursuing specialties with little chance of success. What the service needs to do is to examine how service could be delivered without relying on "training" posts—either by re-design, or by employing doctors in service grades.

6. Strengths and Weaknesses of MTAS

It is difficult at times to disentangle problems due to the MTAS process from those associated with the introduction of MMC, especially the contentious aspects of run through, which alienated many trainees and Colleges.

MTAS embodied massive changes in the selection of trainees, apart from the electronic platform which had to be developed. Many of the changes were in the direction of increased transparency, fairness and objectivity, and were not universally welcomed by Consultants who were used to systems which allowed them to identify and appoint "their" trainees. So blinding the short listing process to a candidate's sex, age, name and race, as well as their employment history, led to much (ill-founded) dissatisfaction with the process among consultants.

Such major changes should only have been introduced with testing and piloting of new methods, together with a coordinated communication and education process to inform trainers and trainees (and Trusts, Colleges and Deaneries).

The DH did not allocate resources to develop recruitment processes and fund pilots at an appropriate time. This should have started as plans for foundation Programmes were being drawn up in 2003. Unfortunately, MTAS coincided in 2006 with the discovery of a £600 million "black hole" in the DH budget. There was no money available for any developmental work, and Deaneries were threatened with a 10–15% budget cut (which would have forced redundancy onto trainees).

There was an urgency to implement recruitment in 2007 because the first trainees were emerging from Foundation Programmes and the SHO grade was disappearing. Large-scale recruitment to ST1 and 2 was required and probably justified a national online process. ST3 recruitment had always been conducted locally by Deaneries and need not have been included. Its inclusion caused much resentment from specialties, especially because the generic, white space application (which might have been suitable for ST1) did not allow vital information for specialty selection to be available. Inclusion of ST3 was a fatal mistake of the Strategy Group.

The inadequate and delayed resourcing of MTAS (coupled with some inertia by specialties in providing specialty-specific details—but they were not engaged with the process) meant that the time scale to prepare electronic application forms was severely compressed. "Methods" were eventually working only a few days ahead of the requirement for Deaneries to access the system. Vital days were lost in February by late decisions in the London/KSS Deaneries about the way they defined their GP programmes. The loss of several crucial days at this time led to problems for many specialties and Deaneries because shortlisting of many hundreds of applicants had to be paper-based rather than online as intended.

The shortlisting burden on Consultant trainers was enormous. It would and should have been eased by piloting the use of other objective methods to sift candidates (as had been done for GP recruitment).

The Strategy Group did not seem to have fully explored the impact of the combination of the number of choices allowed to applicants and the capacity of Deaneries to conduct interviews. Deaneries could only interview in a ratio of about 2:1 compared to their number of vacancies.

Candidates were allowed 4 choices. The result was that "good" applicants were offered 3 or 4 interviews; slightly less "good" applicants were offered none. This was inevitable and predictable, but led to dreadful disappointment amongst applicants and their Consultant trainers, which spread thereafter through most of the medical establishment.

The other predictable result of the way this was done was that specialties were interviewing many candidates who had little interest in working in a particular locality. There was therefore going to be a low "fill rate" in Round 1 and many vacancies in Round 2. This was not well communicated to applicants who had no interview and who felt that their careers were effectively being terminated.

The outcry from the above situation effectively led on to the formation of the Review Group, abandonment of MTAS, and prolongation of Round 1 and the ensuing near catastrophe for Deaneries, Trusts and Service.

7. Lessons from MTAS

- That major structural change (such as the MTAS recruitment process) should be properly resourced, piloted and not rushed.
- That with a major task and limited resources, a project should focus on changes which have to be made (ie recruitment above ST2 did not have to change).
- That lack of continuing protest (from Colleges, BMA, juniors) does not signify assent.
- That the views of stakeholders should be actively canvassed and respected.
- That good communication is fundamental to success. Colleges, Deaneries, the service, trainers and especially the trainees were kept in ignorance of the detail and context of what was going on.
- That an electronic portal should be used to support a process, but that the IT should not dominate such that applicants thought they were being machine processed to be churned out after a variable time with or without a job and with no human intervention.
- That structured competence-based interviews using trained interviewers represented a major improvement in terms of the transparency, fairness and robustness of the interview process. Its introduction attracted spontaneous expressions of approval from both trainers and trainees.

8. MMC and the Supply and Demand of Junior Doctors and the Number of IMGs Eligible For Training in the UK

The UK has a history of utilising the professional workforce from developing nations when its policies result in deficiencies of trained staff. In 2003 and 2004, thousands of doctors were recruited (mainly from the Indian subcontinent) to populate on-call rotas to meet the 58 hours per week demanded by the European Working Time Directive in 2004.

Many of these doctors are now in the pool (12,000?) of medical HSMPs.

The medical manpower shortage was at lower and middle grades, but bore no relation to the requirement for specialists in any given specialty.

The HSMP doctors now wish to progress up a training pathway, but there is not enough training capacity or workforce need to accommodate them. If they are successful in getting training posts there is a real danger that numbers of UK graduates may be displaced.

The only manageable solution might be to exclude HSMP applicants until all appointable UK doctors are placed. The ethics of this are open to debate.

9. Will MMC Increase the Flexibility of the Medical Workforce?

The evidence so far is that MMC has done little or nothing to increase the flexibility of the medical workforce. In fact the imposition of run through training, without attempts to identify shared competences to allow trainees to ladder across to a different specialty seems to have increased the rigidity of the system.

In addition, PMEB may have contributed to this by insisting on a clear single curriculum for entry to CCT in every specialty. This has tended to prevent entry by trainees to higher levels of different specialty programmes. In fact, if a trainee were to access a programme with competences acquired outside that programme PMETB would be likely to tell them to apply for the "Certificate exempt" route to the Specialist Register which may be more expensive and perhaps less prestigious in the eyes of contemporaries (and may not be recognised in other EEA countries).

10. Roles of the DH/SHAs/Deaneries/Colleges/PMETB

DH did not resource adequately or early enough.

10.1 SHAs were preoccupied with the £600 million shortfall and were harassing Deaneries to make financial cuts when they actually had a need for additional resource to implement a daunting change agenda.

10.2 Deaneries debated the actual implementation of MTAS but did not appreciate the implications of the recruitment process adopted until too late. The Strategy Group did assume responsibility for key decisions and perhaps other agencies felt that the Strategy Group could be trusted to take forward implementation. The governance of the process was somewhat unclear but seemed to rest with the Strategy Group and DH.

Deaneries had a challenging task in implementing the process and at the same time engaging with and supporting Consultant staff and trainees. Hundreds of trainers had to be trained in competency based interviewing. The burden of shortlisting became almost overwhelming when IT support failed. Trainers had then to reconvene interview panels at short notice to complete Round 1b at the same time as realising that all the effort of shortlisting had been wasted because all first preference applicants were to be interviewed.

Royal Colleges were signed up in theory to the broad plan of MTAS. They were not fully engaged with aspects of MMC, in particular the concept of run through applied to Medical and Surgical Specialties. There was delay in producing specialty-specific criteria to feed into selection.

PMETB seemed to contribute to the rigidity of training by demanding a single curriculum from entry to CCT. This tacitly seems to imply a run through system.

It took a harsh line by insisting that any trainee who had acquired competence by working abroad (eg in Australia) had worked out of programme without prospective approval and was therefore not eligible for CCT. They were told to apply for the certificate-exempt route. Many UK doctors were trapped by this retrospective imposition of regulations when they had simply followed a well-established route to acquire foreign experience which had been recognised by the Royal Colleges.

Professor W A Burr
Postgraduate Dean (Yorkshire)

September 2007

Memorandum by the English Postgraduate Deans Group (MMC 17)

1. Executive Summary

1.1 The following represents the written evidence produced by the English Postgraduate Deans group. The views presented reflect the majority view point of the English Deans but it is important to emphasise that it is almost impossible to achieve a unanimous viewpoint with particular regard to the details of some of the implementation of the MMC reforms, and the selection and recruitment arrangements for specialty training. This reflects the differences between particular geographic areas in England which are often as great, if not greater, as those between England and the 3 other national administrations in the UK. With these points in mind I have been asked to state that the following submitted evidence to the Select Committee excludes the views of the London Deanery which has contributed to the London NHS submission.

1.2 The English Deans ask for the Select Committee's understanding with respect to the length of the evidence provided. The PG Deans are responsible for both organising the local implementation of the MMC reforms and their quality management—they are, therefore, the one group whose predominant roles and responsibilities relate directly to the inquiry topics.

The following summarises the key points:

1.3 *MMC principles*

The English Deans have supported the development of the MMC principles and believe they have a sound educational basis. In addition they build on the experience arising from the implementation of the Calman reforms and the introduction of the Specialist Registrar Grade.

1.4 The MMC reforms were a response to well recognised deficiencies in the early stages of specialist training—the SHO grade posts/programmes.

1.5 A major deficiency in the MMC principles is a formal (and funded) commitment to evaluation of both the process and outcome of the educational reforms. Work has been done to evaluate elements of, for example, the Foundation Programme assessment framework. However, this evaluation is not part of a co-ordinated and comprehensive evaluation. The English Deans feel this should be an integral element of such a radical reform programme.

1.6 *Practical implementation of MMC*

The initial phase of MMC implementation created the Foundation Programmes. These sought to establish a solid foundation of clinical experience in employment whilst conforming to the MMC competency principle by describing an explicit assessment framework for the 2 year programme together with an underpinning, detailed curriculum framework with a clear educational outcome. It was clearly linked to developing a trained workforce who was able to deal the initial management of acutely ill patients in a variety of settings.

1.7 The Foundation programmes have just completed there first full 2 years and are judged by senior clinicians and the Deans to have been an overall success. Part of this success has been achieved by virtue of the additional funding identified to support the implementation of the Programmes including the establishment of the Foundation Schools. The Schools comprise a dedicated and identified workforce with explicit responsibilities for delivering education and overseeing educational, clinical and professional progression amongst the Foundation trainees.

1.8 There are, however, some possible problems with curriculum delivery which may require revision of the curriculum and methods of curricula delivery in due course. A funded approach to comprehensive evaluation would probably have confirmed which problems was the result of the first phase of implementation ie bedding down issues, and those that represented more fundamental deficiencies in the curriculum framework and/or mode of educational delivery. Nonetheless the English Deans are fully committed to this element of MMC and can see no convincing argument for its wholesale revision at this time.

1.9 Career management has worked reasonably well and is firmly embedded in the Foundation Programmes. However, there remain concerns about the extent to which medical undergraduates are prepared for their future career options at medical school.

1.10 The English Deans have supported the plans for implementing specialty training and feel that the current proposed arrangements are a pragmatic response to a very large reform agenda implemented to a very constrained timetable. As a result some of the underlying MMC principles may not have been as effectively embedded as we would have liked. In particular there has to a question mark as to the current level of flexibility within the specialty training arrangements. In general, however, much has been achieved in a remarkably short time frame and the curricula and assessment frameworks have the potential to deliver a well assessed and competent specialty trained medical workforce.

1.11 The English Deans remain concerned that the specialty training element of MMC implementation is not appropriately funded. This is particularly the case with respect to the early years of training (ST1, 2 and 3), the Postgraduate Schools development and the development of IT systems to help deliver and monitor education and learning eg e portfolios, e learning packages and educational management systems. In addition the Postgraduate Medical Education and Training Board standards require an expanded quality management role for Deaneries which has also yet to be recognised in central allocations to SHAs.

1.12 *MTAS process—strengths and weaknesses*

The electronic platform and wider functionality of the MTAS system has worked well for entry to Foundation Programme training. This element of the system has been subject to year on year refinement which has gradually improved functionality. The English Deans support the continued use of MTAS (but under a different name) for Foundation Programme recruitment.

1.13 The deficiencies and problems associated with the use of MTAS for entry to specialty training are well known. The English Deans view the problem to have been predominantly due to failing to scope and commission the process properly. Original plans were far more conservative in their scope but grew rapidly without regard to the possible consequences, and without time to test the consequences. There is no doubting the commitment of those involved in establishing and operating the MTAS platform but without a comprehensive and fully worked up initial commission it is not surprising that problems occurred.

1.14 The English Deans are concerned that the whole of the MTAS process should not be dismissed in its entirety, despite the deficiencies. There has been much publicity over those elements that are perceived to have been unsatisfactory but far less attention paid to those Deaneries and specialties that experienced few problems and where the outcome in terms of the quality of appointees has been excellent. Some Deaneries did have difficulties with long listing and short listing but the majority had relatively few. The interview phase worked well in the vast majority of cases and the 3 station structured interview was broadly welcomed by interviewers and applicants alike. It is important to recognise that deaneries and specialties with lower rates of application experienced far fewer problems than those with high application rates.

1.15 It is also important to highlight the commitment of Deanery, Trust staff and consultants during the MTAS process. Staff were under huge pressures but managed to keep the process running and ensured most posts were filled by the August start date, and most trainees placed in posts/programmes.

1.16 The use of IT systems will inevitably underpin future selection and recruitment processes and the English Deans hope that this recent experience can be used to scope and commission IT projects better in future.

1.17 For 2008 the English Deans would like to draw attention to the relative success of the Round 2 interview process with respect to possible arrangements for 2008.

1.18 *Project management*

The English Deans believe the key lesson is to ensure that any future project has clear lines of governance and accountability whilst ensuring that individuals can make decisions in a timely fashion. Similarly the scope of projects and their desired outcomes should be defined properly at the start and not adjusted unless there are very persuasive arguments to do so. Where changes have to be made there must be sufficient time to evaluate the wider implications of the proposed change and ensure its effective and successful implementation.

1.19 *Workforce planning considerations*

The PG Deans have worked closely with the Workforce Review Team and specialties, over a number of years, to ensure that medical workforce plans for specialty training are matched as closely as possible to predicted demand within the service. It is not a precise science and demand modelling 5 or 10 years in advance is notoriously difficult within the NHS, but this level of forward planning is needed when addressing specialty training in medicine.

1.20 There have been 2 issues that have affected these plans. Firstly the introduction of the so called "Hutton"" or Working Time Directive additional NTNS which reflected a need to achieve compliance with the 2004 Working Time Directive and secondly the substantial expansion in medical students in the 1990's without a comparable increase in specialty training opportunities.

1.21 The consequences are that the additional NTNs were not implemented in line with future demand models for the production of trained specialists and the medical graduation issue means that some medical graduates face an uncertain future in specialty training after Foundation programme training.

1.22 In terms of MMC too little attention was paid to the effect of streamlining specialty training at a time when the number of medical graduates was increasing and the population of international medical graduates eligible for training in the UK had reached a high level. The impact has been a significant number of displaced specialty medical trainees who have already completed one or more years of specialty training. The prospective figures for the 2008 recruitment round suggests this situation may well deteriorate for next year.

1.23 Lastly the distribution of specialty training posts doesn't accurately reflect service demand with respect to the FTSTA grade posts and this needs review. Similarly the distribution and funding of specialty training programmes doesn't reflect geographic demand modelling.

1.24 *Roles of organisations in MMC implementation*

Colleges and Faculty representatives have worked with PG Deans to develop the Foundation Programme curriculum and linked assessments, and these have just been revised in the light of the first year's experience. This work has been approved by the GMC and PMETB.

1.25 Colleges and Faculties, with the support of Lead Deans for specialties, have developed comprehensive, new specialty training curricula and assessment frameworks in a very short time frame. These have been, or are just about to be, approved by PMETB. The scale of this exercise should not be underestimated.

1.26 At the same time Deans have established new Foundation Programmes and managed the implementation of the assessment framework within the structure of new Foundation Schools. A similar body of work has been undertaken to implement specialty training. There is, however, much still to be done in establishing Postgraduate Schools and the wider infra-structure for the full delivery and quality management of specialty training. Nonetheless the new Postgraduate Schools will ensure a close co-operation of deaneries, Colleges and Trusts in the delivery and oversight of postgraduate medical education.

1.27 During this time many Deaneries have been through one or more significant reorganisations as the SHAs were established, WDCs merged with SHAs and SHAs themselves reorganised.

1.28 The new SHAs are demonstrating a far greater engagement with the medical education agenda than their predecessor organisations and the DH has been increasingly involved over the past 6 months or so. The appointment of a Senior Responsible Officer and Chief Operating Officer and a dedicated team has emphasised a significant change in approach.

1.29 The MMC team nationally has contributed significantly to the establishment of Foundation Programme training and were instrumental in developing the Gold Guide which underpins the management of specialty training amongst other initiatives.

2. Introduction

2.1 Whilst there had been significant incremental reforms with respect to the pre- GMC registration, higher specialist and GP vocational training elements of postgraduate medical education over the past 20 years or so, there was an urgent need to review and reform, fundamentally, the overall arrangements for postgraduate medical education.

2.2 The Calman reforms, with the establishment of the Specialist Registrar (SpRs) grade, were an excellent start but more needed to be done with respect to the junior grade of medical trainee (those in SHO posts) and the workforce linkages to higher specialist training (SpRs). The concerns and related proposals highlighted in Unfinished Business were a fair summary of the key outstanding issues facing postgraduate medical education and were supported by all the PG Deans in the UK. The consultation phase established broad support, across the medical profession and service, for the proposals and led to the publication of Modernising Medical Careers (MMC).

2.3 Any such reform needed to take clear account of the requirement to provide safe and improving patient care whilst addressing the wider needs of a developing health service, as well as the individual career aspirations of doctors in training. Thus the overall MMC plan to ensure that the outcome of any medical training process was a high quality, well trained and accredited doctor/medical workforce was fully supported by the English Deans. The key principles outlined in Unfinished Business were also supported by the English Deans ie that medical training:

- Be programmed based
- Be broadly based to begin with for all trainees
- Provide individually tailored programmes to meet specific needs
- Be time capped
- Support (allow) movement of doctors into and out of training and between programmes

2.4 The refinement of these principles within the final MMC recommendations continued to have the full support of the English Deans (see appendix A). The English Deans believe they are based on sound educational principles.

2.5 Within COPMeD (the Conference of postgraduate medical deans—UK) there was universal support for a consistent UK wide approach to the high level organisation, administration and delivery of postgraduate medical education whilst respecting the differing needs of the devolved administrations and the populations they served.

2.6 In particular the PG Deans were anxious to see an appropriately trained medical workforce providing the majority of services for patients, with far less reliance by the NHS, on service delivery by those still in medical training. This is as much a patient safety and clinical governance issue as an educational one.

2.7 The following outlines the main MMC areas and provides extra evidence to support the executive summary.

3. Foundation Programme

3.1 In general this MMC linked reform has worked well and has adhered to the key MMC principles. It has an explicit curriculum with a well developed, though incomplete, assessment framework. It has been generally welcomed by senior clinicians and trainees alike and has been successful in trying to ensure a common end point to this training period linked to the provision of safer patient care. The first full 2 year cycle of posts, in the Programme, has generally been deemed a success.

3.2 The variation in content (that is the specialty placements) within Foundation Programmes (FP), whilst encouraged in the original proposals, is causing some difficulties with respect to comprehensive curricula delivery.

3.3 In particular many would view GP experience as essential. The trainees value it and it consistently receives amongst the most positive trainee feedback in terms of learning and the quality of educational feedback from trainers. The original MMC plans were for approximately 80% of FP trainees to have GP experience. This was subsequently downgraded, on financial grounds, to 55% despite the manifest educational arguments for the higher figure. Others would argue for guaranteed experience in paediatrics and psychiatry amongst other specialties. This would ensure a full exposure to the broad spectrum and context of acute illness which underpins the curriculum for FP training. Consideration may need to be given to a careful review in this area in due course. Currently there are no formal plans to evaluate the outcomes of FP training—the English Deans are disappointed that this evaluation was not built into the reform implementation process.

3.4 Although a number of deaneries have taken a firm line on ensuring fitness for purpose of assessors it is less clear as to the extent that this is uniform across the country. Recent QAFP (GMC and PMETB) visits would indicate a less than systematic approach.

3.5 Foundation Programme core formal training (half day a week) is generally of an acceptable standard and improving but attendance is still often, unacceptably, limited by service demands on the trainees. There needs to be more thought as to how access to essential formal training is delivered or service requirements adjusted—no other profession would be allowed to miss an integral element of their core training. E learning may assist but it cannot be viewed as a substitute for face to face peer group, facilitated learning.

3.6 There is still work needed with the Foundation Programme Directors (based in Trusts). They increasingly need additional education and teaching skills, together with a capacity to lead the local faculty of educators and assessors. There are some local examples of excellence using small group resolution of issues which encourages the key skills of professional self awareness and reflection.

3.7 Foundation Programme linked assessment methods (eg DOPS, mini-CEX, multi-source feedback) have worked well but the current methods do not blue print fully to the curriculum framework. Further work is needed in this area but will require funding to develop, pilot and evaluate additional assessment tools and approaches. Work also needs to be undertaken to ensure common application and outcomes of the assessment methods so that the NHS, and patients, can have confidence that doctors assessed in different parts of the UK are achieving the same standards.

3.8 Careers management has, in general, worked well but is largely dependant on enthusiasts who develop an explicit local project plan and ensure delivery across a Deanery. Work is still needed to develop 'career' tasters and further consideration as to how this fits with the wider clinical curricular demands of Foundation Programme training. In addition more work is needed at medical school to prepare medical students for the relatively narrow window of career choice, in particular introducing an air of reality over career options ie 20% plus of medical students want to be surgeons but less than 6% can be. The NHS needs more psychiatrists, paediatricians, obstetricians, diagnostic specialists and GPs in workforce terms. Medical students must be prepared to make adjustments to their career aspiration in light of the wider needs of the NHS. However, they need more focussed feedback on their aptitudes and performance, and more information on he workforce opportunities open to them.

3.9 Selection into Foundation Programme training has worked well, including in 2006 for 2007 entry, whilst utilising the MTAS platform. The impetus over the past few years must not be lost as a result of concerns over the difficulties with the recent specialty training linked MTAS process.

3.10 The additional funding made available to support FP training has been key in ensuring the successful development and delivery of this MMC reform. In particular the monies for Foundation School Directors, School Managers and FP Directors in Trusts have been critical in ensuring the current success of FP training. This should be seen against the current paucity of additional funding to support the remainder of the MMC reforms.

3.11 Careful consideration needs to given to the longer term desirability of separating responsibility for F1 (GMC) and F2 (PMETB). The present situation perpetuates an unhelpful separation of responsibilities.

4. Specialty Training—(Including GP)

4.1 Specialty training needs to be different, from that which preceded it, as a result of the implementation of the MMC reforms. However, it needs to build on prior experience of postgraduate medical education and to take account of the shorter working week due to the Working Time Directive provisions, the changing NHS and the need to demonstrate that all specialty curricular competences are met. ie breadth as well as depth of understanding and meeting the wider demands of professional and clinical practice.

4.2 One of the key principles underpinning the MMC reforms is the need to ensure that patients receive increasing elements of their care from doctors whose competences and competency is assessed and confirmed. This should ensure a safer clinical environment and provide confidence to both employers and patients.

4.3 There has to be greater clarity over what represents failure and how such failure to progress should be managed. This must include recognition that the acquisition of competences alone does not confirm the level of professional and clinical performance associated with entry to the specialist or general register.

4.4 With these points in mind some trainees need an alternative career structure within Medicine to that offered by the route to CCT or CESR/CEGPR and entry to the specialist or generalist register. The Staff and Associate specialist (SAS) grade offers a potential alternative route but the present impasse over the SAS contract is having a very negative effect on junior doctor's perception of this grade. Choice and Opportunity offered a mechanism to explore the educational infra-structure to support this grade but this remains largely unexplored. Some funding was made available in the 2007–08 MPET levy distributions to SHAs but it is unclear that this funding is recurrent, and without this it is difficult to establish business plans which will ensure continuing developments in this area. Further work in this area offers the opportunity to develop a more flexible medical workforce, and one that more closely meets the needs of the service. A system of intermediate credentialing of training and competency needs to be considered.

4.5 The Colleges have achieved an extra-ordinary task by creating new curricula and assessment structures and methods in a very short time frame. However, these curricula will need evaluation and possibly revision in the light of practical experience of delivering and reviewing the outcomes of the new curricula. The English Deans are concerned that this important work is not the subject of an agreed project plan and an identified resource package.

4.6 Where a small number of Colleges/Faculties were late with the curricula it has posed a problem and there are considerable challenges still to be faced over implementing the work place based assessments. This is a particular issue for the early years of specialty training since Deaneries and senior clinician educational supervisors did not intensively manage this group of trainees pre MMC, indeed that was one of the issues MMC was intended to address (x ıreference : resource issues).

4.7 Deaneries are experiencing some difficulties at present because not all Colleges/Faculties are fully and reliably engaged with deaneries about the use of educational portfolios and the wider delivery of the specialty curricula.

4.8 Deaneries began to fall behind schedule in ensuring that consultants are fit for purpose to deliver the curricula and linked assessment methods during the delays and complications created by the MTAS process ıbut this is not so in all specialties. General Practice training, for example, is not anticipating any problems. Deaneries have in place plans to ensure they catch up with the backlog and are making considerable progress.

4.9 The *Guide to Postgraduate Specialty Training in the UK* (the so-called Gold Guide) published in June 2007 sets out the arrangements for the introduction and management of competence based specialty training in the UK. Whilst it primarily deals with operational issues to support the transition from specialist training (which has been in place since 1996) to specialty training it is nonetheless a critical element in implementing the MMC reforms. It makes clear to all those involved or interested in specialty training what will happen at an operational level, is an excellent practical guide and is a good example of co-operation between the Postgraduate Deans, Colleges and Faculties and the four national health departments.

4.10 There is an urgent need for a national resolution to the ST2 to ST3 closed competition issue, for those specialties commencing with core training (mainly the physicianly and surgical specialties). Importantly this should not include a loss of core training, as this continues to have much to commend it. Indeed it could be argued it is only by widening the availability of such programmes that the MMC commitment to broad based initial specialty training would be delivered.

4.11 The arrangements for closed competition must take account of both specialty interests and those of the trainees. Most specialties favour national competition but trainees will differ in their preferences for specialty over geography or vice versa. Trainees may have entirely legitimate reasons for remaining in a particular geography. In addition to go for complete national competition will almost certainly result in the weakest candidates going into the less glamorous specialties and does not allow or encourage themed entry at ST1. Such themed approaches can achieve a level of specialty focus whilst preserving the broad based aspects of core training models. There are a number of possible solutions to this problem but these need to be agreed and implemented as soon as possible.

4.12 The Acute Care Common Stem Programme (ACCS) is a very good example of a an apparently flexible approach to the early years of specialty training but its early promise has been hampered by problems with the training programme approval by PMETB. Consequently much of the flexibility has been lost.

4.13 One of the original aims of MMC was to have considerable flexibility for trainees to change or move between specialties. Whilst run through training streamlines specialty training it does introduce an element of inflexibility that the original MMC proposals did not intend. It is now clear that a considerable proportion of doctors in the early phases of postgraduate training do not know which specialty they would like to train in. Colleges have done some work on transfer of competences between specialty programmes but the actual practicalities of moving between specialties have not been resolved. If this is to become a reality more work needs to be done and consideration given to expanding the range of available core or common stem training programmes. It will also need adjustments to the operational elements of MMC delivery; this will require the Gold Guide to be revised. This does not, however, undermine run through training for many specialties where it will ensure an effective and efficient progression to the specialist register.

4.14 There are other problems with implementing flexibilities. For example there is still great misunderstanding amongst a number of Colleges about the needs of GP training and an assumption of smooth transition from, for example, core medical training to GP if an individual is not making progress in their first specialty. Experience over many years suggests that transition from an established hospital specialty to GP is often problematic and requires careful trainer support and a considerable engagement on the part of the trainee. Much of this relates to the context and nature of practice. This may also be true of movements between specialties. Clinical and professional performance is far more than just the acquisition of competences.

4.15 Some of the challenges arising from MMC implementation which have yet to be resolved are:

(i) Evaluation and calibration of the outcomes of assessment ie how do we know that a trainee who passes an assessment in Glasgow is achieving a comparable standard to one in Exeter. This is a process of assessment quality control, and needs funding to implement.

(ii) Educational supervisors and those with other training roles will need to be selected after specific preparation. Reselection will need to be determined by their performance as educators/assessors. Whilst this is a confirmed and well established process in GP, it is not in hospital specialties.

(iii) Similarly a question needs to be asked as to whether selection to an educational role should be, in part, determined by confirmation of the individual doctor's standards of care.

(iv) A small number of medical graduates will not be able to progress in postgraduate medical training. There needs to be an agreed mechanism for dealing with this situation which avoids, as far as possible, the potential for legal challenge. Currently removing these doctors from training is difficult and hugely time consuming.

4.16 In workforce planning terms the English Deans are concerned that the investment in specialty and GP training is not currently planned to keep pace with the expected number of medical graduates resulting from the expansion in medical student numbers in the 1990s. This will become more urgent as we approach 2010–11 when the medical graduation numbers reach their peak.

5. Governance Arrangements

5.1 The overall governance arrangements for both MMC and MTAS were unsatisfactory and have contributed significantly to the problems the English Deans, and others, have identified.

5.2 There were many groups (some would say too many) involved, and in the absence of an explicit governance structure it was difficult to determine who could or should make key decisions. Consequently decisions were not always made, and/or followed through or reached in a timely fashion.

5.3 There are a number of examples of decisions being made without reference to the wider implications or with appropriate engagement with stakeholders. Most of the technical problems with MTAS relate to last minute tinkering and changes to the specification. The English Deans would suggest that this contributed significantly to the later difficulties. Changes had to be made at very short notice with insufficient time to check whether they individually worked as intended or had unpredicted effects elsewhere in the system.

5.4 Further there was an absolute lack of clarity over the scope of the entire MMC implementation project—whilst much has been achieved this has not been due to the excellence of the overall project implementation documentation and plan but rather the determination of individuals and groups of individuals. Claims are made about a well defined MMC project plan but the English Deans would argue that it was not fully comprehensive particularly from an educational perspective; it was under resourced (see resource issues) and was not established through a process of full engagement with the key stakeholders.

5.5 An additional problem has been the lack of clarity over what elements of MMC were UK wide, national (England, NI, Scotland and Wales) or more local ie at the level of SHAs or Health Boards. Further some issues seemed to require Ministerial sign off but others did not, and this created additional, often inappropriate delays and did not seem based on a logical analysis of the type of issue under consideration.

5.6 The recent changes implemented since the appointment of the senior responsible officer (Prof Martin Marshall) and the interim chief operating officer (Terry Hanafin) have all helped to provide clarity but much of the work to date, has, by necessity had to focus on the aftermath of MTAS 2007 and planning for selection and recruitment in 2008.

5.7 This leaves other important elements needing review but with no identified resource to undertake it. Examples include the longer term development of a sophisticated selection and recruitment process for specialty training which is viewed as fair and equitable by trainees and which has confirmed predictive validity. In addition there remains uncertainty about the role and authority of the national Programme Boards and the MMC UK Co-ordinating group. What happens, for example, if something is in the general best interests of the UK but one of the Programme Boards doesn't wish to comply? Who is the individual or group that reviews such a decision, and can such a review process be completed in a timely fashion?

5.8 One of the key pieces of outstanding work is that of evaluation of the impact of the MMC reforms (see section on FP training). This is not part of any explicit public project plan for MMC and seems to the English Deans to be a significant oversight. Without such evaluation it will not be possible to address deficiencies in implementation and overall outcomes in a planned, efficient and effective fashion.

5.9 Finally the PG Deans in England would ask for greater involvement in the next phase of MMC implementation. Currently, for example, they are represented by a single Dean on the English Programme Board and the extent to which they are involved in the wider development of strategy is limited. PG Deans and Deaneries are responsible for the implementation and quality management of the MMC reforms, and their involvement in planning is absolutely key to ensuring that what is planned in future is deliverable and ultimately successful in producing the desired training outcomes.

6. The MTAS Process

6.1 The Foundation Programme successfully used the MTAS electronic platform to manage the selection and recruitment process for the whole of Foundation Programme training across the UK for August 2007 entry.

6.2 The GP recruitment process also worked exceptionally well utilising a previously piloted and validated selection approach. This selection centre approach with short listing based on a machine mark able Clinical Problem Solving Test and a Situational Judgement Test has taken almost 7 years to develop and is a model that might be used more widely. However, there is little doubt that the GP recruitment phase would have worked more smoothly if they had been allowed to utilise the electronic application platform they had used in previous years.

6.3 Deanery experience, and the report of the Douglas review, highlighted that the interview stage of specialty selection and recruitment was the most successful element with general agreement that a minimum of a 3 station structured interview approach should be used in future, whatever else is changed. This viewpoint is supported by both consultant interviewer and applicant feedback.

6.4 There were considerable difficulties with long and short listing with some specialties in some Colleges, and in certain geographical areas. The surgical specialties seemed to throw up more problems than any other specialty area. Part of the problem related to the very high numbers of applicants; much higher than Deaneries had been led to expect.

6.5 This must, however, be balanced by the large number of selection episodes that passed off without problem and which led to the appointment of excellent specialty trainees.

6.6 MTAS itself did not prove fit for purpose but much of that can be attributed to 2 key factors. Firstly it was not adequately commissioned—the original specification was for far smaller numbers of trainees and initially limited to ST1 entry only. It was then subject to ever more complex and late modification, with no opportunity for pre-operational testing of the changes. Secondly the Deaneries, and probably most of the Colleges, expected a limit to be placed on IMG access to the programmes advertised—the failure to address this issue almost doubled the number of potential applicants which impaired the functionality of a system designed for smaller numbers and created far greater competition for places than had been planned for.

6.7 White space elements in application forms are an acceptable selection tool but not in volume, and not when a percentage of candidates were prepared to embellish their responses or commit acts of plagiarism for which there was no functioning soft ware (which was promised as part of the initial specification). Their continued role in ST1 selection is important.

6.8 In addition it is clear that by modifying the initial plans for ST1 entry to higher levels of entry (ST2, 3 and 4) insufficient note was taken (in short listing scoring) of prior experience and achievement in the person specification for the specialty for which the trainee was applying.

6.9 There need to be different methodologies for different specialties depending on what we are trying to assess and how popular the specialties are. There is no need to have highly sophisticated short-listing for a specialty which has less applicants than places, in such instances it might be more appropriate to interview them all but perhaps have a test of competence run nationally to select out those that cannot or should not be considered for training.

6.10 As indicated above processes for selection need to be different at different levels of seniority. For example the entry to ST1 has to be predominantly based on aptitude and this will almost certainly require a carefully planned selection centre approach once short listing has been conducted. Ranking candidates in highly competitive specialties is problematic, and a properly piloted and evaluated approach to a clinical problem solving and situational judgement test as a means of ranking should be piloted and evaluated.

6.11 Each College/Faculty, working with their Lead Dean, should now consider what worked well for their specialty and what needs improving/changing. Some Colleges eg the RCOG are already quite close to a centrally managed selection process which would limit the number of interviews and the involvement of consultant time in the selection process—they need resource to develop their models. It is important that the dissatisfaction with certain elements of the MTAS process doesn't result in the loss of those elements that did work well.

7. Communication and Stakeholder Engagement

7.1 It is probably this area where many of the more serious problems with MTAS, and to a lesser extent the wider implementation of MMC, developed. It is at least in part linked to the problems already identified with the governance arrangements.

7.2 Whilst stakeholders, eg Colleges, trainee groups, were involved throughout the MMC and MTAS design process it is clear that misunderstandings did occur. Applicants in particular did not fully understand the various stages of selection and in particular that there was intended to be a large second round. This suggests that far more attention needs to be taken of this area in future, with careful testing of the wider understanding of any proposed changes amongst key stakeholder groups.

8. Academic Training

8.1 The Walport proposals should begin to address the needs of the academic community, research and undergraduate training but more investment will probably be needed. It is also critical that the Walport iniative is not viewed as the totality of national investment in training for academic medicine. This may be particularly relevant with respect to developing medical education and training as an explicit career option as described in the original MMC proposals. There is currently a tendency to view the academic workforce as homogenous. Thus there is a belief espoused that an investment in a future generation of researchers will deliver a reliable supply of medical educators at an undergraduate level. This is almost certainly not the case as researchers will need to focus more and more on their research to retain research grants, in future. MMC proposed medical education as a possible additional "specialty" and the English Deans would strongly support this iniative.

8.2 Something similar may also be needed to encourage early thoughts and development with respect to medical management as a career. This may impact positively on the level of medical clinical engagement with health service development in the longer term.

9. Resource Issues

9.1 Modernising Medical Careers (MMC) represents a major reform of the delivery and quality assurance of postgraduate medical education. The newly approved specialty curricula include significant explicit requirements for formal work place assessments; both formative and summative. This is an inevitable consequence of the explicit move towards documented competence acquisition which forms an integral part of the reforms. Such a structured approach to assessment and documentation of assessment did not form part of the pre MMC medical education framework in most specialties. This means that MMC will create an added workload for clinical and educational supervisors and other consultants with extended educational roles. The introduction of these changes comes at a time when consultant's non-clinical activities are under ever greater scrutiny at Trust based job plan reviews. Consequently the resource model for MMC cannot be predicated on the loose set of arrangements, predominantly founded on the goodwill of individual clinicians and Trusts, upon which pre MMC medical education was based. Further the results of assessments will require collation and this will require more administrative time than is currently funded.

9.2 Colleges and Deaneries are seeking to establish electronic portfolios and linked electronic education management tools to support MMC implementation. These are key elements in a comprehensive educational governance and legally defensible approach to the MMC reforms. However, the implementation of these elements has not, in general, been funded and neither has the implied administrator support for oversight of the portfolios and the education management platform(s).

9.3 Historic postgraduate medical education arrangements seldom offered explicit governance arrangements for the work of the specialty Training Programme Directors (TPDs) who have been, and to a large extent remain, the key day to day managers of specialty training programmes. The absence of such governance arrangements is not sustainable post-MMC but requires a mechanism to link the TPDs to Deaneries and the new PG Schools—such a link will require a contractual relationship almost inevitably linked to some form of remuneration. Currently the funding of TPDs and other elements of the wider educational infra-structure for specialty training is inconsistent and patchy across Deaneries.

9.4 The changes in postgraduate medical education also need to be seen against the changes in the service. In particular the changes associated with the Working Time Directive have resulted in the establishment of rosters that severely limit trainee's attendance at formal education sessions. This places a premium on the development of e learning materials, but again these are largely un-resourced within the MADEL budget.

9.5 The following reflects the key points highlight some of the major issues that need to be considered if the implementation of MMC is to proceed satisfactorily.

(i) The introduction of Foundation Programme training was supported by the introduction of additional funding to support the administration and delivery of the new curriculum and assessment methods and to provide training placements in General Practice and a number of so called minor specialties.

(ii) The success of the Foundation Programme (FP) to date is, at least in part, due to the additional funding support and the education management posts it created.

(iii) The introduction of the new arrangements for specialty training is predicated upon especially close scrutiny of trainees' progression (educationally, clinically and professionally) during the first 2 or 3 years of specialty training (both ST and FTSTA). This is new work and was almost universally not previously funded or in place.

(iv) The new arrangements for the first 2-3 years of specialty training are comparable to the changes associated with the introduction of FP training, and, it could be argued, should be similarly funded.

(v) The establishment of PMETB and the approval of the new specialty curricula and associated assessment methods expand the quality management responsibilities of PG Deaneries. Such a change will inevitably increase the cost of overseeing the implementation of specialty training at a Deanery level.

(vi) The quality management arrangements in Deaneries are predicated on improved and documented quality control mechanisms within individual specialties. This work has never previously been funded at a local level, and probably never at a national level ıunless within the framework of Colleges "grant in aid" funding.

(vii) PG specialty schools offer an organisational and governance model to deliver and quality control specialty training at a programme level. The PG School model requires an administrative and educational infra-structure which will require funding and/or the recognition of key roles within existing consultant job plans in Trusts as part of a corporate investment in the commonwealth of education and training. To date no such arrangements are agreed and in place nationally.

(viii)The additional trainees in specialty training (approximately 1/3 rd more) should be reflected in an expansion in Deanery resources and staffing.

(ix) The new GP curriculum has been designed to meet the needs of patients and the planned development of primary care services within the NHS. The curriculum requires an extended period of experience and training in the environment of GP. This is currently not fully resourced, and failure to deliver this key educational opportunity creates a potential un-costed liability for extensions to training due to the trainees' inability to demonstrate the competences described in the new curriculum. Currently GP trainees undertake 12 months in a GP placement and 2 years in hospital posts, the new curriculum requires at least 18 months in GP but 6 months less in hospital. Such a change is not cost neutral due to the added costs associated with GP training placements.

10 SHAs and Deaneries

10.1 Deaneries are now part of the SHAs in England. This relationship has existed in some parts of England for a number of years but in others was only completed quite recently. A few Deaneries are co-terminus with SHA boundaries and in all other cases SHAs have more than one Deanery. SHAs are accountable for the delivery of the MMC reforms at a local level but normally devolve both strategic planning and operational delivery to Deaneries. The newly established SHAs are more closely involved in medical education than predecessor organizations.

10.2 Over the past few years some SHAs (prior to the recent reorganisation) have used elements of the Multi-professional Education and Training levy (MPET), including the Medical and Dental Education levy (MADEL) element, to balance local overspends in Trusts. This has contributed to some problems with effective investment in medical and non-medical education.

10.3 2007–08 has been a better year for MADEL investment in medical education but a few Deaneries are still experiencing difficulties. In a number of Deaneries very positive steps have been taken to ensure an ongoing investment in partnership between SHAs and their linked Deaneries with respect to investment for the implementation of MMC. Concerns exist as to the extent to which central budgetary allocations to SHAs will keep pace with the implementation of the changes necessary to support MMC implementation together with the wider aspects of multi-professional healthcare education and training.

10.4 During this time individual Deaneries have ensured a successful implementation of FP training and are beginning to develop the infra-structure to deliver the new elements of specialty training. In particular all are currently planning or in the process of instituting Postgraduate Schools which will help with educational delivery, oversight of educational progression amongst specialty trainees and local quality control of education.

10.5 At a national level PG Deans working in their Lead Dean capacity have supported Colleges and Faculties in their development of the new curricula and assessment methods, and continue to work on refinements.

Professor David Sowden
Chair English Deans

September 2007

APPENDIX A

Modernising Medical Careers: the response of the four UK Health Ministers to the consultation on unfinished business—proposals for reform of the senior house officer grade set out the following recommendations:

- the end product of the training process, whether a hospital doctor or a general practitioner, should be a high-quality, well-trained and accredited doctor who can deliver the care and treatment patients need in the modern NHS
- (postgraduate) medical training will take account of the training and development of other health service staff. It will prepare doctors to work in multi-profession settings and employ shared learning and cross-professional (inter-professional) training where necessary
- all postgraduate medical training should be organised in structured programmes (usually a series of co-ordinated placements) with progress monitored against clear curricula. In general, assessment should be competency-based and should be focused on outcomes with the ability to perform as the underpinning competence
- training should be applied to clear, consistent UK-wide standards
- programmes should be designed and managed to ensure that trainees complete them in the minimum necessary time. There should be explicit career pathways and explicit career goals
- individual programmes should be available to meet individual needs
- training should as far as possible be seamless and conducted within a grading structure which supports this process
- training must be supported by strong educational management and underpinned by skilled trainers
- a clear structure is necessary to encourage and support the development of academic, research and teaching skills and to support those who opt for an academic career
- programmes should be broadly-based at first and lead on to greater specialisation where appropriate
- the responsibilities given to doctors completing training should match their skills and competencies. Similarly, doctors in training should be able to take on progressively more responsibility as they are assessed as acquiring the competencies needed
- training should be trainee-centered and programmes should reflect a variety of career choices, from those who decide on a particular career early on to those who need more time to do so and to those who want to train part-time. Individual programmes should be available to reflect individual needs
- rigorous counselling and career advice should be available throughout training (now usually referred to as career management support)
- new training structures must allow trainees to change training programmes according to service need with the minimum duplication or retraining
- programmes should be designed to suit the needs of overseas doctors who may enter training at a number of different levels and in a number of different ways
- the development of new training structures, programmes and the delivery of training itself must be effectively quality assured.

These proposals were and are fully supported by the English Deans.

Memorandum by Mersey Deanery (MMC 18)

Mersey Deanery welcomes the opportunity to submit evidence to the Commons Health Select Committee inquiry into the Modernising Medical Careers Programme and its implementation through the Medical Training Application Service.

Executive Summary

Mersey Deanery recognises and is sympathetic to the anxiety and distress caused to junior doctors and their families over recent months. This understandably has had high profile in the press. However, we would specifically make the point that it is vital that evidence and facts are considered, and not opinion and anecdote.

The Mersey Deanery agrees with and supports the submission to the Commons Health Select Committee prepared by Professor David Sowden. In addition, the Mersey Deanery would make the following points:-

1. There was insufficient recognition of the effect of having four choices (high quality candidates having four interviews, lower quality candidates having few or no interviews). This was inevitable given the process that developed.
2. The application form and person specifications were not sufficiently specific to select appropriate candidates.
3. The Mersey Deanery adopted an assessment centre approach for all specialties and this was thought to be successful.
4. The interview stage included a variety of "stations", including a portfolio assessment station, many of which were developed in consultation with local specialty training and education committees.
5. The fill rate for Round 1 in Mersey was 97%. It is expected that it will be as high for Round 2.
6. The perception of Consultants on interview panels was that the candidates were of very high quality, indeed some of the strongest calibre doctors ever interviewed.
7. The perception was that were very few candidates included after round 1b, displacing round 1a candidates. This data is being currently being analysed.
8. The Deanery worked closely with Trusts/service and Lead Employers throughout the recruitment process.
9. The Service wishes to be assured that applicant references are available, together with medical clearances for new starters, prior to doctors commencing appointment.
10. The Deanery would wish to thank and commend all involved.

September 2007

Memorandum by The Medical Women's Federation (MMC 19)

MODERNISING MEDICAL CAREERS (MMC) & THE MEDICAL TRAINING APPLICATION SERVICE (MTAS)

The Medical Women's Federation is the largest organisation representing women doctors in the UK, and several of our senior members have national and regional roles in medical education and training. We welcome the opportunity to comment on the MTAS process, as it seemed to have a particularly negative effect on women doctors. The large geographical areas covered by regional ST rotations, and the uncertainty of placements within these regions seemed to be causing great difficulties for doctors with family commitments. Moreover, medical couples applying through MTAS to more than one region had to make decisions on the priority of one partner's career over the other; in our opinion this was a retrogressive step in which women doctor's careers were likely to suffer. We were saddened to see so many talented young doctors so deeply demoralised.

During the spring and summer of 2007, the Medical Women's Federation received much e-mail on this subject from young doctors in training and also from some mothers of junior doctors who are members of MWF. We also held a meeting at The Royal Society of Medicine on 7 July on the subject. Professor Tooke attended this meeting along with several people from the Department of Health including Professor Martin Marshall and members of RemedyUK. The points we raise below are mainly social, relate to the family situations that have resulted from this year's process and are derived from the e-mail and verbal comments given by the trainees themselves.

All our contacts have stressed how difficult it is for women doctors in training to cope with the relative rigidity of the centralised application system. There are many medical marriages within the current cohort of junior doctors and a large proportion of the young doctors involved would normally be thinking about starting a family or already have done so. As you know trainees were able to apply to several different deaneries and as a result some of those who were lucky enough to get posts via the centralised system found themselves being appointed to a different deanery from their spouse.

Many of them did not yet know at which Trust in the deanery their post was going to be until a few days before their start date, making it almost impossible to organise moving to the area. The result was that some of these young families ended up living several hundred miles apart, which will place a lot of strain on them during this coming year. This is very different from the previous system, where female doctors of our generation only applied for posts that were possible to manage in terms of commuting to work, arranging childcare and covering on-call responsibilities.

It would be an improvement if next year's MTAS process did not have restrictive rules about the number of specialties or deaneries that they can apply to, and they were allowed to just apply for posts they could manage geographically.

It was also very difficult for trainees this year to make decisions about posts because of the way MTAS was completed, so that job offers from different specialities were made to the trainees at different times. Some of them had to choose whether to accept their second choice of post before they had heard from their first choice, with little time given for them to accept or reject offers. Many of them have had to make momentous career decisions without much discussion with their spouse, whose own job situation may not have been clear at the time. Others have accepted posts in their last choice of speciality or region because they thought that they were lucky to have a job offer at all. Several said that they had made a decision to leave the country, do locum work until the situation improves or actually leave medicine altogether which is obviously a waste of their very expensive training. Reading their stories made me feel very sad and I enclose a few excerpts by way of illustration. I also collated those from the meeting at the RSM, and they are attached at Annex A.

If the centralised application process is going to continue, then job offers should be made to trainees right across the country at the same time so that trainees are all making their decisions concurrently which will help those in medical marriages work out what is best for them.

The officers of the Medical Women's Federation, some of who work in deaneries dealing directly with MTAS as well as being clinicians, were concerned about the secrecy that has surrounded the whole process. Many trainees told us that they were unable to get advice from the deaneries regarding the reasons their application had failed or any feedback at all. We do not think that there is any cogent reason for trainees not to be given their scores, as this would have helped them to make decisions about their choice of posts. In every other interview process we have been involved previously, feedback was an integral part of the process and was usually given immediately by a member of the panel so that the applicant could benefit in terms of future applications. Some provision for this should be built in to the new system.

The other issue relevant to women doctors is that not many trainees applied for flexible training in this round of MTAS. We are not yet in possession of the figures for England, but in Wales only 2% of trainees ticked the "flexible" box. Now that over 50% of trainees are women, this is a bit surprising. We suspect that they were all worried about doing anything that would prejudice their application, but it is obviously our remit to watch this situation in the future. This problem has been highlighted in the recently published annual report of the Chief Medical Officer, in a chapter entitled "Opportunity Blocks".

To summarise, although we are happy with a centralised system for application rather than a return to the old deanery-based system, some adjustments need to be made to ease the difficult decisions young doctors have to make about career versus family life.

We did not see a problem with the standard application form or the new form of interview process which seemed to be much more discriminatory than the interviews we used previously.

However we were upset to hear from so many of our trainees that as a result of the MTAS process they were considering giving up a career in medicine because it does not seem to be compatible with raising a family.

Miss Susan Ward DM, FRCS (Ed), FRCOG
MWF President 2007–08

October 2007

Annex A

Excerpts from e-mail sent to MWF by female trainees regarding MTAS experiences

I put General Surgery as my first choice in 2 deaneries. Got shortlisted to my first choice deanery for round 1A. I was 2 weeks post delivery when I went for my interview. I had a difficult labour and ended up with an emergency caesarean section. Had a difficult post operative recovery and had my interview 2 weeks post delivery. The interview I thought went OK. Everyone ended up being interviewed in my deanery in round 1B. I didn't get an interview in my second choice deanery although had an opportunity to go for interview in round 1B which I did not take as I did not feel like moving to a new deanery with a baby. Anyway my husband is well settled in his job (he is a civil servant) and is unable to move anyway as his job is so specialised.

Unfortunately I now have no job. Not even an FTSTA and I am very upset. I doubt there will be any jobs in round 2 for ST2/FTSTA General Surgery in my Deanery let alone other deaneries. I do not know what to do. I am waiting for GP clearing as well as round 2 posts.

I am a 3rd year surgical SHO and applied for st2 surgery in 4 deaneries with no offers. I am 37 weeks pregnant and have just started 9 months mat leave. I ticked the "need to defer start" box and also the flexible training option. I feel I am disadvantaged by there only being the option of applying for jobs once a year. As it stands even I get a job in round 2, no one knows whether I would be able to realistically defer for 9

months or if I'd have to reapply for Aug 2008 and therefore potentially miss out on "golden ticket" for run-through training. There are obvious implications re. my current maternity pay as if I don't have "proper" job to go to I'll have to pay it back and I don't know if doing locum work would count. Any advice would be most welcome. Feeling stressed enough as it is!

Thanks for bringing this to everyone's attention. MTAS has been an unmitigated disaster for me. Yesterday I had to turn down my ST2 CMT position in Yorkshire as they refused to acknowledge that I needed a job near to home. Yorkshire deanery have decided in their wisdom that placements will cover the whole of Yorkshire, from Scarborough to Grimsby, Hull and Leeds/Bradford.

My husband is a GP in Headingley and our house is in South-west Leeds. I asked them to consider the possibility of placement nearby and the reply is that I could be sent anywhere including the two six month jobs being 'geographically remote' (ie not even any point moving anyway). I have two girls aged 3 and one and obviously have childcare commitments, but more importantly I would like to at least get home at a reasonable hour so that I can spend some time with them. I see this as an abuse of women's rights, and also human rights. I have accepted a trust registrar job at Halifax, which is in commutable distance, but obviously have now foregone my right to run-through training. This could have consequences on my whole career, but I have to think of my family.

Yorkshire deanery is even refusing phone calls about MTAS and I am still waiting for an official reply about the above issues.

As for flexible training, I was a flexible trainee for my SHO rotation in Southampton, but when we moved to Leeds, the Yorkshire deanery had no funding. I am therefore stuck in working full time. Finding a job share is a sick joke, you have to find someone who is at the same level of training, wanting to do the same career and willing to work in the same place.

I am trapped now as I have no option but to remove myself from the training scheme until next year. Even then, what are the chances of a geographically feasible job?

I am very interested to hear how you plan to help with these issues and am very willing to be involved myself. I would love to know if we have a legal basis for challenging MMC/MTAS because of this.

Which other job to any other sane person would be acceptable if the employer said to you that they will offer you a job, but will not tell you the location, pay, rota or even what the job actually entails?

My friend's wife was 40 weeks pregnant when the form came out. She felt too unwell to complete it at the start of the fortnight and was expecting to go into labour at any moment and thought she'd do it when she finished. She went into labour 2 days before the deadline. She gave birth, left hospital on the day before the deadline, and stayed up until the early hours of the morning of the deadline completing her form. She has not received any jobs despite being a strong candidate.

This does not apply only to women as of course men can get appendicitis or something, but women of childbearing age are far more likely to find themselves in such situations as a result of pregnancy and labour, and the tight and inflexible deadline with once-a-year applications is ridiculous.

I found out I was pregnant immediately before the application fortnight in January. Fortunately for me I started my application straight away and had managed to do about half of it in the first few days. Then I was suddenly taken ill at work halfway through the fortnight as a result of pregnancy complications and was on the point of needing an operation. Instead of worrying only about what was happening with the pregnancy, I was lying in my hospital bed wondering how I could get my form done in the next five days if I was going to be operated on.

Fortunately I avoided the operation and left hospital with a couple of days spare to do the form, but it could have been very different. This was despite my being organised and not leaving it until the last minute. However I was still pretty unwell and it was a real struggle to fill the form in on time.

This does not apply only to women as of course men can get appendicitis or something, but women of childbearing age are far more likely to find themselves in such situations as a result of pregnancy and labour, and the tight and inflexible deadline with once-a-year applications is ridiculous.

The other problem is with the interview schedule and complete inflexibility there. I unfortunately went on to develop other pregnancy complications including hyperemesis gravidarum and bleeding. I was off work for the whole of February until the 5th march and could hardly walk, and even fell down the stairs because I was so weak. I was vomiting up to 20 times a day and had lost 10% of my body weight, putting me into an underweight BMI category. I also developed anaemia. I continued vomiting until 16 weeks and although I had returned to work, I probably should not have done, and it was an enormous struggle. Despite

this, I had to attend 4 interviews around the country. For each interview, I had barely slept as I tended to vomit late at night and feel nauseated during the night as well as the day, and was vomiting on the morning of many interviews. I had no choice but to attend as there was no option to delay or be interviewed at another time of year. At the Eastern Deanery my interview was held 4 and a half hours later than the scheduled time, and it was at Newmarket racecourse where there was no access to food other than crisps and chocolate, and these stopped serving at 4pm (some candidates were there until after 8pm). I had expected to be finished before lunchtime and left at 5, having had nothing to eat since the previous evening, (as I could only tolerate eating at lunchtime at that point) and was light-headed and shaky by the time I entered the interview panels.

I am a female doctor who qualified in 2003. In 2004 I gave birth to my beautiful daughter. In Feb. of 2005 I returned to work as an SHO, and secured a 6 month post in Paeds. In August 2005 I had not found a post yet as I was restricted geographically—I was not prepared to commute too far, and with my mother as the main carer for my daughter, I could not ask her to do any more than she already did. I eventually managed to get a post with an hour and ten minute commute, just bearable.

I am not prepared to risk the chance of being allocated to a post 2 hours from my home, having to leave before my daughter wakes and then getting home long after she has gone to bed. If I were to work a weekend, I could potentially not see my daughter for 12 days. This is a situation I am not willing to put myself or my family in for any amount of money. I have therefore decided to withdraw entirely from the MTAS process, and I will be moving house away from my extended family in order to reduce my mortgage to a level we can afford on my husband's single salary. Oh and I'm leaving medicine—perhaps for good, perhaps I may return in several years when the dust has settled. That is, if the system has not shut me out altogether.

I take my hat off to any woman with children who is willing to battle with this mess and hope to come out the other end unscathed. I, I'm afraid, am not.

I hope I have conveyed my anger at feeling pushed out of a profession I have devoted my life to since I was 12 years old. I could of course go for a staff grade post, but I haven't enough experience. Goodbye and good rid to a profession that cares more about bowing to government than providing it's patients with good, dedicated doctors.

I am having problems as my fiancé is living in London. I saw the programme directors for general surgery who assured me that I would get an ST3 in general surgery but recommended I had some experience in a teaching hospital. I have moved from home and with weekly commuting and rent it is costing me £900 per month. I have failed to get any relocation expenses. I have got no offers through MTAS. I am keen to get back to London as my fiancé is tied to London and I plan to start a family in October but looks as if this means sacrificing my career.

I had my first daughter on the 16th of November 2006, so was in the middle of my maternity leave when this all happened. I felt very much 'out of the loop' as my main priority was being a mum and found the whole application process a nightmare.

I have been given a definite no from the only interview that I had which was in round 1b.

My biggest fear currently is that I have to give my nursery 4 weeks notice if I'm to take Lara out of her place, and if I don't find a position for August then I will have to as we cannot afford her childcare if I'm not working. I don't think the current system will give me that kind of notice.

I have an excellent CV with superb references, my bosses are shocked that I have no job. I am seriously considering leaving medicine to be a full time mum.

Finally, why on earth work for the NHS. The damage that this process has had on morale for a whole generation of doctors can not be measured.

I am 28, qualified in 2002 with Honours at medical school. Was successful with many prizes at university. Since qualification I have 2 years of teaching hospital accredited Medical posts. I am due to take my PACES MRCP exam in October. During this time I have married a doctor and have an 18 month baby boy. I would like to continue my training part time. We are paying off a substantial mortgage. MTAS have made no attempt to accommodate these circumstances. I intend to continue my career despite all that has happened. I was not even offered an interview initially in round one, and have not as yet been offered a post for August.

When MMC came along and asked that I choose between specialty and area, what it was effectively asking me to do was to choose between a career I have always wanted and my family. I decided I could not give up either, so applied for ST3 jobs in psychiatry in London.

After doing a 1a interview, I have no job offer. Not sure what I should do next.

It feels like no one cares about women (and men) who are trying to juggle careers and families. This is going to drive a lot of women like me to consider giving up medicine or consider non-training jobs.

I was at a conference in France when I got the email (if it hadn't been for my blackberry—I would never have known—would have missed the deadline by the time I came home). Given 48hrs to make a decision—unable to speak to my husband face to face.

We are very fortunate that my husband has been offered RTT in London, and myself in Oxford. Happy to give it a try but lots of anxieties. Will be hard enough as a couple but we have also been waiting for some stability to start our family—don't know if this will be possible with us working in two different cities.

My instincts were that my marriage was my priority—I wanted to reject the offer and try for a Round 2 post to try and be with my husband in London.

My husband wouldn't let me pass the opportunity of RTT up and said he would commute from anywhere to make it happen for me.

So we accepted. What I'm finding so hard now is that if my name came up for RTT in London tomorrow—I would not be offered it because I have accepted Oxford.

The decision has been made, I just hope I'm not being a "ruthless female surgeon" and putting my career before my family. My husband and family will always be my priority and I hope he knows that despite the decision we have taken.

I am so so grateful to have RTT, I will make this work. I owe it to all the other families who have NO JOB to make it work and be grateful. I am devastated that this has been allowed to happen to doctors. I have no right to complain—my husband and I are in the best possible situation we could have wished for, but it is hard to be happy when so many of our friends and colleagues have been completely screwed over.

My husband and I applied for linked application this year under MTAS. We are both 5 years post qualification and he applied for ST3 cardiology and myself ST1 radiology. We have been working our whole careers towards this (my husband is a cardiology reg already and therefore applied 1 speciality 4 regions. As both specialties are competitive we had limited options for choice of deaneries needing regions that had both specialties available. There fore ended up applying to regions all over the country. I had 4 interviews in Round 1a; my husband had 1 in our home region. We fortunately both have got ST posts, but mine is in Wessex, his in Severn. The system failed to place us together, despite Severn telling me I was appointable and if they had been able to use the 4 posts they have for round 2 in round post they would have been able to appoint me. It has been a really difficult decision but we have accepted the posts rather than gamble on me getting a post in round 2. I am moving to Wessex with our 19-month-old son and he will stay in Severn. It is not ideal but we are expecting our second child in January and need both incomes. Also as round 2 posts will not start work until October I would no longer be eligible for maternity pay due to a break in career with the NHS so we felt we had no choice. I am now struggling to find child care for 6 weeks time in a region I do not know well. I will move in with my parents and commute to work, as it is a 2 hours drive to Wessex from my home in Bristol and not commutable. I am told hopefully I can have slot share and work 3 days a week but this has not be confirmed. I will then travel back to Bristol for the rest of the week. I face doing this whilst heavily pregnant and also will have to travel back for antenatal care.

I am concerned about my decision and the fact my husband will see less of my son and I but felt we had to make the best decision for the family on in a short space of time (I had 3 days) so this is high hassle but low risk. With all jobs being appointed at one, there was no the option of finding alternative work which would boost my CV and applying for posts in 6 months time.

We feel lucky to have jobs in the current climate but deep down I am distraught about breaking up my family, I really hope deaneries will be sympathetic to my request for an interdeanery transfer and hope it won't take more than 1 year or I shall be forced to resign and give up Radiology and possibly medicine.

The MMC website states that information given is not relevant to Wales. The MMC website for Wales is completely uninformative and we do not know what is going on.

Wales claim that they are not having a round 2 yet jobs are being advertised.

Without uncoupling of ST3 applications I have no future in medicine. I have a 1st class degree and prizes. Of course I have skills. I will never be able to fulfil my career aims and goals. My consultants tell me they think very highly of me. Prof Tooke unless you decide to uncouple I have lost my dream . . .

The upheaval involved in moving deanery cannot be underestimated. Selling house, finding new schools, etc. We do not want to do this again between ST1&2 and ST3 if they are uncoupled.

The response from the helpdesk was "tough luck".

The stakes have never been so high—run through training leads to a consultant job Many of us have financial commitments eg mortgages and may seek financial security out of medicine altogether.

Memorandum by North Western Deanery (MMC 20)

1. Background—The Underlying Principles

1.1 There has been an urgent need to review postgraduate medical education for about 20 years. The process of the reforms began with creating a single higher training grade as recommended by the committee chaired by the then CMO, Sir Kenneth Calman. However, although the changes improved the experience and the consistency of the higher trainees they did not address the problems facing more junior trainees, many of whom spent many years "queuing" to gain entry to higher training and some of whom were unable to progress out of the SHO grade.

1.2 The Calman system of training has been very dependent on opinion as opposed to evidence of achieving competence. It has been largely dependent on paper records of observations as opposed to the observation itself, there has therefore been little opportunity to calibrate and triangulate assessments. The exception (to some extent) has been the video-recording of consultations in general practice and innovations such as the workplace based assessments in Emergency Medicine.

1.3 MMC was introduced against a background of shorter working hours, greater care of patients in the community and increased technology these combined factors reduced the opportunities for doctors in training to observe first hand the emergence of disease processes. The principles of MMC are sound; it is self-evident that medical education should be based on evidence of competence and the judgement that a doctor is fit for "independent practice" should be based on fair, valid and fit for purpose assessments. With the changing NHS it is also clear that the way that medical education is delivered had to change. There needed to be a more proactive approach to learning with clear curricula and a more coaching approach to delivery. As MMC is implemented there is need to consider alternative learning environments which have not been used extensively to date to gain additional skills, such as the independent sector and primary care.

2. The Extent to Which the Practical Implementation of MMC Has Been Consistent With the Programme's Underlying Principles

2.1 Foundation training has been a success. There has been a material difference between the doctors working in their second foundation year from the previous group of SHOs. They are much more articulate and realistic about their aspirations. Almost all those training in the North Western Deanery have taken part in careers seminars which encouraged them to think about their individual strengths as well as their career preferences. This Deanery was clear from the outset that unless there were valid reasons to do otherwise all foundation trainees would spend 2 years in one health economy and all would spend four months in general practice to ensure that they get a full range of experience to meet the curriculum. There was initial resistance to remaining in one location for foundation training, but two years on all the trainees are clear that this was a sound principle and that would want moves between Health Economies to be kept to a minimum.

2.2 The Deanery (medical educators and service) set clear parameters for foundation training as above and had fantastic support from the SHAs to fund general practice experience for all programmes. All trainees in the North Western Deanery have community experience; about 95% spend four months in general practice. All the trainees are extremely positive about their experiences in general practice and we are seeing general practitioners and consultants coming together facilitated by their common interest in foundation training which will hopefully result in improved standards of patient care as they discuss their common issues. We anticipate that by establishing communities of educators across the Health Economy we will encourage PCTs to think about medical education when they are commissioning patient services Consultants are now asking for the same development opportunities that general practice trainers have been familiar with for many years. The Deanery is establishing the equivalent of trainers groups for all involved in foundation training which is great for faculty development.

2.3 The only negative response that remains about all trainees spending time in general practice comes, unfortunately, from a small group of senior surgeons, who believe it to be a waste of time if a trainee is considering a surgical career. Despite repeated efforts there has been a failure to understand the importance of all trainees understanding the psychological impact on disease on the patient and on the progress of the disease. I enclose[25] a paper published by one of our foundation trainees who changed career preferences from surgery to general practice.

2.4 There is now much greater consistency in assessment of foundation trainees, but there is still activity needed. The Deanery established a programme of skills development for consultant educators in the preferred assessment tools. Our data show that a high proportion of the workplace based assessments are undertaken by more senior trainees; so we are developing skills in our specialty registrars. We need to expand our skills development to staff grades and associate specialists and non-medical health care professionals so that they too are able to assess in the workplace with confidence.

2.5 Foundation core programme (half day a week) is good but attendance is still limited by service. We need to think through how this is delivered or service adjusted—no other profession would be allowed to miss one third of their core training. Electronic delivery would be one way but would lose the opportunity to discuss common problems. It is much more important to review the current working arrangements for young doctors to ensure that their working week includes time for reflection with their peers.

2.6 F2 is working well. The trainees have settled in by their second year and become much more confident, there is a striking contrast between the bubbly F2s that we meet and their counterparts in their first year of SHO posts two to three years ago. Two years in one locality has certainly helped. Our programmes of careers management skills has worked well because we have an enthusiast who has set a project plan and ensured delivery across the Deanery. The Deanery has invested heavily in developing expertise in the trusts in careers information and skills in non-directional interviewing. We probably need to extend the latter much further; we are hearing in the aftermath of MTAS that trainees have apparently been given well meaning advice which really hasn't helped them. The careers strategy in the Deanery includes working with our local medical school so that there is consistent advice throughout training.

2.7 Selection into foundation also worked well. There was a great buzz about the day and great consistency amongst those involved. We have lay involvement across the board.

2.8 There is still work needed to detect and manage struggling trainees early. The lack of a firm structure means that we need to establish new ways of identifying trainees in difficulty.

2.9 There is also ongoing need for development of medical educators; we are running master classes for Foundation Programme Directors to help them develop group skills etc. We have some examples of excellence using small group resolution of issues.

2.10 Much of the success of foundation training has been due to the clear funding strategy which has allowed us to appoint a dedicated clinician to lead each programme and full time administrative support for all of our programmes. The other funding which was greatly welcomed was that to encourage the creation of opportunities in less popular specialties. We are convinced that this has had an impact on recruitment to these specialties. The final source of funding was for academic trainees; many of these doctors have been successful in their applications for the "Walport" training scheme at Academic Clinical Fellow level.

2.11 Funding for the four months in general practice for all foundation trainees has been an issue. Initially it was proposed that funding would come centrally for 85% of trainees to spend four months in general practice. On this understanding we secured agreement from the service and SHAs for 100%. NHS North West is committed to general practice experience for all trainees and has supported the use of budgets to implement despite the significant financial shortfall..

Specialty training

2.12 Early indicators are that the specialty training programmes will also be a success; there is a significant difference in the enthusiasm and commitment to specialty amongst the new cohort. There is urgent need to review the adequacy of funding to ensure effective implementation.

2.13 However, where the colleges were late with the curricula it has posed a problem for introducing run-through training and there remains considerable misunderstanding about the role of FTSTAs.

2.14 We have or will have issues where colleges are not fully engaged with deaneries about the use of portfolio and delivery of the curricula. MTAS has so consumed energy and time that we have not been able to manage the change around portfolios. Already we are seeing multiple electronic portfolios and management tools; there is urgent need to review current investment in technology to keep accurate records of assessment and at the same time provide electronic management of the training programmes.

[25] See *British Journal of General Practice,* November 2006, page 895.

2.15 Although we are confident that the general practice aspect of GP training will be fit for purpose we remain concerned that the consultant educators may not have had time to absorb the impact of the new curriculum.

Academic training

2.16 The concept of Clinical Academic Training (Walport) was sound. We now need to make it work. It has not been easy because of poor communication. Our SHA/Deanery/University established an implementation group which I believe is a model for all.

2.17 However, it was impossible to advertise the medical education posts on MTAS because there was an assumption that medical education was the territory of the physicianly specialties.

2.18 It was impossible to meet the needs of MTAS and Walport in selection to all levels. We welcome the proposal that recruitment to academic programmes should run in advance of the main stream recruitment, however we would want to ensure that any trainee appointed to an academic programme met the standard for clinical training in that specialty.

3. The Strengths and Weaknesses of the MTAS Process

3.1 Traditionally the choice of individual medical careers had been determined more by the desires of doctors than the needs of patient care and service provision. In moving towards a more appropriately planned medical workforce it was inevitable that those trainees who were "queuing" to enter their preferred specialty would be disappointed when that door was apparently closed. This does not mean that the principles of MMC were wrong or that the principles of the MTAS process were flawed.

3.2 Review of the F2 trainees who completed foundation training in July 2007 demonstrates its success; of the 396 who completed in the North Western School all but 14 have been successful in gaining employment. 3 of the 14 were not eligible for MTAS. Interestingly, trainees who had been working in the larger teaching centres appeared to be less successful (as judged by the date of their notification of appointment) as those in district general hospitals. We have also collected data on the trainees who were eligible for the Secretary of State's employment promise and of the 130+ who were identified none were of the group which have been described as "stars".

3.3 Meeting the trainees in the North Western Deanery before and after MTAS there is a clear difference in those working in ST1 and ST2. Whereas before MTAS we would have met bright and able doctors who were progressing through their career in the teaching centres, this would not always have been the case in the more remote district general hospitals. With a centralised appointments process patronage has been prevented. Although previous recruitments had followed all the principles of good HR practice, when faced with 600 applications for an SHO post it is inevitable that those trainees who were known to the selectors were more likely to succeed. This resulted in a preponderance of overseas qualified in the more peripheral units, particularly in the surgical specialties. Early indicators are that this is no longer the case.

3.4 The interviews or selection stations worked well, at the time we had good feedback and focus groups of trainees who were recruited have been positive about the interview stations. The trainees particularly welcomed the opportunity to present their experiences and abilities. The written tests for entry to general practice training were successful in the Deanery and need to be considered in specialties which are similar in their recruitment patterns and standards.

3.5 The information held in the North Western Deanery needs to be closely scrutinised; that process is in progress. However the indicators are that the short-listing process did identify the better candidates (as judged by those who were offered posts in the combination of round 1a and round 1b).

4 What Lessons About Project Management Should the Department of Health Learn From the Failings in the Implementation of MMC

4.1 The management of MMC has posed problems. In the early stages there was lack of clarity about what was to be undertaken by the project team and what was expected of Deans. Although COPMED established a group to lead the implementation of MMC our input seemed to be undervalued.

4.2 The implementation of foundation training was left to individual deaneries and without the need to negotiate with all the medical royal colleges it was relatively easy. There have been some difficulties, created often by those who did not understand the process and the content of the curriculum. However, any difficulties were relatively easy to overcome.

4.3 COPMED established the Joint Academy and COPMED Specialty Advisory Group (JACSTAG) which was intended to oversee the smooth implementation of run through training. However, in its early stages most of the meetings were spent discussing the recruitment process rather than the principles of run-through training.

4.4 The creation of PMETB at the same time increased anxiety in colleges and resulted in loss of attention to the project time-lines.

4.5 The issues are not resolved, there remains to be resolution as to whether run-through training really is run-through or whether we should revert to a hybrid of the previous era. The arguments for creating an artificial break in run-through training are educationally unsound; they have been made to help resolve a tension between allowing a doctor to choose their specialty and location in their late twenties and encouraging the most able (who ever they are) to compete for the most popular specialties. The proposal for "uncoupling" has the potential to destabilise the workforce in the less popular parts of the country with the most able choosing the popular specialties in the most highly doctored parts of the country.

4.6 On reflection there may have been little that anyone could have predicted or altered. Although one wonders whether greater managerial expertise and less clinical input would have resulted in improved success. Many Deans were supporting the process with no funding to back-fill in their deaneries.

Selection

4.7 It does seem that although all the colleges agreed to the MTAS process that the agreement was not shared with their membership and insufficient time or attention was devoted to consultation. On the advice of the SHA the North Western Deanery established regular communications which seems to have helped smooth implementation.

4.8 White space application forms are used widely in selection; but not in volume necessary in MTAS and not when a percentage of candidates were prepared to embellish their responses. The plagiarism software was not ready in time to identify this group and when it did emerge it appeared less than full strength.

4.9 We needed to have different methodologies for different specialties depending on what we are trying to assess and how popular they are. There is no need to have highly sophisticated short-listing for a specialty which has less applicants than places, we might as well interview them all but perhaps have a test of competence run nationally to select out those that we can not accept. The problems associated with the one process for all could have been anticipated if we had had more accurate data on the numbers of doctors queuing for higher training posts.

4.10 MTAS had been very good aspects which should not be lost because they were implemented too rapidly. GP selection did work well, however this is not to say that their methodology would work well for other specialties. The general practice community has been working on selection into training for many years (some of the early work was undertaken in the 1990s), this has allowed much greater ownership and ironing out of differences between the RCGP, COGPED and the General Practice Committee (GPC) through their interaction in the Joint Committee on Postgraduate Training for General Practice (JCPTGP).

4.11 The project management team was insufficient to manage all the complex issues associated with the change management project in a group who had individual and group reasons to maintain the status quo. Each college working with their lead dean now needs to consider what worked well for their specialty and what needs improving, if this activity could be adequately supported with skilled individuals in change management we can move forwards.

5. The Extent to Which MMC Has Taken Account of the Supply and Demand of Junior Doctors and the Number of International Medical Graduates Eligible for Training in the UK

5.1 It was inevitable that it would be impossible to reconcile worldwide recruitment, limited numbers of training opportunities, restricted access to popular specialties, expectations of continued employment and entry to training, large numbers of HSMP applicants and even distribution across the country.

5.2 However, although less popular specialties such as psychiatry, paediatrics, O&G and anaesthesia have vacancies, these are now spread across the UK as opposed to the less popular parts of the UK as has been the case in the past.

5.3 Applicants to MMC have been appointed fairly evenly across the country.

5.4 However, increased applicants are expected for 2008 and there is need to review all the national policies which together could create a similar situation.

5.5 There is also need to tackle the 'hidden curriculum' which exists in medical education that medicine and surgery are regarded more highly than other specialties. This is compounded by applicants from countries where there is no effective general practice and therefore no effective training programme. There is urgent need for colleges to work with universities, deaneries and SHAs to reverse some of the messages about the worth of specialties.

6 The Degree to Which Current Plans For MMC Will Help to Increase the Flexibility of the Medical Workforce

6.1 The current plans for MMC, leading to a CCT with defined competencies in a defined time frame have the potential to increase the flexibility of the medical workforce. However, it will depend on the senior medical workforce and employers understanding the strengths and limitations of the graduates of the new training schemes. It will also depend on the NHS employers understanding that a new graduate from run-through training may not have seen or taken part in every procedure they will encounter as an established practitioner. Run-through training needs to be different, building on our experience to date but appreciating the shorter working week, the changing NHS and the need to demonstrate that all competencies are met. ie breadth as well as depth. Although we agree about reaching for excellence if we have a pass/fail assessment (as we do with all assessments) this may be difficult; we have to define competence in order to define pass fail.

6.2 The employers will need to make the service sufficiently flexible to allow this cohort additional support and fund post CCT training so that they develop the skills which the employer will need to deliver the service.

6.3 We must accept that the graduates from our training schemes will not be the finished product of the past. Indeed many of us have learned many of our skills as established practitioners.

7 The Roles of the Department of Health, Strategic Health Authorities, the Deaneries, the Royal Colleges and the Postgraduate Medical Education and Training Board in Designing and Implementing MMC

7.1 The MMC project has been difficult to implement. Several assumptions seem to have been made which compounded to create problems.

7.2 The communication between the MMC team and the Deans was not always effective and although most deaneries established MMC project boards which included the SHAs, this was not always the case.

7.3 Communication between colleges and deaneries was not always effective. Although JACSTAG should have been the forum where issues were discussed and debated in reality it became preoccupied with recruitment.

7.4 PMETB came late to the overall project and had its own internal difficulties as a newly established organisation. It was inevitable that there would be resentment from the parts of the medical profession who had enjoyed greater freedom. This led to delays establishing the framework for the curricula and delays submitting the curricula in a way which was meaningful.

7.5 Underpinning the whole project was an NHS reorganisation which resulted in loss of key individuals in SHAs and disruption in deanery staff. Coping with a project the size of MMC with 15% cuts in staffing was an unreasonable expectation to be delivered by SHAs. The decision not to reorganise significantly in the North West has resulted in better recruitment and stronger relationships between deaneries and employers.

Quality assurance

7.6 Although the questions do not specifically focus on the Quality Agenda it is important to recognise that we will need to establish new and effective quality processes to meet the PMETB Quality Framework and more importantly to gather data to demonstrate whether or not the MMC programmes are delivering doctors fit for the future. The whole of MMC is dependent on a competent senior workforce to deliver suitable experience and learning yet to date we have invested minimally in ensuring that this group understand their specialty curriculum and know how to deliver it effectively and efficiently.

8 The Future

8.1 We need to build on and learn from what we have achieved.

8.2 We need to trust PMETB and the Quality Assurance of Foundation Programmes (QAFP) and look for examples of good practice and build on them.

8.3 We need lead deans to work with their colleges to help them develop specialty training so that it is fit for purpose and will deliver the doctors that our patients need. All colleges need a committee dedicated to developing training which needs to include the lead dean, service, probably a chief exec and lay. (most have the committee but the only non-college person is frequently the Dean). Each specialty needs to think how it can recruit fairly and without bias to its specialty.

8.4 We need to think about the structure of deaneries so that they encourage specialty specific development within an overall framework. Specialty Schools have the potential to achieve this. The PMETB Quality Framework will help.

8.5 Deaneries need to make realistic estimates of the costs of implementing MMC and the associated quality management processes expected of them so that they can make an appropriate case for additional funding.

8.6 Deaneries need to bring together University, College and Service. They can best do this without being under the umbrella of any one of the three organisations. We sit most comfortably with the SHA or as in the case of Scotland as an independent Health Board or Trust.

Jacky Hayden
Postgraduate Dean North Western Deanery

October 2007

Memorandum by Dr Gordon Caldwell (MMC 21)

MODERNISING MEDICAL CAREERS

1. Executive Summary

1. The DH must learn from the failings in its implementation of MMC and MTAS. The management of these changes went seriously wrong despite adequate warnings.

2. The "curricula" in MMC were not real curricula in an education sense. They were amateur attempts by clinicians with an interest in education. There should have been far more consultation with experts in post graduate learning.

3. MTAS was meant to be a selection process, but again appeared to be based on a very amateur and superficial understanding of the complexities of being a medical professional. The project was too large and too complex to be safely implanted in such a short time scale.

4. The Department of Health (DH) had plenty of warning from senior and junior members of the profession of impending disaster, yet ignored advice and continued into disaster. The DH has acted in an autocratic and controlling style of management and suffered the consequences. The DH must adopt a style of leadership which commands the respect of NHS employees and experts outside of medicine or other major projects will suffer similar disasters. Such changes in style can likely only be achieved by a wholesale change in personnel in the DH.

5. The Chief Executive of the NHS must also learn to identify and act on poor performance. The message that has come across to shop floor consultants is that the DH can get away with major failings in performance, whilst we are subject to ever increasing control and scrutiny.

2. Introduction

1. My authority to provide evidence is that I have been Director of Medical Education at Worthing Hospital for six years, and was Chair of the Kent Surrey Sussex Clinical Tutors for three years to Spring 2007.

2. I believe that the most important lessons for the NHS to learn from the seriously flawed implementation of Modernising Medical Careers (MMC) and the MTAS process will be in project management. Senior members of the medical profession and staff at the Department of Health thought and acted arrogantly, believing that because they were medical professionals they knew and understood curriculum design and recruitment processes. They chose to ignore a groundswell of serious wise criticism from senior and junior members of the medical profession, as well as criticism from professionals in postgraduate university teaching. MMC and MTAS were pushed through by a solely autocratic and controlling style of management, whereas modern successful business like ventures usually succeed on the basis of a mixed democratic, listening and autocratic style. This same autocratic and controlling style of management is afflicting many other changes in the NHS. The Department of Health and senior members of the profession must regain close links with and understanding of healthcare of patients in the workplace, and learn to listen to health care professionals and to take advice from professional experts outside of medicine.

3. The implementation of MMC and MTAS has caused immense hurt to Junior Doctors, has been expensive in time and money. I believe that the management of the process has at times been so poor that the Chief Executive of the NHS should have relieved several senior members of the DoH and MMC of their duties or arranged for retraining in modern management skills. The NHS must learn to identify and act to correct poor performance.

3. Evidence

1. I am not submitting much evidence. I am sure that you will be provided with massive quantities of documents by the two review panels, the Royal Colleges, the BMA, RemedyUK etc. My main point is that both MMC and MTAS were criticised extensively prior to, during and after implementation, and yet the DH, MMC, PMETB and COPMED unanimously ignored or undervalued the criticisms, and went ahead into disaster. Many times disasters happen with little warning despite the best of intentions, however in this case many serious warnings were ignored. Certainly for MTAS the writing was on the wall by summer 2006. I suspect that much of the philosophy of MMC was also wrong, and that the whole approach to the implementation of new curricula will have to be reset.

2. I personally submitted many criticisms of the assessments in the Foundation Programme to MMC, and I think became known in MMC as a troublemaker. These very same assessments underpin all the Specialty Training Programmes. The claims by MMC and the Colleges that these assessments are validated and valid measures of professional performance are nearly completely unfounded. I submit the document KSS FP Evaluation Final report from KSS Deanery as evidence. This describes many important criticisms of the Foundation Programme, the flagship of MMC. Although this document is from October 2006 much of the thinking was known to KSS Deanery from early 2006. Some quotes:

a. Page 69 "Our view is that the Foundation Programme is not a curriculum in the educational sense of the word. It lacks a clear educational rationale, there is no description of the educational model it is built upon or of what alternative models were considered but then rejected."

b. Page 25 "Several administrators felt that their workload was greater than they had anticipated: for example, the volume of paperwork; what people saw as excessive documentation of an excessive number of assessments; invalid selection processes where personal references and achievements in the Foundation years do not contribute."

c. Page 28 "Generally, trainees were unhappy at the process of selecting placements, both from medical school into F1 and then from F1 to F2. Some felt that the selection process was unsatisfactory and had no confidence in it."

3. There had been extensive senior criticism of a selection process from medical schools to Foundation Programmes in early 2006. This selection process was based on the same philosophy as the MTAS selection process, but without interviews. There were interviews in MTAS, but if the shortlisting was flawed the wrong selection of candidates would come to interview. The article and letters in The Times of March 4th 2006 are submitted as evidence. There is now far less criticism of the selection process from medical school into Foundation, in my opinion only because the students have learned to play the game, not because it is the right game!

4. I also submit a letter that I wrote to those responsible after a national consultation in September 2006. Maybe I should have been more forthright, but I thought negotiation and discussion might be better! This letter (Chown document) discussed many of my fears about MTAS. By that time I was convinced that MTAS would end in failure to appoint the best juniors to the best posts.

5. By the early December I gave up exerting pressure for a one year delay in starting MMC and MTAS and put my efforts into supporting Junior Doctors going through the process and working hard to highlight the failings in the processes.

6. I had many other concerns about MMC, MTAS, service provision, training, effects of the EWTD etc, and could have provided voluminous evidence. My Chief Executive said to me recently "Gordon, you were right about everything to do with MTAS." In March he had called me in to explain why I was causing so much trouble!

7. Since the start of MMC and MTAS I have read quite extensively on assessments in education and employment, and recruitment processes in modern business. My impression from talking with senior members of MMC and COPMED, is that none of them did this—a weeks' reading of books available with a simple search at Amazon, could have helped avoid disaster. I have also read on leadership and management, and fear that it is the DH, MMC and COPMED management that needs "modernising", and not our career structure!

4. Conclusion

Those managing MMC and MTAS had immense resources and claimed to have adequate time and understanding to implement these major changes. The very damaging failings in both MMC and MTAS are directly related to the management style and performance of those given the responsibility for implementation. The very same style of management is seen in many other DH projects and is resulting in very poor value for money in healthcare for our taxpayers. The NHS must learn to identify poor performance at these high levels and be seen to take action.

October 2007

Memorandum by the Association of Surgeons of Great Britain and Ireland (MMC 22)

MODERNISING MEDICAL CAREERS

1. Introduction: Why ASGBI is Different From the Surgical Royal Colleges, and How the Perspective of a Specialty Association is Different From That of a College

1.1 ASGBI acts as an umbrella Federation for a number of other national associations and societies (AUGIS, ACPGBI, ALS, VS, BAETS, ABS at BASO, BTS, SARS, ASiT, BADS, ASPC, NAASP, BHS), as well as being the SAC-defined Specialty Association for General Surgery, representing approximately 33% of the total UK surgical consultant workforce. The Association is Consultant driven, across Great Britain and the Republic of Ireland, and provides professional services to its membership, especially in terms of consultant level CPD, education and training. Through its Strategic Plan, the Association is evolving a pan-surgical focus with strong links to the FSSA. ASGBI has increasing European and International influence and has developed a number of strategic partnerships with sister surgical societies around the world.

1.2 A distinct role of Surgical Specialty Associations is the delivery of annual scientific meetings as part of the provision of clinical CPD. The annual ASGBI International Surgical Congress includes scientific symposia from around 25 national and international associations and societies both within, and outwith, General Surgery. The Association's 2007 Congress in Manchester attracted over 1250 submitted abstracts from around the world and was attended by 1600 delegates over three days, making it—arguably—the largest annual surgical conference in Europe.

1.3 Specialty Associations are non-regulatory, but exist—as membership organisations—to maintain the professional standards within their specialty. Whereas the Surgical Royal Colleges may be viewed as facilitators, Specialty Associations are providers. For example, each specialty develops the curriculum for its area of expertise, through their respective SAC, which is then fed into the overall Intercollegiate Surgical Curriculum Project (ISCP). Specialty Associations also, subsequently, provide trainers and examiners to the Colleges to ensure that the standards of the curriculum are met. Thus, the nine SAC-defined Surgical Specialty Associations—which vary greatly in size of membership—set their own unique curriculum and may have differing criteria for entry; for example, Maxillofacial Surgery requiring dual, medicine and dentistry, degrees. The nine Specialty Associations come together under the Federation of Surgical Specialty Associations (FSSA) and join the four Surgical Royal Colleges to form the Surgical Forum (previously the Senate of Surgery).

2. What Are the Principles Underlying MMC and Are They Sound?

2.1 ASGBI recommends that the Health Committee Inquiry into MMC be exhaustive and consider all aspects of MMC, PMETB and MTAS and the future of medical education and training. At present, MMC is too preoccupied with "training" rather than careers. ASGBI would like less emphasis on the end of training, and more on a CCT being a gateway to a career in surgery. ASGBI aspires to produce professionals, who have honesty and integrity, rather than Health Service employees.

2.2 ASGBI notes, with some disappointment, that the Health Committee Press Notice (24th July 2007) does not mention 'Specialty Associations', only Royal Colleges, which fails to recognise the contribution to training and the vast efforts that the Specialty Associations have made to make MTAS "work".

2.3 MTAS, MMC, PMETB and Manpower are all inter-related and the Health Committee Inquiry must explore all four to ensure symbiosis in future postgraduate medical education and training. ASGBI stresses the imperative of working to a quality agenda and encourages MMC to give priority to UK graduates and those already in the UK system.

3. To What Extent the Practical Implementation of MMC Has Been Consistent With the Programme's Underlying Principles?

3.1 Flexibility was supposed to underpin MMC, which now seems to be dominated by finances and EWTD. ASGBI supports the five principles of SHO Training, outlined in Unfinished Business:

- Programme based with a defined curriculum (ISCP).
- Initially all trainees were broadly based (Foundation Years and ST1 and ST2).
- Individually-tailored programmes, meeting specific needs (ST3 to ST8).
- Time capped, but also competency based (indicative years).
- Support movement into, and out of, training and between training programmes.

3.2 ASGBI believes that there should be two types of doctor; the fully trained, and those training to join them. There must, therefore, be identified budgets to support education and training, and "craft specialties" must be part of an apprenticeship. Given the time restraints imposed by the EWTD, the increasingly conflicting roles of training and service delivery must be clarified, with appropriate resources being allocated to both.

4. The Strengths and Weaknesses of the MTAS Process?

4.1 MTAS, effectively an untried national matching scheme, was abandoned in the Spring of 2007 as not being "fit for purpose". However, the North American experience of a National Matching Scheme has worked well for many years. Surgical applicants to the US scheme are ranked on the basis of academic and clinical credentials, personality traits and surgical attributes and a searching series of interviews. Programmes define their academic and clinical requirements and rank the applicants on their suitability. Residents undergo an Annual In-Service Examination and all programmes are inspected regularly and may be placed on probation for poor performance at Board Examinations. The best quality programmes match with the best quality applicants. It is highly competitive with significant time and effort probing each applicant's strengths and weaknesses and suitability for specialty training. Quality is the final arbiter for selection. It is a National Matching Scheme that works, not an "online computer dating system" that masquerades as the discredited MTAS.

4.2 Though recognising that seamless training cannot be guaranteed, ASGBI strongly urges that the Quality Agenda must be defined. To this end, ASGBI supports the re-introduction of peer-reviewed assessment using visits (SAC), which have been abandoned by PMETB.

4.3 Entry into training must be selected using "quality" as the most important criteria; the Association wants to recruit the brightest and best graduates (with the appropriate skills, knowledge, aptitudes, attributes and attitudes) to surgery.

4.4 ASGBI believes that Run Through Training should start at ST3 after a period of Foundation Training (F1 and F2) to develop generic medical skills including experience in emergency medical and surgical care and exposure to critically ill patients. Surgery is a craft specialty where time is needed to develop the skills, knowledge, manual dexterity and attributes that allow a "fledgling surgeon" to identify a surgical specialty and acquire the rudiments of his or her craft. This is best taught and learned as ST1/ ST2 trainees (previously Basic Surgical Training) during a "probation period" of training, prior to selection into ST3 for RTT. Selection into ST1 and ST3 should represent significant opportunities to assess surgical commitment and competence using a competitive system of appointment, which includes generic surgical knowledge, skills and demonstration of surgical attitudes and aptitudes.

5. What Lessons About Project Management Should the Department of Health Learn From the Failings in the Implementation of MMC?

5.1 It was no surprise to the Association (see: Consensus Statement on MMC and General Surgery, 2004) that the introduction of MMC at the same time as EWTD was a disaster, due to conflicting priorities of education, training and service delivery using ideas and working practices that had not been thought-through or road-tested.

6. The Extent to Which MMC Has Taken Account of the Supply and Demand of Junior Doctors and the Number on International Medical Graduates Eligible For Training in the UK?

6.1 ASGBI believes that the Trained Doctor/Trained Surgeon of the future will practice in a service driven culture where there will be a balance between short-term employment, jobs for life and life-long career development. The "Generalist versus Specialist versus Consultant" debate requires resolution, if only for the sake of those already in the system.

6.2 Inevitably, we must acknowledge the possibility, in the future, of medical unemployment, but the encouragement of career development, allied to manpower planning, should mitigate against this spectre; ill-considered actions now must not be allowed to create uncertainty for future generations.

6.3 The above should be contextualised within the current demographics and the ratio of female to male undergraduate medical students. Future workforce planning must work to Full Time Equivalents, rather than "head counts", as the number of "heads" will logically exceed the required number of FTEs. This must be viewed as a positive, as future generations—both male and female—will make legitimate work/life career choices, and, for example, a mid-career 50% FTE appointment in elective surgery may well be an attractive proposition to many, supporting the intended flexibility of MMC outlined in paragraph 3.1 above.

7. The Degree to Which Current Plans For MMC Will Help to Increase the Flexibility of the Medical Workforce?

7.1 ASGBI believes that there must be an academic component to education and training as part of a continuum of personal and professional development (see: Consensus Statement on Academic and Research Surgery, 2005). Traditionally, academic training has involved a period of research training prior to the acquisition of a surgical NTN. ASGBI would encourage a more liberal definition of academic training to embrace Education, Leadership, Business Management, Health Administration and Economics as postgraduate diplomas and degrees. ASGBI has developed an expanding portfolio of such postgraduate opportunities in partnership with major universities and would support a strong NHS/ University interface.

7.2 Differing surgical skills are required to obtain a CCT in each surgical specialty. This should be reflected in examination processes that test a candidate's suitability to commence specialty training and map progress towards completion of a CCT.

7.3 ASGBI encourages the MMC Inquiry to give consideration to the end product of training. UK Medical Schools and postgraduate training must not become "doctor factories". The end of training is a gateway to the rest of a career, and it is vital that consummate professionals retain the ability to reinvent themselves several times over a surgical lifetime. It is, therefore, imperative that we train tomorrow's surgeons to embrace both new opportunities and inevitable clinical obsolescence by encouraging flexibility and versatility. Examples, over the years, of the need to adapt to change are surgery for peptic ulcer, laparoscopic cholecystectomy and the recent developments in vascular, breast and surgical oncology.

8. The Roles of the Department of Health, Strategic Health Authorities, the Deaneries, the Royal Colleges and the Postgraduate Medical Education and Training Board in Designing and Implementing MMC?

8.1 ASGBI believes that MMC must deliver a quality agenda. There must be clearly delineated investment in training and education. The Department of Health and Strategic Health Authorities must stop raiding the training budget to support goods and services. There should be some separation of training from service delivery with dedicated time for trainers. Apprenticeship and "on-the-job" experience is essential for clinical advancement. New clinical methods and surgical innovations should be introduced by evolution rather than revolution. The main beneficiaries of quality education and training will be our patients and the public. They expect a "quality driven", rather than a "target driven" service. They expect high clinical and academic standards, not a "dumbed down" NHS.

8.2 ASGBI believes that the issues of MTAS, MMC, PMETB and manpower planning are all inter-related. There has to be corporate responsibility and accountability.

8.3 ASGBI believes that, as it currently stands, PMETB is over-regulated. Specialty Associations and Surgical SACs have to be responsible for the curriculum, entry requirements, quality assurance and credentialing. Given the role of the Surgical Specialty Associations (see paragraph 1.1 above), one possible model could be for PMETB to directly accredit the curriculum of each of the nine Specialty Associations, with the Quality Assurance function being undertaken by the respective SAC.

8.4 The Health Committee must determine the end product of MMC. There is considerable concern within the medical profession as to what the future holds, and a generation of trainees have been sacrificed on the altar of political expediency and educational theory, at considerable financial and emotional cost. ASGBI believes firmly that our patients, and society, desire—and deserve—autonomous professionals rather than accountable practitioners; this means "excellence" rather than "competence".

Dr Nicholas P Gair
Chief Executive

October 2007

Annex

GLOSSARY

AUGIS	Association of Upper Gastrointestinal Surgeons of Great Britain and Ireland
ACPGBI	Association of Coloproctology of Great Britain and Ireland
ALS	Association of Laparascopic Surgeons of Great Britain and Ireland
VS	The Vascular Society of Great Britain and Ireland
BAETS	British Association of Endocrine and Thyroid Surgeons
ABS at BASO	Association of Breast Surgery at BASO
BASO	British Association of Surgical Oncology
BTS	British Transplantation Society
SARS	Society of Academic and Research Surgery
ASiT	Association of Surgeons in Training
BADS	British Association of Day Surgery

ASPC	Association of Surgeons in Primary Care
NAASP	National Association of Assistants in Surgical Practice
BHS	British Hernia Society
SAC	Specialty Advisory Committee
CPD	Continuing Professional Development
FSSA	Federation of Surgical Specialty Associations
ISCP	Intercollegiate Surgical Curriculum Project
MMC	Modernising Medical Careers
MTAS	Medical Training Application Service
PMETB	Postgraduate Medical Education and Training Board
CCT	Certificate of Completion of Training
EWTD	European Working Time Directive
RTT	Run Through Training
NTN	National Training Number

Memorandum by the Queen Victoria Hospital NHS Foundation Trust, East Grinstead (MMC 23)

MMC/MTAS

Our Trust experience of MMC/MTAS

— Our Doctors in training have not been well served by a process that has caused so much uncertainty. They have been put under the stress and strain of not knowing when or how their medical training would continue, a completely unacceptable outcome of the failure of the MTAS system.

— Trusts have been dependent on a centralised recruitment system and have not had any control over a process that has been so wholly unsatisfactory. Consultants have lost all faith in the system, Medical Staffing teams have been subjected to vastly increased workloads and pressures and the Deanery staff themselves have had an enormous amount of work to absorb. With 3 weeks to go until the change over on 1st August, there was a continuing failure to fill QVH Run Through Grade posts and there was total confusion at the Deanery. At that stage we were unable to determine whether this was just misinformation or a genuine threat to our delivery of services on August 1st. In the end, on 1st August we were 2 Max facs juniors down, one unfilled and one pulled out 3 days before because she said her Trust had put pressure on her to stay where she was.

— We always had major concerns about the statement made by Patricia Hewitt, Secretary of State for Health, regarding the "guarantee of employment" for Doctors who were applying for round 2 of the recruitment process. This blanket guarantee showed no understanding of the way that contracts of employment operate, the fact that Trusts hold service posts as well as training posts nor the complexities added by the changes to the immigration rules which were made in April 2007. Further more, as a Foundation Trust we do not consider it appropriate or acceptable that this guarantee was made on our behalf without any reference to or consultation with our organisation.

— We wrote to Monitor, requesting that they engaged in a dialogue with the Department of Health and the Deaneries to ensure that the recruitment problems of 2007 were not repeated in 2008. However, Monitor's response was that this was not part of their remit. Unfortunately, we found it difficult to find anyone who considered it their responsibility to sort out the problems. This was brought into sharp relief when a copy of our letter to Monitor, which outlined our concerns and was sent to Candy Morris at the South East Coast SHA, was referred back to us—we were asked to provide a reply to our own letter.

— Our perception is that we were not well served by the arrangement whereby the London Deanery led the process on behalf of Kent, Surrey and Sussex (KSS) Deanery. As a small acute specialist hospital with an excellent reputation, we have never had difficulty filling our posts until this summer, when there was a distinct lack of doctors. On occasions it seemed like we had been forgotten about, and we had a phone call from a doctor who told us that despite putting our Trust as his first choice, he had been offered a London Trust that he hadn't even listed as a choice. This did not help dispel the suspicion that London posts were being filled first, to the detriment of KSS posts. However this view is based on anecdotal rather than any substantial evidence.

— The process has been unmanageable at Trust level when we were not being informed until the last possible minute of who was recruited to our posts. A common KSS view is that KSS should be de-coupled from London and we work with our own Deanery to improve recruitment processes.

— There does not appear to have been a sufficient understanding of employment law to justify decisions made centrally on behalf of Trusts, nor were there sufficient staff to ensure a seamless recruitment process.

— The problems that have been imposed on all Trusts may well have impacted on the quality and quantity of the services provided. Our Max Facs service was under huge pressure during August and September because of the two vacancies we had.

Pauline Farrell
Head of HR

October 2007

Memorandum by Penelope Jane Berry (MMC 24)

As the mother of a junior hospital doctor, I have been able to follow the twists and turns of the MMC and MTAS saga and its effect on my daughter and her peers. These are the points I would like to bring to the attention of the committee.

— It was never clearly explained why a new recruitment system was needed. Were patients dying in their hundreds of thousands under the old one?

— Who decided that for jobs that are literally dealing with life and death a system that ignored CVs and references from senior colleagues would be suitable? A woolly questionnaire dreamed up by some "psychology partnership" seemed to me totally inappropriate and also to favour female applicants.

— Who imagined that mass interviews held in places like football grounds and racecourses could possibly do justice to the individual candidates, who felt they were being treated like cattle. It must have been an impossible task for the interviewers too.

— Why were candidates made to choose regions rather than individual hospitals? Scotland and Wales are each a "region" but there are considerable differences as well as distances involved. Junior doctors were in some instances made to choose on geographical rather than medical grounds. The system was supposed to help advance the careers of the young doctors involved, which would mean that they should have been able to choose specialties rather than towns or at least to have been informed of the actual posts available in each town.

— Every letter I received from the DoH in response to my letters repeated the same trite phrase—"the right people in the right places". This aim can best be achieved by individual doctors applying with CV and references for posts that interest them and facing an individual interview for that post. It has become clear that that some doctors are not "in the right place" and have even had to have their access to patients restricted because of their lack of expertise in certain areas. This is not the fault of the junior doctor nor of the deanery, but of a system that had never been tried out and yet pretended that this was the best way forward.

— These junior doctors' posts are the only jobs in Britain that have been decided by this obviously unsuitable system. Why has freedom of choice been removed from these professionals? Such important work demands well-trained people who are happy in their jobs. Only thus can patients be reassured that their treatment will be the best. I have seen for myself the unhappiness and uncertainty that has been inflicted on these young doctors for many months now. They have worked hard, at the expense of us British taxpayers, to qualify and many have continued to pass the examinations of the various medical royal colleges, yet no weight seems to have been given to these achievements at all. This system has failed and must be abolished.

Penelope Jane Berry, MA

3 October 2007

Memorandum by Alison Matheson (MMC 25)

I wish to make a submission to the Health Select Committee. As a member of the public and potential patient I am unhappy with the way in which Modernising Medical Careers (MMC) has been implemented, particularly the use of the badly flawed Medical Training Application Service. I would like to see a return to the old system of appointments for junior doctors until such time as a properly tried and tested method is available. I would also like to see a change in MMC so that the choice of future senior doctors is not made after the Foundation Year 2 at a time when many doctors are still unsure of their future career choices. I feel there should be a much greater level of flexibility to allow doctors to have a more varied career, starting run through training when they are only two years out of medical school does not allow for changes in specialty or geographical location or even to take a short break away from medicine. I hope that some provision will be made for the many people who have suffered during the disastrous application process of

2007 so that their careers are not completely curtailed. Almost any person who has graduated from medical school, particularly those who have gone on to take higher degrees and to pass the membership examinations of the Royal Colleges must be worthy of further training. I understand that in many cases training and non-training posts are identical in content and remuneration, if this is the case, why is it necessary to cut the number of training posts, surely it would be better to have a larger pool of doctors from which to select the consultants of the future.

I believe that the inhumane way in which junior doctors have been treated in 2007 could have had severe repercussions for patient care. That this did not happen must reflect the professionalism and dedication of these doctors, surely they must be cared for so that they can continue to care for their patients to the highest standards we have come to expect from them.

Alison Matheson

10 September 2007

Memorandum by NACT UK (MMC 26)

MODERNISING MEDICAL CAREERS (MMC)

1. Introduction

1.1 NACT UK represents Directors of Medical Education (DMEs), Clinical Tutors (CTs) and Foundation Programme Directors (FPDs) who lead Postgraduate Medical Education (PGME) in all trusts/hospitals in all four countries of the United Kingdom. DMEs, CTs and FPDs are all full time consultant clinicians who are constantly in touch with both trainees and consultant colleagues in their own hospitals. They have been instrumental in supporting trainees and trainers with the implementation of the Foundation Programmes in 2005 and Specialty Training programmes in 2007. Individual members work closely with their Deanery colleagues and to a varying degree with their local management structures.

1.2 Members of NACT UK are in the unique position of straddling the service delivery requirements of the local organisation with the educational requirements of the Specialty Training programmes led by the postgraduate Dean and his/her team. With the increasing rigour required of the new Specialty Training programmes at a time of increased service demands and service delivery targets, there is significant concern amongst trainers that training will lose out to achieve financial balance. Trust managers view service targets much more seriously than the need to support and develop the specialists of tomorrow with clinical supervision and individual feedback in a shortened, WTD compliant, Specialty Training programme.

1.3 NACT UK is an independent organisation, a registered charity, with membership and democratically elected council and officers. Due to the unique position of NACT UK to provide the perspective from the local education provider level, we have, over the last couple of years, been increasingly invited to attend National committee meetings as well as COPMeD, Academy of Medical Royal Colleges, Foundation Programme Committees and the Medical Work Force Forum of NHS Employers. The recent NACT UK publication entitled "Proposals for the organisation of postgraduate Medical Education at the provider level" published in August 2007, created significant debate amongst most of the major stakeholders in postgraduate Medical Education.

2. Key Points: Executive Summary

2.1 Clear leadership and structure for decisions made about strategy and implementation of MMC should be written down and widely circulated to ensure that all understand the processes involved in this major change in postgraduate Medical Education. Who is accountable to whom?

2.2 The process should be removed from DH control and ensure wide representation of all stakeholders and informed parties. There should be equal opportunities for all stakeholders, not just junior doctors, to inform decisions.

2.3 Significant education and explanation of the philosophies behind MMC is required at all levels and a clear distinction made between implementing the educational MMC agenda and doctors' recruitment.

2.4 Local education providers (Acute and Primary Care Trusts) should value education and training and hold their tutors in much higher regard. There must be a board director, a Director of Medical Education and an accountability structure within all local education providers. DMEs should be valued for their contribution to MMC so far and encouraged to work with Specialty Programmes and Deaneries as well as local Board Directors to ensure a joined up approach to achieve high quality Specialty Training imbedded, encased and within quality service provision.

3. Our Work to Date

3.1 CTs and DMEs were instrumental in establishing some Foundation Programme pilots in 2003/2004 and for the National role out of the Foundation Programme in 2005. Implementing this National Strategy required CTs and DMEs to engage locally with departments and medical staffing to adjust the PRHO year and create the F2 year from existing SHO or Trust Doctor posts. This was done at a time when the majority of Trusts were in major financial difficulties and investment in education was not forthcoming. The introduction of the concept of an educational portfolio reflecting practice and work based assessments, needed significant explanation to both trainees and trainers and a change in the culture of the learning environment. As this programme was deemed to be part of generic postgraduate education, there was varying enthusiasm from individual specialties to be involved in the role out of the programme, or to contribute to the formal education programme addressing the professional and generic skills aspect of the written curriculum. Most CTs & FPDs achieved this by local networking and using significant negotiating skills with friends and colleagues.

3.2 The introduction of Specialty Training with the Quality Control required by PMETB requires much more integration between the DME and specialty departments. This has been variable in the past. DME/CTs have had a variable link with College Tutors for SHO training, but only a minimal involvement in SpR training and the RITA process. The need to reorganise SHO posts into Specialty Programmes, and in particular the expansion of the GP Training Programmes, required a significant organisational overview within provider organisations which only the DME/CT could provide. In the main, this was achieved and the DMEs managed to retain the same number of doctors to ensure that the organisation could continue to deliver its service.

3.3 The last two years, and in particular the last nine months, have been the most challenging for DMEs/CTs in their local environment. The work of reorganisation of posts was made even harder by the need for repeated explanation of the MMC plan to trainers, trainees and management. Our members feedback their individual difficulties and solutions to NACT UK via email cascades which are then shared with members throughout the UK by email and quarterly news letter. This information cascade enables the issues to be aired by the Officers at the National Committees on which we have seats.

4. What Are the Principles Underlying MMC and Are They Sound?

4.1 Most of the broad principles outlined in the MMC documents are sound. We support the strategy of run through structured training with specialty curricula, work based assessment, regular feedback and robust career advice and support. Colleges are to be congratulated in providing curricula for every year of training and for starting to map the assessment framework to this. This is a huge improvement on previous training where it was unclear what was expected of the trainee and there was an inconsistency in training and a variable end product which depended on the opportunities provided within individual training programmes. Trainees welcome a written curriculum and a focus for their self directed learning.

4.2 The specific remain unclear (or at least unclearly stated) at all levels. DH statements like that under the Terms of Reference of this Inquiry appear to demonstrate a poor understanding even at Department level: "an inquiry into the MMC programme and its implementation through MTAS." MTAS is a recruitment process; implementation of MMC is about curricula, models of supervision, workplace assessment, personal learning etc.

5. To What Extent Have the Practical Implementation of MMC Been Consistent With the Programme's Underlying Principles?

5.1 The introduction of the Foundation Programme was achieved in most places by additional resources to fund Foundation Programme Directors and administrative support. This enabled programmes to be redesigned and an education programme to be mapped appropriately alongside the curriculum. The concept of learning portfolios and regular work based assessment needs significant administrative back up to ensure that all the necessary paper work is completed in a timely fashion and that the weaker trainees are identified and supported early in the programme.

5.2 However, there was insufficient time prior to the introduction of the Foundation Programme for Faculty development and many Doctors and non medical staff, involved in performing the work based assessments, remain unclear as to the purpose and focus of these assessments which has resulted in them being perceived as a tick box exercise. Significant work is urgently needed in this area to ensure that the work-based assessments consistently achieve what is required and are a focus for constructive feedback to the trainee.

5.3 There remains a lack of clarity in the role of the Foundation assessment tools in specialty selection which has detracted from their use as an educational and developmental tool within the Foundation Programme. There remains an inconsistency across the land in sign off at F1 for GMC registration and at F2 for the completion of the Foundation Programme.

5.4 Although time was given for the overall management of the Foundation Programme, no time was given in the work place for clinical education and training. The reorganisation of junior doctors as a result of working time directive has removed the team structure and many Foundation Doctors have fragmented clinical supervision, particularly in surgical areas.

5.5 Career planning in many Medical Schools remains inadequate and within many individual hospitals, insufficient time and expertise is available from CTs, DMEs or Specialty Tutors to provide rigorous career advice during the F1 and early part of the F2 years. This lack of structure in career management means that the Foundation Doctors are poorly prepared for their choice into Specialty Training The lack of visible flexibility between specialty pathways adds to that stress. More attention and resource must be available within undergraduate and Foundation training to overcome this. The planned career website will address many information needs but many trainees will require counselling time from knowledgeable tutors. Feedback from our members is that there is insufficient time to provide this in the current system.

5.6 Specialty Training started in August without any additional resources for Training Programme Directors or local Specialty Tutors. These ST1 and ST2 doctors are, in the main, working to exactly the same job plan as the previous SHOs which are very service heavy. Educational and Clinical Supervisors have a limited understanding of the new specialty programmes, the curricula and the expectations of the programme. Their mode of supervision has not changed with this new structured Specialty Training. The e-portfolios have been introduced late with poor functionality of IT systems adding to both trainer and trainee frustration. It would seem more appropriate to introduce these tools following smaller pilots to ensure acceptance from the profession.

6. The Strengths and Weaknesses of the MTAS Process

6.1 A national electronic recruitment with standardised paper work and processes is the right way forward for high stakes run through Specialty Training, however, all tools used in this process should be adequately created and piloted prior to national usage. The application process should be based on academic and experience grounds rather than some of the softer objectives sought in this year's MTAS selection process. There was a variable level of understanding of MMC in its principles, and MTAS recruitment in its specifics, amongst Consultants, Training Programme Directors, undergraduate leads and Specialty Tutors. The terms MMC and MTAS were used interchangeably by many and the general lack of national information and the constantly changing rules, led to enormous anxiety which spiralled out of control despite attempts by many DMEs/CTs to provide information and prevent inaccurate anecdotes worsening the situation.

6.2 The MTAS database might have worked if it had been slightly faster, if there had been no security breaches and if it had assisted in the job offers. As it was, its actual functioning led to significant confusion and a huge work load for the people in the system. Structured application forms, structured short-listing process and structured interviewing is the right way forward and has been achieved in many specialties—this should be worked on in the future. The strength of a national portal is that we have competitive ratios by specialty and Deanery to assist in career planning. Carefully thinking through a time line and limited preference would reduce the work load of consultants. The huge amount of interviewing and short-listing that occurred required the consultants to be away at a time of intense service delivery targets and the introduction of the 18 week wait.

6.3 Much comment has been made of the "white spaces" on the application form. In the way these were implemented they appeared to allow some poor candidates to gain unfair advantage and to disadvantage some good candidates whose skills did not extend to selling themselves in this format. Having said that most people who scored well on white space questions did well in subsequent interviews. Encouraging applicants to display personal attributes to be taken into consideration in short-listing must be a good thing, but a better method for doing so needs to be implemented, and that only after piloting and gaining a wider degree of acceptance in the profession.

7. What Lessons About Project Management Should the Department of Health Learn From the Failings in the Implementation of MMC?

7.1 The history of integration between those involved in Medical Education and those involved in service delivery has been patchy and inconsistent. We are not convinced that there is the mechanism for Deans to engage fully with Trusts and the Trusts are not universally prepared to engage locally with the leaders of Medical Education. Very few DMEs/CTs sit on any Executive Committee within their organisation and yet they were instrumental in leading this MMC/MTAS agenda. Many Trusts Boards and senior managers do not seem to understand or visibly value their Medical Education role, although they willingly accept the "free doctors" which they are given by the Deanery for their potential service contribution without paying true regard to the training requirements of these young doctors. Consultation with the service about the concepts behind MMC began too late. There needs to be much more integration between education and service delivery at all levels of the NHS.

7.2 There was a lack of leadership at the top about who was leading the change with it being unclear as to the role of the MMC team, the postgraduate Deans, the academy of colleges and PMETB. Clear leadership evident to all is needed for success in projects such as this.

7.3 The changes were introduced at a time of immense pressure on clinical services driven by the need to restore NHS funds to balance. The service issues came to Trusts with targets, rewards and penalties. The training changes of MMC/MTAS were "imposed" on top of this, but without such pressing requirement to comply. Engagement in the project from senior provider unit management was therefore patchy and rarely as high a priority as the service changes. The lesson should be learned that human beings who have to implement changes at the local level cannot cope with radical change in multiple areas of activity and give them all equal attention.

7.4 Many NHS clinical employees are suffering from "change fatigue". Lack of engagement therefore came from all levels in the organisations.

7.5 There remains, in many places, old and slow IT infrastructures with poor network of communication between consultants and trainees within the organisation, across organisations for rotations between Trusts, and between Deanery and Trusts. In some hospitals there is not a distribution list on email of consultants or of trainees making it very difficult to inform doctors on shifts about any of these changes. This allowed the head in the sand mentality to continue. Effective means of communication that actually work are essential to facilitate change.

8. The Extent to Which MMC Has Taken Account of the Supply and Demand of Junior Doctors and the Number of International Medical Graduates Eligible for Training in the UK

There was clear uncertainty at the outset of the recruitment process as to how many international medical graduates would be eligible for inclusion in the MTAS process. It was disappointing that the decision regarding HSMP doctors and international medical graduates was delayed for so many months within the DH and other departments of Government. This created the difficulties for recruiting into the new Specialty Training programmes. There are some very good international medical graduates in the UK currently and they could have been included but the restriction on HSMP status should have been implemented many months ago. It is disappointing to hear that there are still 1000 doctors being granted HSMP status each month. As a result of this lack of decision the high number of applicants meant that each post was highly competitive. There had been inadequate time to prepare the current doctors in the system for this competition.

8.1 Having run through grades and knowledge of training posts within hospitals will allow the medical work force review team to have a much greater handle on numbers and trajectories than have been in the past.

8.2 There does appear to have been a dislocation between undergraduate and postgraduate planning centrally with no planned F1 & F2 expansion within the DH to cope with the increased output of UK Medical Schools. This led us to believe that the various departments within government work in isolation.

9. The Degree to Which Current Plans for MMC Will Help to Increase the Flexibility of the Medical Workforce

9.1 The current plans for MMC will not increase the flexibility of the medical work force. Trainees must have the ability to switch between specialties and also have some Specialty Training if wishing to have a career in primary care. The issue about GPs with a special interest, which would fit with the NHS strategy of moving care closer to the community, is not addressed and it is difficult to see how it could be addressed in run through training programmes as currently laid out by the colleges and approved by PMETB.

9.2 Significant work on competencies and transferability of competencies across specialties needs urgently to be done to allow trainees to change from one pathway to another.

9.3 Trainees develop and mature at different rates and it should be possible for someone to leave the training programme to consolidate their skills in a non-training job and then resume training.

10. The Roles of the Department of Health, Strategic Health Authorities, the Deaneries, the Royal Colleges and the Postgraduate Medical Education and Training Board in Designing and Implementing MMC

10.1 The concept of MMC was created by a variety of stakeholders led by the Chief Medical Officer. After the initial documents were published, it was unclear as to who was actually in charge and the overall direction of the implementation of MMC. The colleges were working on curricula and sharing them through the Academy of Medical Royal Colleges which did not seem to have the status or leadership that it needed to take on the helm of the MMC agenda. At the time the Deaneries were under major threat and challenged by being reorganised into the SHA and the SHAs changing their boundaries. COPMED is a conference of Deans with no clear structure or identity and were not able to take the lead in owning this education agenda. PMETB was working on standards and it wasn't clear where their remit ended.

10.2 Who was in charge of strategy of MMC and ensuring that all the stakeholders understood the strategy prior to discussing implementation? There was insufficient explanation of the vision of MMC and many were left discussing implementation in an unco-ordinated way. Structures were not in place to discuss the process and the Training Programme Directors, who should have been taking some major role in the implementation of the educational component of their new specialty programme, were overtaken by the challenge of recruitment.

10.3 It still remains unclear as to who is in charge and to the mechanisms for membership of the various groups currently "inquiring" into the MMC & MTAS. It is uncomfortable to consider that a major reform into Postgraduate Education is now embedded within the political walls of the DH; that the Deans are now civil servants beholden to the SHAs and that elements of implementation are being set as targets for SHAs. The Colleges are consulted on specialty specific matters only, leaving the generic path of MMC in the hands of civil servants. NACT UK considers there has been insufficient local expertise from people who actually deliver the training in busy clinical environments around the committee tables of London throughout the entire process of the design and implementation of MMC.

10.4 The Deaneries require much more control locally of the process, but as their resources have been significantly cut by the SHAs as a result of cuts in MADEL and MPET they have inadequate resources now to manage programmes and ensure quality. There are still many Deaneries with training databases which do not communicate with local education providers. An investment is urgently required in IT and programme managers both within the local education providers and at the Deanery level.

10.5 Deaneries are starting to establish structures with postgraduate specialty schools, but many of the clinicians becoming engaged with this process are new to the complexities of postgraduate Medical Education management and few have any training in adult education. A huge amount of time and energy and resources is required to educate the trainers, the faculty, the programme educators and assessors in order to ensure that these robust specialty programmes will produce skilled individuals with the required specialist and generic skills to perform independently within a team in future NHS.

10.6 Within Trusts, departments rarely discuss education. Being a tutor is not always a sought-after position as it involves negotiation with colleagues, potential conflict and is poorly rewarded either in PAs or in distinction awards. The current consultants in educational supervisory and College Tutor roles have varying understanding of education theory and of the principles of MMC. Managers have difficulty dealing with medical education as it is not easily quantifiable or easy to cost accurately. CTs and DMEs are in a unique position as they have many years experience of managing education, understand adult education theory and the challenges of embedding education within the work place. The current push to education delivery via specialty programmes is in danger of sidelining the local expertise unless the local organisation takes greater local control. CTs and DMEs should play a major role in establishing the learning environment, faculty development and establishing local infrastructures for good quality control. They need and deserve more influence in the design of future postgraduate medical training.

Liz Spencer
Chair

October 2007

Memorandum by the Postgraduate Medical Education and Training Board (MMC 27)

MODERNISING MEDICAL CAREERS

1. Executive Summary

1.1 PMETB is responsible for the standards and the quality assurance of postgraduate medical education. PMETB's role in the training of doctors is very different to the government's Modernising Medical Careers project. It is not for PMETB to determine the exact shape of specialist training, or the career paths that doctors should follow, but to quality assure training and to approve the content and outcomes of curricula against PMETB's published standards and requirements. PMETB's statutory remit in matters of selection for specialist training is limited to determining that the selection process can identify those who are eligible to undertake it.

2. Introduction

2.1 The Postgraduate Medical Education and Training Board is pleased to be given the opportunity to provide written evidence to the Health Select Committee Inquiry into MMC.

2.2 Our submission focuses on our role in postgraduate medical education and training, and in particular our responsibilities in relation to MMC/MTAS. Our submission also addresses the extent to which the practical implementation of MMC has been consistent with the programme's underlying principles as far as the Board's responsibilities are concerned.

2.3 This paper has been drafted prior to the publication of Sir John Tooke's report of his Independent Inquiry into Modernising Medical Careers. It may assist the Committee if the Board provides a supplementary submission having considered Sir John's report.

2.4 To aid the Committee's understanding of PMETB's role, the following background briefing is appended for reference.

— The development of an independent postgraduate medical education and training regulator—Annex A.

— PMETB's key achievements since taking up its responsibilities—Annex B.

3. About PMETB

3.1 The Postgraduate Medical Education and Training Board (PMETB) was established by the General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003 (the Order) to develop a single, unifying framework for postgraduate medical education and training. It began operations on 30 September 2005, subsuming the responsibilities of the Specialist Training Authority of the Medical Royal Colleges (STA) and the Joint Committee on Postgraduate Training for General Practice (JCPTGP). The Board reports to Parliament through the Secretary of State for Health and acts independently of the Government as the UK competent authority. The Board's statutory remit is to oversee the content and standards of postgraduate medical education and training (PMET) across the UK. The Order sets out the legal framework for its operation.

PMETB's statutory responsibilities

3.2 The principal functions of the Board are as follows:

— To establish standards of, and requirements relating to, postgraduate medical education and training;

— To secure the maintenance of these standards and requirements

— To develop and promote postgraduate medical education and training in the United Kingdom.

3.3 The main statutory objectives of the Board in exercising its functions are to:

— safeguard service users;

— ensure that the needs of those undertaking education and training are met;

— ensure that the needs of the employers are met.

3.4 PMETB's remit does not extend to:

— undergraduate education;

— recruitment and selection in postgraduate medical education and training (including the application process and scoring system) other than determining the standards to be reached by doctors in order to enter specialist training;

— workforce planning;

— determining the number of training posts.

4. The Respective Roles of the Postgraduate Medical Education and Training Board and MMC

4.1 There has been a good deal of confusion about the respective roles of PMETB and MMC, not least because they were established at much the same time. However, PMETB and MMC are quite different. PMETB is the UK competent authority discharging functions required under EU law whilst MMC is a project, established by the Department of Health, aimed at making changes to the delivery of medical education and training. Indeed, even if MMC ceased to exist, PMETB would continue to have a statutory duty to implement standards for postgraduate medical education.

4.2 The different nature and responsibilities of PMETB and MMC is shown below:

PMETB	*MMC*
Statutory	Non-statutory
Accountable to Parliament through Secretary of State	Accountable to the four Departments of Health
Determines standards of Postgraduate medical education	Determines the career pathways of postgraduate medical education
UK-wide	Four separate programmes

4.3 PMETB played no part in the design or implementation of the MMC career structure beyond offering guidance on how the proposed model would relate to our standards and principles.

PMETB and the content and outcomes of Postgraduate Medical Education and training

4.4 Our role as it most directly relates to MMC is approving curricula for all 57 specialties, plus 30 sub specialties, against new standards for curricula drawn up by PMETB prior to August 2007. We are also in the process of approving new assessment frameworks for each of these. This work is important in its own right. When the Board assumed its statutory powers in 2005, fewer than half of the specialties in the UK had a defined curriculum.

4.5 The training environment is changing rapidly with considerable pressure on the provision of training. These changes include the European Working Time Directive, the new consultant contract, concern about short term financial pressures on training providers and major social and technological change. Our role in agreeing, for the first time, explicit standards, curricula and assessment frameworks for every speciality will be a critical factor in ensuring that the doctors of the future are safe for patients and fit for service.

4.6 To ensure that the standards are met the Board has recently consulted on and agreed a new quality assurance framework for postgraduate medical education, building on our work over the last two years.

4.7 This work provides the structure in which both providers of training and specialist bodies such as the medical Royal Colleges and the Specialist Societies can work together to maintain the UK's strong reputation for medical education. The medical Royal Colleges and Specialists Associations play a central role helping to develop curricula and assessment frameworks, defining specialty specific standards, providing information nationally against which we can benchmark providers and working locally with Deaneries to provide external input into their own local quality management processes.

Flexibility and the curricula

4.8 There has been a concern about the level of flexibility provided by MMC. This is reflected in the recent consultation paper by the Department of Health for England. Some of this concern relates to the ability to move between the speciality curricula approved by PMETB.

4.9 It is not easy to predict how much flexibility exists with training courses until trainees start to progress through their training. The ability to move between specialities is dependent not just on the transferability of skills and knowledge learnt, but on a range of factors outside of the curricula such as service need and the educationally approved training posts available in excess of the number of actual trainees. However, many of the curricula that PMETB have approved include core elements in the early years that are common to a number of specialties. This structure already provides some measure of flexibility.

4.10 Furthermore, with PMETB's establishment, a new route to specialist registration has been developed which offers much greater levels of flexibility for doctors seeking specialist or general practice registration. Doctors who have not completed a full training programme can seek to demonstrate to the Board that they have the same level of skills and knowledge as a doctor who has successfully completed a specialist training course leading to the award of Certificate of Completion of Training (CCT). If their application is successful then they will be entered on to the specialist register and be eligible to compete for consultant posts within the NHS. This route to specialist registration offers a high level of flexibility for the trainee. A similar process has been put in place for seeking entry onto the General Practice Register.

Competence, excellence and the curricula

4.11 A further concern about the new curricula and the MMC model is that training now focuses on achieving competence at the expense of the pursuit of excellence. All doctors must be competent—that is, properly qualified, to do what they purport to do. The public, employers and, above all, the profession itself, would be incredulous if a medical professional were to claim otherwise. However, the requirement to be competent should not in any way undermine the pursuit of excellence which has been a feature of the culture of medicine for centuries.

4.12 PMETB requires that curricula make clear the knowledge, skills, behaviours and attitudes that must be demonstrated before a CCT can be awarded. The Board would fail in its duty to the public and to trainees if it did not do so. This is no different to the undergraduate medical curriculum where the GMC has, for many years, required that everyone receiving a primary medical qualification has a basic minimum level of knowledge and skills. Yet that requirement has not diminished the pursuit of excellence by medical schools and their students; nor should it in postgraduate medical education and training.

PMETB statutory powers in relation to Medical Training Application Service

4.13 The Order establishing PMETB sets out the Board's statutory functions. Under paragraph 4(4)(a), PMETB's function is to establish "the standards required for entry to training". The precise use of words, taken together with context, allows only one reasonable interpretation of this function, which is that PMETB must determine the standards that a doctor must have achieved in order to enter specialist training.

4.14 Candidates who meet those standards are eligible for consideration for training, and candidates who do not meet the standards cannot enter training at all. PMETB's statutory remit in matters of selection for specialist training is limited to determining that the selection process can identify those who are eligible to undertake it. PMETB does not have statutory powers over any other aspect of the selection process, including the methods used to select between eligible candidates.

4.15 Under its general powers, PMETB can give guidance and set principles across the range of its work. The Board has done so in regard to entry to specialist training but that guidance and those principles do not have statutory force and non- compliance, by itself, cannot be a basis for withdrawing training approval.

Mark Dexter
Head of Policy

October 2007

APPENDIX A

THE DEVELOPMENT OF AN INDEPENDENT POSTGRADUATE MEDICAL EDUCATION AND TRAINING REGULATOR

1. The move to establish an independent regulator for PMET has a long history. Recurring themes in reports and debates that examine postgraduate medical education and training include the need for clear standards, and to ensure input from patients and the health service into PMET.

2. In 1975, the *Merrison Report*[11] concluded that PMET was in need of a regulatory framework. The Committee found that neither the Royal Colleges or the then Postgraduate Councils nor the NHS, had control of overall standards. The Report recommended that the General Medical Council (GMC) undertake this role in addition to its existing responsibilities for undergraduate and pre-registration training, and should hold a register of specialists and GPs. This recommendation was not put into effect.

3. The *Calman Report*[2] of 1993 recommended that legislation should be enacted introducing the UK Certificate of Completion of Specialist Training (CCST)—awarded by the GMC to trained specialists on the advice from the appropriate Medical Royal College—thus ensuring consistency with EC law. Holders of CCSTs or EU equivalents could then have this reflected on the Medical Register. The report also recommended that medical Royal Colleges and Faculties should set standards in medical education, but that greater cooperation between bodies was required. It argued that the NHS management and Postgraduate Deans had a legitimate interest in training.

4. The April 1995 consultation paper,[3] which followed the Calman Report, proposed that the statutory arrangements in relation to training requirements should be adjusted to reflect practice at the time—the medical Royal Colleges and Faculties having responsibility for the content and standards of training in their specialties. It was, therefore, suggested that all functions listed in the Medical Directive relating to specialist medical training be assigned to a new body comprising representatives of all the UK Medical Royal Colleges, called the "Council of Medical Royal Colleges" or the "new College Council" (later to become the STA), which would be the UK competent authority. The GMC would still be issuing CCSTs on receipt of appropriate information from the new College Council.

5. *The European Specialist Medical Qualifications Order (1995)*[4] created the Specialist Training Authority of the medical Royal Colleges (and theSpecialist Register held by the GMC). The legislation gave the Authority the statutory responsibility for specialist training, and defined a predominantly profession-based membership. General Practice training was overseen by the Joint Committee on Postgraduate Training for General Practice.

6. In 2000, the *NHS Plan*[5] called for a joint regulator for both specialist and general practitioner training, called the Medical Education Standards Board (MESB), with membership drawn from the profession, the NHS and the public. The *Bristol Inquiry* of 2001[6] called for more public involvement in all healthcare regulatory functions, and recommended that postgraduate medical education should be regulated by the GMC, as undergraduate medical education had been for many years. Later in 2001, the Government consulted on the proposed creation of the Medical Education Standards Board[7] (later to become PMETB). The consultation document set out the argument in favour of an independent overarching regulator of postgraduate medical training, with due public and NHS representation and influence. The document says: Decisions about PGME have substantial impact on NHS services, but the PGME system currently has little or no input from the NHS or patients. It has grown up piecemeal, and does not have a single authoritative body to ensure consistent standards across the United Kingdom.

7. It goes on to say: The Royal College representatives form the dominating majority of members of the STA. Acting in concert as the STA, they therefore approve the standards and examinations they offer individually as Colleges. As a result, individual Colleges and Faculties are effectively free to make decisions about curricula and training approval for their respective specialties. However, the growing awareness of the need to ensure that decisions taken about PGME do not adversely affect the provision of NHS services means that training systems now need to reflect the views of the NHS and patients working alongside the

medical profession. It was suggested that the Board remain separate from the GMC. As a consequence of the consultation, the Board was renamed the Postgraduate Medical Education and Training Board (PMETB) to better describe its remit.

8. The 2002 consultation paper Unfinished Business[8] sets out the case for reform of the Senior House Officer training grade. The paper emphasised the importance of a new framework to ". . . publish programme curricula, ensure a coherent approach to setting standards and managing delivery of training . . . ensure a consistent and valid approach to assessment, place a strong emphasis on quality assurance of training . . . ". The document concluded that " . . . a new Postgraduate Medical Education and Training Board will be required to ensure that, throughout training, all assessments and examinations . . . are appropriate, valid and reliable."

9. The legislation[9] creating PMETB was made in 2003 and the Board assumed its statutory responsibilities on 30 September 2005. The proposals in the Chief Medical Officer for England's Report *Good Doctors, Safer Patients,*[10] issued in July 2006 in light of *The Shipman Inquiry: fifth report,*[11] included transferring the responsibility for undergraduate medical education from the GMC to PMETB for greater consistency across the continuum of medical education. Sir Liam subsequently acknowledged publicly that his key aim was to place responsibility for all medical education and training "under one roof" whether that be the GMC or PMETB.

APPENDIX B

KEY ACHIEVEMENTS

In less than two years PMETB has achieved much:

— *Standards:* Published the first-ever generic standards for postgraduate training across all medical specialties: bringing consistency and greater transparency to the postgraduate training of doctors. The standards include a patient safety domain.

— *Curricula:* Approved curricula for all 57 specialties, plus 30 subspecialties, against new standards for curricula drawn up by PMETB. When the Board assumed its statutory powers in 2005, fewer than half of the specialties in the UK had a defined curriculum.

— *Engagement with key partners:* Ensured that, across all our work, there has been input from lay and service representatives. For example, seeking input from the service through NHS Employers and National Education for Scotland on the curricula as part of our approval process.

— *Assessments:* Worked to ensure assessments are fit for their educational purpose by undertaking a rigorous process of testing against PMETB's principles.

— *Academic Medicine:* Ensured clear career pathways for those wishing to pursue a career in academic medicine. PMETB has encouraged and approved curricula that have generic academic competencies.

— *National Trainee Survey:* Undertook the first-ever national survey of postgraduate medical trainees. The first survey, in 2006, organised with the support of COPMED, attracted nearly 25,000 usable responses—a 64 per cent response rate.

— *Certificates of Completion of Specialist Training (CCT):* Issued over 7,500 CCTs in all specialities (including General Practice) since we went live in September 2005. (Doctors may not take substantive consultant or GP posts without a CCT.)

— *New routes to the Specialist Register:* Developed and introduced new equivalence routes to specialist registration. Prior to the Board's establishment there were limited pathways for doctors who had not followed a traditional training programme to join the specialist or GP registers. Consequently, their career development opportunities were limited.

— *The Future Doctor:* Established a major project examining the future requirements for the content and outcomes of specialty training. The project will focus on the needs of patients, trainees and the service.

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Memorandum by the Royal College of Paediatrics and Child Health (MMC 28)

MODERNISING MEDICAL CAREERS

We note that a committee will hold an enquiry into MMC and its implementation through MTAS and has invited written evidence to be submitted. We provided a large amount of evidence to the Tooke enquiry. We attach the summary report submitted to the Tooke Inquiry and if any of the original evidence referred to is required that could be submitted if needed.[26]

Meanwhile we enclose additional responses to each of the areas it has been indicated that the Committee will focus its enquiry on.

WHAT ARE THE PRINCIPLES UNDERLYING MMC AND ARE THEY SOUND?

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

Unfinished Business stated that the modernisation of postgraduate training would be guided by the following principles:

— The end product should be a high quality well trained and accredited doctor who can deliver the care and treatment patients need in the modern NHS.

Even before *Unfinished Business* had been published the RCPCH had begun work on revising its curricula. We began by considering first the roles we thought paediatricians would be undertaking in the future and then considered the most appropriate ways in which to prepare them for those roles. Therefore fundamental to our design was "the end product" enshrined in this principle of MMC.

— Postgraduate training will be organised in structured programmes with progress monitored against clear curricula. Assessment should be competency based. There should be consistent UK wide standards. Programmes should be broad based at first and lead on to greater specialisation. A clear structure to encourage and support academic careers. Responsibilities given to doctors should match their competences

We have developed detailed competency frameworks for all 3 levels of training, including 15 subspecialty curricula at level 3, which have been approved by PMETB. This work was undertaken by a wide range of paediatricians, many with a strong medical education background and supported by our training and assessment advisor, an expert in education. We have aimed not for competence as a minimum standard, but a structure to support the development of both expertise and excellence. Academic training is strongly supported and fits well with this competency based model. We have provided advice to deaneries to ensure that posts within programmes match the level of competence expected at each stage of training.

[26] Not printed.

Our competency frameworks have a large common set of generic competences with a different set of specialty competences for each subspecialty. Whilst the majority of trainees will train as general paediatricians, selection into the subspecialties at level 3 through our "National Grid" subspecialty training scheme allows careful matching of numbers trained to the predicted small numbers of paediatric subspecialty consultant opportunities.

We have also developed a comprehensive and robust assessment strategy. This builds on the assessment system used in Foundation but is modified for paediatric use and for different stages. In addition to the consideration of the PMETB principles for assessment, the utility index was used to inform development and quality assurance of this assessment system and we have demonstrated all aspects of the utility index in our evaluation. In particular we have addressed the issues of feedback and its educational impact as a driver to raise standards.

Not only have we developed and evaluated a comprehensive suite of workplace-based assessments but we have revised our MRCPCH examination. Although this work began before the new curriculum, it has been blueprinted against the new curriculum and modified in response to it.

— Individual programmes should meet individual needs. Training should be in trainee centres programmes and reflect a variety of career choices to reflect individual needs. Programmes should be designed and managed to ensure that trainees complete them in the minimum time.

A key message of our model is that becoming a consultant is dependant on competence, confidence and choice. The ability of an individual to gain competence would be dependant on their ability, their motivation and the contexts in which they train. For these reasons we felt that the overall length should be flexible and variable. Flexibility is a core principle of our training model and it does allow trainees to progress more rapidly if they are competent to do so. Trainees need to be able to move between programmes of different specialties and outside of programmes to obtain the most suitable training for their needs. It is essential that this flexibility is maintained and supported.

A great deal of emphasis has been placed on "MMC shortening training time" We note the principle Programmes should be designed and managed to ensure that trainees complete them in the minimum time; however we have never taken this to mean that we expect our trainees to complete paediatrics within the minimum possible time of 5 years. We believe the vast majority will take 8 years. We do however support the principle that those who are able to progress more quickly because they have demonstrated they have acquired the competences should be allowed to do so. This was not possible with Calman training and we believe that to have been a disadvantage.

Therefore our belief is that the RCPCH has worked with those principles of MMC that we believe are sound and we firmly believe that if trainees are supported to be able to access the learning opportunities underpinning this curriculum, and that our robust assessment strategy is implemented, then those trainees exiting training will be of high quality and that this will drive an improvement in standards and thus quality of patient care.

However there are aspects of delivery of the training also enshrined in the MMC principles that are beyond our control such as the need for training must be properly resourced and supported by strong educational management at a local level.

To What Extent Has the Practical Implementation of MMC Been Consistent With the Programmes Underlying Principles?

With regard to specialty training the principle that entry will be through a fair and open UK wide competitive selection process informed by evidence derived from the Foundation Programme was not upheld. At this stage it is not possible to comment on the implementation of specialty training because that has not been operational for long enough for an assessment to be made. Therefore comments must be limited to the implementation of the Foundation programme.

The Foundation programme aims to build on the undergraduate curriculum and provide trainees with basic practical skills and competences. All general practitioners and virtually all specialists have responsibilities for children either through direct care (emergency medicine, surgeons, anaesthetists and radiologists) or through the need to be aware of child protection issues when caring for adults (psychiatrists, obstetricians). We saw the extension of training from a pre-registration year through to a two year Foundation programme offered considerable opportunities to increase the awareness of the needs of children and the skills required in caring for them. It was therefore a great disappointment to us when the first Foundation curriculum seemed to be overambitious for adult practice and inappropriate for paediatric practice. We were particularly concerned that there was no mention of Child Protection issues and that many of the competences referred to skills to deal with all ages and clearly trainees could not be expected to have developed the same level of skills for example in clinical assessment, resuscitation and prescribing in children as in adults. We continued to express our views strongly and were pleased that a number of our recommended changes were incorporated into the revised Foundation curriculum. There has to date been no published evaluation of the Foundation programme although through our assessment processes in specialty training we will be able to undertake our own evaluation of how well the Foundation Programme has prepared trainees for future practice. However our concern has always

been that four monthly rotations are too short. An increased number of short placements ultimately lead to a lack of a meaningful experience as the trainee has little time to establish working relationships which enable appropriate supervision assessment and acquisition of core knowledge to take place. Many short placements increase the stress on the service with its need for induction and supervision.

The Strengths and Weakness of the MTAS Process

Strengths

As a centralised portal for the receipt of applications it worked well. This enabled trainees to apply through a single portal without the need to duplicate applications. It also enabled there to be a limit set on the number of applications made by any individual.

As a method of centralising interview dates and allowing trainees to choose dates to avoid clashes of interviews and minimise disruption to the service by planning in this way was also extremely valuable.

Ability to score on line made processing of applications easier.

Had the algorithm for matching and linking tied applications been able to be used this would have been an enormous advantage.

The principle of having a standardised national process for selection is a sound one. The fact that it allowed there to be a way of ensuring trainees were limited to the agreed number of applications meant there was some control over the unexpectedly high number of applications although the choice to limit this to as many as 4 choices was in hindsight clearly inappropriately high.

The RCPCH is very disconcerted there will be no centralised application system in 2007. Without a central portal it would be very difficult to control the number of applications a trainee makes and thus potentially produce an unacceptable work load at the deaneries.

Weaknesses

The weaknesses of the IT system itself were the lack of security.

For the majority there were no problems submitting data although there were occasional difficulties.

The main weaknesses in the application system were not in the IT system itself but in the design and content of the application form which was not fit for purpose with its lack of objective data that could have been obtained from a structured CV based application but instead relying on "white space" information which could not be validated. The attempt to have a "one size fits all" person specification and application with disregard for specialty specific needs was also unhelpful and the scoring system inappropriate and not sufficiently broad to allow discrimination between candidates. The use of experience as long listing criteria rather than short-listing criteria and with inappropriate upper limits setting eligibility to apply caused confusion and was totally inappropriate.

What Lessons About Project Management Should the Department of Health Learn From the Failings in the Implementation of MMC?

We agree with the statements in the Tooke report that there is "evidence of deficiencies in policy making with ambiguous accountability structures for policy development and very week governance and risk management processes".

Lessons to be learnt:

Need to be clear from outset the nature and boundaries of the project

For example the original invitation to tender for the selection processes and information given to Colleges was for ST1 only.

Need to be more certain of the information on which planning is based

For example there were severe mis-judgments on the predicted number applying and thus the capacity required of the IT systems and deaneries to implement.

Need to listen

Royal Colleges and Deaneries predicted many of the problems that did occur. Need to involve and listen to all stakeholders and in the event of dissenting views have a clear process for prioritising those views.

Need to work to realistic timeframes

Unfinished Business was published in 2002, *Modernising Medical Careers* in 2003 and *Next steps* was published in April 2004 and yet the planning process for entry into specialty training did not really begin until the middle of 2006 with planned implementation in February. Planning should have begun far earlier.

Need clearer roles and responsibilities of those involved

Need single accountable body with clear roles and responsibilities for all those reporting to that body.

Need better communication

Need clear lines of two way communication channels.

Need to be sure of ranking of priorities within the project

Which is more important trainee choice or maximum fill? These two dictate different processes to be adopted.

The Extent to Which MMC Has Taken Account of the Supply and Demand of Junior Doctors and the Number of International Medical Graduates Eligible For Training in the UK

Clearly MMC were not realistic about the numbers of overseas graduates who would be interested in applying. If this were due to doctors applying exclusively from overseas this could be understood. However it is remarkable that there seemed to be inaccurate knowledge of the total number of doctors in the UK. One of the mistakes is to consider that the numbers of doctors is equal to the number of posts. From a specialty with a large number of less than full time trainees and trainees out of programme and on maternity leave we know that the numbers of doctors is always far greater than the number of posts. Added to this there was the number of doctors unemployed, or in career grade posts, hoping to enter training. Not only was the total number not known the number of IMGs was grossly under-estimated. There needs to be far better data on workforce numbers if any realistic planning is to occur.

The Degree to Which the Current Plans For MMC Will Help Increase the Flexibility of the Medical Workforce

The original intention of MMC was to have broad based stems to allow for greater flexibility and movement between specialties. For the most part this has not occurred except for the creation of the acute common stem. Although popular it has not yet been evaluated, so it is unclear how much influence this will have in increasing flexibility. At present those entering are evenly allocated to go into one of the parent specialties. If workforce needs change it would be interesting to see if someone graduating from that stem with the initial intention of being a physician could equally become an anaesthetist.

It is perhaps naïve to believe that giving trainees common early training across specialties will allow training to be adapted to workforce needs, because predictions still need to be made 5–8 years ahead as to what those workforce needs are. As yet the NHS has not shown itself that able to make such reliable predictions.

We believe within paediatrics we have within our allocation to subspecialty training a system that is very sensitive to workforce needs. In this we adjust the numbers entering subspecialty training according to predicted vacancies in the subspecialty that are likely to occur in 2–3 years time. This shorter timeframe makes it much more realistic to predict numbers accurately.

We have always envisaged there would be the possibility to move between specialties and our flexible length of training programme allows this to happen. For example a doctor training in another specialty who wished to change to paediatrics may well be one of those trainees able to progress through in the minimum 5 years training period rather than the standard 8 years because of the competences they had gained in the other specialty. Unfortunately the lack of such flexibility in the other specialty training programmes would not allow a reciprocal arrangement.

The Roles of the Department of Health, Strategic Health Authorities, the Deaneries, The Royal Colleges and PMETB in Designing and Implementing MMC

Department of Health

- To ensure that the strategic direction is in line with other governmental policies.
- To ensure that adequate funding is made available

— Accepting the limitations of workforce planning, to give due consideration to longer term service needs in planning medical school entry

— To support delivery of WTD 2009—in particular evaluating the impact to date of advanced and extended roles, and making realistic predictions about the additional measures necessary to achieve compliance within the required timeframe.

— To work with key stakeholders to give urgent consideration to the development of consultant careers, and to provide stronger guidance to Trusts on overall targets for consultant expansion necessary to provide a truly "consultant-delivered' service.

Strategic Health Authorities

— To ensure that adequate resources are made available to deliver appropriate training.

— To ensure the needs of the service are considered alongside the needs of training.

— To lead local workforce planning.

— To take a stronger and more supportive role in local service planning and reconfiguration in order to ensure that services are fit for purpose in terms of both patient care and training capacity.

Deaneries

— To work with Royal Colleges to design programmes able to deliver the curriculum.

— To recruit into those programmes, ensuring equitable and transparent processes are in place.

— To ensure that standards developed are delivered.

— To develop the necessary infrastructure to support creative and novel approaches to curriculum delivery.

— To develop robust quality management processes to ensure that educational standards are met within each Deaneries local trusts.

— To support faculty development—both within the Programme Management teams for each speciality, and at local trust level.

Royal Colleges

— To set standards for the curriculum including its assessment strategy.

— To provide expert advice on recruitment and through its members work with deaneries to undertake that recruitment.

— To provide educational resources and/or to provide broad guidance on the range of locally developed resources necessary to support delivery of the curriculum.

— To support local educational leads (eg College Tutors and Regional Advisers) in discharging their duties, providing relevant training as appropriate for these individuals.

PMETB

— Establishing frameworks and generic standards for postgraduate medical education and training and ensuring Royal Colleges and other organisations keep to these when designing specialty education and training.

— Setting a system of Quality Assurance for medical education and training, and monitoring the quality management of deaneries, assisted by the Royal Colleges regarding specialty specific standards for training.

October 2007

Memorandum by The Royal College of Surgeons of England (MMC 29)

MODERNISING MEDICAL CAREERS

Introduction

The Royal College of Surgeons of England (RCSEng) welcomes the opportunity to provide evidence to this inquiry. The College hopes that it will consider fully the merits and the shortcomings of the Modernising Medical Careers (MMC) initiative, the failings of the Medical Training Application Service (MTAS) and the need to look forward to the fundamental changes that are required to ensure that the NHS has the correct medical career structure, recruitment procedures and regulatory processes in place that will ensure the highest standard of care and safety for our patients. The draft recommendations put forward by Professor Sir John Tooke would go some way towards addressing these issues.

The College would value the opportunity to present additional oral evidence should the Committee feel that this would be of assistance.

Executive Summary

- The Royal College of Surgeons of England supports the underlying principles of MMC
- However we are concerned that there is insufficient flexibility in the system as implemented
- We consider MTAS to be inherently flawed.
- We have a number of proposals to improve the recruitment and selection processes for 2008 and beyond*
- We believe there must be a fundamental re-think on the roles and responsibilities of those bodies involved in postgraduate medical education and training.

Responses to Questions Raised Under the Terms of Reference

What are the principles underlying MMC and are they sound?

1. The College wishes to state at the outset that it supports the underlying principles of MMC. We remain committed to a streamlined and more structured training programme underpinned by a surgical curriculum defining explicit standards and based on continuing competence assessment, validated by College examinations. The College has taken the lead in developing such a curriculum as an online resource. It has also commenced a major capital development at its London headquarters that will complement MMC by providing state-of-the-art facilities to run, and develop for national delivery, educational programmes and training courses for all members of the surgical team. These will be based on the curriculum.

To what extent the practical implementation of MMC has been consistent with the programme's underlying principles

2. The practical implementation of MMC has left the medical profession with significant concerns about flexibility. MMC does not take account of the particular needs of craft specialties and those non-surgical specialties with a craft component.

3. For surgery, it is essential that specialist training comprises a period of core specialty training (following the underlying principles of MMC), during which individuals can acquire/demonstrate aptitude, knowledge (particularly of basic sciences), judgement and technical skills, before selection into specialty run-through training. This is educationally sound and is a further contribution to flexibility in career planning. Professor Sir John Tooke has suggested that core training should take place during F2, ST1 and ST2. We would suggest this might encompass exposure to related disciplines such as emergency medicine, intensive care and anaesthesia. This would ensure surgeons were competent to manage the care of critically ill patients.

4. There is agreement that, for most specialties, selection into run-through specialist surgical training must be at ST3/4 level. Flexibility must, however, be retained to accommodate other specialties and changing circumstances.

5. We consider that selection into surgery must be based on competitive entry with appropriate multi-station assessment by surgeons in recognised centres. The College spent several years developing selection criteria for entry to surgical training at ST3 level. These were offered to the postgraduate deans, but regrettably were not incorporated in the selection procedures. Lack of funding and time to meet the February 2007 deadline were given as reasons for not adopting our proposals. Given the poor implementation of MMC and in light of the Tooke report, we hope that they will now reconsider.

6. Whether competition at ST3 is open (ie. to all applicants who fulfil the required criteria) or closed (ie. for those trainees who have completed core specialist training) needs to be resolved. Should this approach be adopted, stand-alone curricula for the core element of training will need to be agreed by PMETB. Much of the difficulty in this debate centres around the fixed-term specialist training appointments (FTSTAs). This is discussed further in point 8, below.

7. There is widespread agreement within surgery about the need for validated examinations as part of the basis for progression at various levels, not least because workplace assessment remains underdeveloped and unproven. It would be irresponsible to repeat the error of MTAS by implementing a system as yet unproven as fit for purpose. The MRCS examination has been revised to make it appropriate for the new curriculum and the introduction of MMC. The FRCS examination has also recently undergone substantial revision and will remain as the exit examination in each of the surgical specialties and a pre-condition for the award of a Certificate of Completion of Training.

8. The creation of the FTSTA grade, whilst providing increased flexibility for workforce planning and service delivery in some specialties, has not, in our opinion, been adequately thought through. Trainees in FTSTAs complete a one year training post and then have to re-apply for run-through training alongside all the other eligible candidates (many of whom will have achieved the competencies required for progression). This creates potential for an exponential growth in the number of trainees competing for run-through posts each year unless strict limitations are implemented on the duration any individual can remain in a FTSTA post.

9. The time commitment required of consultant surgeons to provide workplace training is not adequately recognised in job plans and the subsequent effects on service delivery have not been fully considered. Consultants take pride in their duty to provide training to the next generation of surgeons. However, the split of "run-through" trainees to FTSTAs is approximately 40:60. Many trainees view FTSTAs as inferior posts and as a potential "trap door" out of surgical training, used as a temporary measure to make rotas working time directive (WTD) compliant and to fill the void left by SHOs.

Our fear is that FTSTAs will become the next 'lost tribe' because trainers need to concentrate their efforts on ensuring those in run-through posts achieve the required competencies whilst maintaining an appropriate level of service.

The strengths and weaknesses of the MTAS process

10. The College has placed on record its dismay at the paucity of planning and piloting for the MTAS service. This was confirmed by the judicial review. It is clear that every aspect of MTAS was introduced with foundation trainees in mind and not the cohort of senior house officers (SHOs) caught in the transition period. It is now well recognised that the online application system had inadequate capacity, poor levels of security and was based on an inappropriate application form that took insufficient account of training, experience and qualifications.

11. The short-listing procedures were inconsistent and fundamentally flawed. It is essential that selection into surgical training programmes is based on full CVs, a portfolio of evidence, and structured interviews conducted by surgeons, as was the case in round 2 of the 2007 selection process.

12. We consider that a "big bang" approach to recruitment is neither necessary nor appropriate. Where there is one recruitment opportunity per year, those trainees who are unsuccessful in obtaining a training post will have to find a position which will help them to improve their application for the following recruitment round (potentially difficult to achieve due to the difficulties with FTSTA posts as outlined above and because career grade posts contain no opportunity for training and education). The flexibility offered by having more than one recruitment round per year would be welcomed both by trainees (because they will have more than one opportunity to compete in a year) and by employers (a staggered start for the new intake of trainees would reduce the impact on the service). We are pleased that the Tooke review has accepted this recommendation.

What lessons about project management should the Department of Health learn from the failings in the implementation of MMC?

13. In the rush to implement MMC reforms there was a failure centrally to take the time required to develop, test and evaluate new methods of selection. It was clear that new personnel were commissioned to assist in July 2006 but no notice was taken of the College's proposal for a transitional three year period of selection—the modelling for which was prepared by Professor Shelley Heard and the RCS President. This lack of commitment made us question who was managerially responsible for MMC.

14. The method of introducing MMC was in sharp contrast to the evolutionary development and high-quality control of surgical Royal College activities such as the intercollegiate FRCS examination.

15. The Royal College of Surgeons of England repeatedly identified potential problems with the implementation of MMC and we were continually reassured. However, in the event the performance of the DH team, deaneries and the Postgraduate Medical Education and Training Board left a number of

questions unresolved and the issue of responsibility remains clouded. It is significant that when the crisis needed urgent resolution the Secretary of State for Health turned to the Colleges as the only means to provide the expertise and commitment to deal with the situation within a very short timescale.

The extent to which MMC has taken account of the supply and demand of junior doctors and the number of international medical graduates eligible for training in the UK

16. A fundamental aspect of the MMC programme, that has been overlooked, is the end point of training—the opportunities available to doctors at certificate of completing of training (CCT) level. The unprecedented growth in the medical workforce offers a remarkable opportunity for the NHS to be a consultant-delivered service. This was aspired to in the 2000 NHS Plan and has the full support of the medical profession. Despite this, the uncertainty created by current NHS reforms and the focus on fiscal matters has jeopardised the chance to achieve a consultant delivered NHS that would ensure safe, high quality care to patients. There needs to be agreement and clarity from the Department of Health and commissioners as to whether the NHS should be a consultant-delivered service or a consultant-led service. Only once this decision has been taken can meaningful workforce planning progress.

17. In supporting the underlying principles of MMC, the College considers that these must be complemented by effective national workforce planning. There has been no evidence that this was recognised as a key requirement in MMC and the recent damning report of the Health Select Committee[27] has indicated the lamentable record of the Department of Health in this area along with the need for fundamental improvement.

18. Our estimates suggest that in 2005 in surgery, an average of 35% of SHOs had qualified overseas (ie. outside of the European Economic Area), approximately 70% of Staff and Associate Specialist grades qualified overseas and 15% of House Officers. We have no method of identifying whether these overseas graduates were part of the highly skilled migrant programme. The matter of international medical graduates is one that has yet to be resolved at DH level and requires urgent attention in order to avoid problems in 2008.

19. The need to link undergraduate and postgraduate workforce planning has not been adequately recognised. The large increase in medical school intake has the potential to create dramatic over-supply in future years if decisions about the role of international medical graduates (IMGs) are not taken by Government. The UK could be self-sufficient of its own doctors if a decision to exclude IMGs from training is accepted as previously proposed in March 2006.[28]

20. We believe that 2008 will be a crucial "make or break" year as those trainees who obtained a FTSTA in 2007 compete alongside other eligible candidates for a very limited number of run-through training opportunities. For this reason, we believe that additional 'transition' run-through posts are required (see below).

21. Despite warnings over a period of years to the Department of Health and direct discussions with the then Secretary of State for Health, Patricia Hewitt, there was no adequate provision of additional training numbers to take account of the need to continue consultant expansion and the unprecedented level of competition for posts between the large pool of highly qualified, experienced and motivated surgical SHOs and the first cohort of foundation trainees. We referred to this in our submission to the Health Select Committee's inquiry into workforce planning in 2006.[29]

22. Surgery is a highly competitive field of medicine. This College strongly recommended additional training opportunities to be available at ST3 level over a three year period for those experienced surgical SHOs caught in the transition. Working with the surgical specialist associations and Specialist Advisory Committees, we identified the potential for an additional 88 posts per year for three years in four specialties: general surgery, trauma and orthopaedics, plastic surgery and paediatric surgery.

23. In order to achieve these additional posts, and in keeping with our long-term workforce plans we submitted proposals to the Department of Health to reduce the intake of ST1 and ST2 trainees in surgery and to move those extra posts to support the temporary expansion of opportunities at ST3 level. This would have made the additional opportunities at ST3 as close to "cost-neutral" as possible. This was rejected by the DH because the numbers of ST1 and ST2 posts had already been agreed and communicated to Trusts—a reduction in ST1/2 posts would affect levels of service.

24. We also suggested that proleptic appointments should be made to run-through training programmes at ST3 commencing in 2008 to give trainees who were unable to achieve a run-through post in 2007 some stability in knowing that they would be placed subsequently in 2008 or 2009.

[27] House of Commons Select Committee. *Workforce Planning. Fourth Report of Session 2006–07* March 2007 (http://www.publications.parliament.uk/pa/cm200607/cmselect/cmhealth/171/171i.pdf)

[28] The Department of Health. *Extra investment and increase in home-grown medical recruits eases UK reliance on overseas doctors.* Press release, 7 March 2006 (http://www.gnn.gov.uk/environment/fullDetail.asp?ReleaseID=190158&NewsAreaID=2&NavigatedFromDepartment=False)

[29] The Royal College of Surgeons of England. Submission to the Health Committee on Workforce 2006. March 2006 (http://www.rcseng.ac.uk/rcseng/content/publications/docs/rcseng—enquiry—workforce.html)

25. After protracted discussions with the DH, NHS Employers and workforce planners, we achieved just 49 additional ST3 posts for 2007 (as part of the package of 215 additional posts identified by the then Secretary of State). We were disappointed not to have achieved more for our trainees, and frustrated to learn that contingency arrangements over the three year period could not be made without reference to the Comprehensive Spending Review. Discussions on arrangements for 2008–09 and beyond are still on-going. It is unsatisfactory for us not to have a defined longer-term plan to communicate to our trainees.

26. Some of the smaller specialties (for example, paediatric surgery) urgently require pump-priming with additional training posts in order to meet their long-term workforce requirements. There appears to be little recognition of this at senior DH and government level.

27. In 2009 the working time directive (WTD) will restrict the working hours of trainee doctors to an average of 48 per week. Coupled with streamlined training under MMC, this will reduce the total hours of training for each trainee to approximately 6,000 hours (from an average of 21,000 prior to WTD and MMC). The impact of a shortened training programme will be to produce a competent, but less widely experienced CCT holder. Future CCT holders employed as consultants should work in teams, with fellow consultants, to deliver healthcare. Team working and the mentoring of newly appointed consultants need to be accepted as fundamental principles of MMC and significant consultant expansion will be required to achieve this.

The roles of the Department of Health, Strategic Health Authorities, the Deaneries, the Royal Colleges and the Postgraduate Medical Education and Training Board in designing and implementing MMC

28. The Colleges were early in the design of run-through training but sought a broad-based period of core training with exposure to other medical disciplines eg. emergency medicine, anaesthetics, ITU, radiology and gynaecology. It was always expected that trainees who failed to progress in surgery might transfer their competencies into other specialties. This core training would provide a holistic approach for doctors before they focussed on their specialty training. The College also expected selection to occur between ST2 and ST3 but the decision by PMETB that selection should be into the specialties removed the possibility of broad-based training. We recognise that we should have, as a College, made stronger representation to overturn this position but we were advised that PMETB had a statutory obligation to pursue this policy. The College made representation about the size of the FTSTA grade recognising that the high competition ratios in surgery would necessitate a larger cohort of FTSTAs than in any other specialty. Sadly these concerns again were not acted upon and we are now in danger of creating another lost tribe of surgical trainees.

29. The College believes that the inquiry must examine very carefully the role of the Postgraduate Medical Education and Training Board (PMETB) in the introduction of MMC and the use of MTAS. PMETB has statutory responsibility for the standard required for entry to training. Its criteria, and the rigidity with which it applied its rules, compounded an already flawed recruitment system and PMETB's unwillingness to accept criticism of its involvement is disappointing.

30. PMETB's principles of entry into seamless training from F2, with assessment by competence rather than experience, moulded the MMC and MTAS processes in a way not suitable for craft specialties. The College does not believe that trainees should be selected to run-through training at ST1 with guaranteed progression to a CCT without further robust selection into specialist training at ST3 (ST4 for neurosurgery).

31. This raises a larger issue that the College believes should be pursued by the inquiry. There has been widespread criticism of PMETB ranging from the lack of robustness of PMETB's quality assurance programmes for training to poor communication and an excessively bureaucratic approach. Recent changes in its QA approaches following the appointment of Patricia le Rolland are encouraging but if it is to continue to exist, it must become a more approachable, efficient, effective and accountable body that recognises rather than dismisses the experience of the medical Royal colleges and our record of working with postgraduate deans across a range of professional activities. It must delegate to colleges, to the maximum extent, responsibility for the quality assurance of specialist training and education. The College welcomes Tooke's recommendation that PMETB's functions should come under the overarching regulatory leadership of the General Medical Council. This would ensure accountability to Parliament and not to the Secretary of State, which is the present and highly unsatisfactory situation and was one of the primary underlying causes of the MTAS failure.

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

33. The decision by postgraduate Deans to offer run-through training to successful candidates even after recognising that the system of selection was flawed needs to be examined. This College, supported by the Senate of Surgery, called for a moratorium on appointment to run-through training and proposed a transitional year for all selected trainees. This was not accepted. As a consequence there are now no opportunities for trainees in 2008 to gain national training numbers (NTNs) unless extra funding is provided by DH.

34. The problems with project management by the DH have been identified above. Importantly many of the architects of MMC remain working for the Department while other responsible officers more publicly associated with the project chose to resign.

35. Although the Colleges were frustrated by the lack of notice given to their views, they were not as forceful in their criticism of the process of MMC as they might have been. Support for MMC continuing was conditional on the IMGs situation being addressed by DH as implied in their March 2006 policy. The failure to enact this decision in 2007 proved critical. The selection date should have been delayed subject to publication of the judicial review. Failure to do so meant that over 10,000 applicants would find themselves without training posts at the end of the first round. The Department's announcement in December 2006 either portrayed over-confidence in its ability to win the judicial review or a lack of insight into the ingenuity of IMGs to circumvent the restrictions by applying for highly skilled migrant status.

The College will be pleased to provide any supplementary evidence required in relation to its concerns and proposals and the President would welcome the opportunity of providing further oral evidence in the light of this memorandum.

Bernard Ribeiro
President

October 2007

Memorandum by Roger Fox (MMC 30)

MODERNISING MEDICAL CAREERS

Executive Summary

1. This memorandum only comments on issues pertaining to the MTAS process and the issue of internationally qualified medical graduates wishing to work in the UK.

2. The findings of the Select Committee will have reverberations in both the UK and throughout the Commonwealth because of the importance of the UK in post graduate medical education for medical graduates of poorer Commonwealth countries who desire further training.

3. An unintended consequence of any stronger controls on applications for further medical training in the UK is not only damage to the UK's reputation for post-graduate medical training but also a loss of income for UK Universities.

4. Futhermore, because the GMC seeks to control the UK medical market through its licensure regulations and the Royal Colleges stipulate whether or not a Doctor is qualified to practise independently as a consultant any strengthening of the monopoly control of the medical profession will have economic consequences in the future. The author contends that the UK's NHS medical staff receive the second highest salaries of any country in the world because of their strength in the UK labour market.

4. Placing the blame for the failures of MTAS on the overseas applicants is an attempt to shift the blame for the MTAS shortcomings onto an innocent group who were seizing an opportunity open to them.

5. There was a way of preventing the deluge of applications. It was the short-listing process which was at fault more than any other feature of the application process.

Evidence

1. Whilst the implementation of MTAS was an attempt to create a systematic system for specialty training it is faulty on several counts.

2. Trying to forecast future manpower needs for medical services is extremely difficult. Who is to say that the number of training places is adequate? Technological change, population trends, preferences of the workforce, restrictions on working hours can all change quite rapidly. So we need a system that has built in flexibility but we have an inflexible system forced on the junior doctors.

3. We need an application system that can absorb the kind of lifestyle choices junior doctors wish to make. Also, one that is fair to everyone. There is no reason why all applicants should not be required to have two years NHS experience before being permitted to apply for a specialty training post at registrar level. This approach would deal with the overseas applicants who do not have the experience a UK graduate would have. It would also enable an overseas student who graduated from a UK medical school to apply. Separate provisions for refugee doctors would need to be worked out.

4. Short listing procedures must be thought through so that applicants are given proper consideration. There should be adequate time for short listing. Those carrying out the task should be able to see the full application form rather than being given only a section to mark. One needs to be confident that the best applicants (on paper) get on the short list.

5. The UK has fewer qualified doctors than other major European countries. We shall continue to have fewer into the future. Demand for medical services increases as countries become wealthier, and the European Working Time Directive will create difficulties when the maximum hours are reduced to 48 hours per week. So NHS Trusts will continue to need to recruit overseas applicants to work in "staff grade" posts. There are also persistent shortages of GPs in some parts of the UK. It will be best to accommodate these vacancies through a free market (with the highly skilled migrant programme and GMC regulations) as at present. Many overseas doctors are well qualified and of great value to the NHS. To prevent them working here would be to our own disadvantage[30].

Roger Fox
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October 2007

Memorandum by the British Orthopaedic Association and the Specialty Advisory Committee in Trauma and Orthopaedic Surgery (MMC 31)

MODERNISING MEDICAL CAREERS

1. Background

1.1 The British Orthopaedic Association (BOA) is the professional body representing Trauma and Orthopaedic (T&O) surgeons in the UK. Trauma and Orthopaedic Surgery is a discrete and well-defined branch of surgery which currently accounts for approximately 45% of all of the surgical trainees in the UK. The service is made up of two distinct components, Trauma care and elective Orthopaedic Surgery, in almost equal proportions, normally delivered by the same Consultants and training staff in District General and University Hospitals.

1.2 The Specialist Advisory Committee (SAC) in Trauma and Orthopaedic Surgery of the Royal Colleges is a Committee formed from T&O surgeons from around the UK who have a solid track record in the organisation and delivery of training in their regions. It works in partnership with the BOA, its specialty association. The BOA is an independent body relative to the Royal Colleges but nominates half the SAC members. The main duties of the SAC are to advise on curriculum content and delivery, standards and to assist in the external aspects of Quality Assurance and quality management of training programmes.

1.3 The Education Committee of BOA and the Specialist Advisory Committee in Trauma and Orthopaedic Surgery of the Royal Colleges of Surgeons jointly produced the curriculum for training future Trauma and Orthopaedic Surgeons, approved by PMETB in August 2006. This was based on the previous curriculum and the experience obtained from the gradual introduction of the methods of curricular delivery and assessment over the last five years.

2. Modernising Medical Careers

2.1 We support the underlying principles of Modernising Medical Careers These are team working, multidisciplinary approaches, more flexible training pathways, meeting both service and personal development needs, taking into account best practice from other countries, and care being delivered by trained doctors, with the patient at the centre of all our planning and strategy.

2.2 We believe however that to date there have been few changes to the current structure for health care delivery such that the principles of MMC cannot presently be achieved in T+O. This is particularly disappointing as Trauma and Orthopaedic Surgery has been at the forefront of new curricular design and delivery and welcomes the potential for change.

2.3 Whereas elective Orthopaedic surgery (typically, for example, hip and knee replacements) for the most part requires low levels of "physician" type care (other than in the most complex cases), most of the Trauma cases (broken hips etc) require extensive physician input. This is because most Trauma patients are either elderly people who hurt themselves because they are frail or have sustained complex multisystem injuries. These patients are the ones for whom a multidisciplinary team approach is essential. However the Trauma service has traditionally been supported by junior surgical doctors in training or junior staff in service posts who are not appropriately trained or supervised for the delivery of the medical (ie the non surgical) needs of the patient.

2.4. Over the years since the publication of "Unfinished Business" there has been an explosion of junior surgical training and service posts in Trauma and Orthopaedic Surgery to staff rotas and make them EWTD compliant.

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[30] See the article: Fox, RG (2007) "An Examination of the UK Labour Market for Doctors", Economic Affairs, 27, pp 58–64.

2.5 Surveys from the Royal Colleges of Surgeons and PMETB have shown conclusively that these junior doctors are not receiving supervision or training and are unable to acquire clinical competencies necessary for progressive careers in surgery because their focus is necessarily the "medical" needs of their patients. This has resulted in a high level of dissatisfaction and frustration amongst this group of doctors (See PMETB survey of junior doctors 2006)

2.6 The historic failure to face up to the separate demands of the two different aspects of care (medical and surgical) required by many trauma patients has led to the medical needs of these patients being underestimated. Moreover, those doctors seeking to be surgeons are being required to allocate much of their time and effort to this aspect of patient care which in many cases could more appropriately be addressed by a true multidisciplinary workforce. Consequently, at present there is insufficient time for the junior surgical trainee to learn the essential craft aspects of surgery whilst not losing sight of the values inherent in being a doctor as well as a technician.

2.7 In the case of T&O the laudable principles of MMC have foundered as a consequence of the rigid budgetary divisions between training and service and, indeed, the training of the various disciplines.

3. Strengths and Weaknesses of MTAS

3.1 MTAS was to have been a process to select StR 1 from foundation programmes. This might have been successful had the process not been extended to cover StRs 2 and 3 where the bland assessment of expressed competencies unsupported by a CV made selection at the shortlisting stage very difficult in those specialties with high competition ratios such as T&O. This is not the fault of the experts asked to carry out the original remit who had these later years doctors foisted on their scheme without notice or proper consultation.

3.2 In addition the IT system was inefficient and insecure and- to make matters worse- the rules in surgery were changed mid-process, subjecting many deaneries to near impossible tasks.

3.3 Despite all of this it is widely held that the individuals selected into StR posts over the various rounds have been good or excellent candidates. The observations of the shortlisting and interview panels were that one third of the candidates were good or excellent, one third just appointable and one third unappointable to posts which were providing training to be a consultant as their prime goal.

3.4 It is also interesting to note that in round 2 in Trauma and Orthopaedics, which mainly looked at appointing FTSTAs, very few acceptable candidates were found.

3.5 In the Scottish Deanery the piloting of an extended OSCE process was found to be extremely useful in giving objective scores for performance and a high degree of correlation was seen between the OSCE and interview performance. T&O would therefore be keen to further pilot and develop this system.

4. Supply and Demand

4.1 Over the last five to 10 years, as hours of work per doctor have reduced and as a direct consequence of the "service" needs, there has been a vast expansion of "SHO" and "Trust grade" posts. These posts have been essential to staff the service, but little attention has been given to the training needs of these doctors or to their ultimate professional development. In other words the supply of posts designated as training posts has been driven by the requirement of service delivery NOW and not by the demand for trained doctors in the future.

4.2 Many of the doctors appointed to these posts had no possibility of entering the few T&O specialty training posts available and have spent years drifting along in unsatisfactory posts which often offer no real training in the craft aspects of surgery. These doctors have therefore not acquired appropriate T&O competencies and consequently are able to deliver care only at a basic level. This means much of service in England in particular is delivered by a workforce who gravitated to middle grade posts rather than arrived there through wish or ability to be there. Also their competencies are assumed rather than proven.

4.3 International Medical Graduates flooded into the UK and were appointed to these posts as there was little competition for what are in reality unattractive posts and so it was easy to find such employment. The best were successful in progressing along with the best of those trained in the United Kingdom but this left many without training posts.

4.4 Some IMGs brought with them considerable skill and experience in defined areas of T&O with which they were able to progress into Career posts (Staff grade and Associate Specialist posts). Although they did not function as independent practitioners these individuals have been tremendously important in service delivery throughout the UK, and have allowed the service to function in the absence of UK trained Trauma and Orthopaedic Surgeons.

4.5 At the most junior levels there is now an increasing number of UK medical graduates—trained at vast expense and looking for future careers in the service. There is a danger that this surplus of medical graduates will act as a disincentive to progress the type of service and training redesign which we feel is essential to provide excellent care for T&O patients and meaningful future careers for these graduates. In a balanced

model we would increase the number of doctors trained and tested to an appropriate level to deliver routine service (not necessarily as consultants but still trained to a proven level) and this would be determined BY the service needs and so in turn would determine how many need to be in training at any given time.

4.6 At the specialist level the numbers of UK training posts has been increased over the last 10 years such that there is now an increasing and steady flow of excess trainees at CCT level over and above the numbers of Consultant posts available. These individuals are therefore already available in the market place to fill service posts at a specialist level. They are trained in the depth and breadth of T&O surgery and can function as independent practitioners. The time has therefore come when the dependence on further IMGs should be curtailed.

5. Increasing the Flexibility of the Work Force

5.1 Flexibility of training opportunity can only be achieved when there is a realistic prospect for trainees of being able to enter and leave the training grades and for the skills they possess to be useful in the provision of a certain type of service need.

5.2 We must stress that patients expect to be treated by physicians and surgeons who are either competent in delivering care or who are being suitably supervised and trained. Indeed care being delivered by a trained doctor was one of the central planks of MMC and the BOA believe that the current CCT is the correct level for independent practice.

5.2 The early years of training in surgery were such that they at best delivered a trainee with knowledge of the principles in the generality of surgical knowledge and a few transferable skills.

5.3 In Trauma and Orthopaedic Surgery we wish to stress that a doctor four years from qualification and with perhaps 18 months of Trauma and Orthopaedic knowledge is of very little use in the provision of service as a whole. They would be ill equipped to deliver any type of operative intervention either to an "in" or "Day" patient and such expertise they would acquire would similarly be of little use in the outpatient environment.

5.4 We feel that it is essential therefore to limit the numbers of trainees entering even the most basic training levels of surgery so as not to dilute training opportunities and produce a realistic number of future individuals who might be in a position to have flexible careers which would be useful to the service in future.

6. Roles of Varying Bodies in Designing and Implementing MMC

6.1 A fundamental problem remains: how best to deliver the care necessary to run the acute services for the benefit of the patient at the same time as training the next generation of medical professionals to provide that care.

> We accept that it is essential to consider the financial limitations of the Trusts but stress that there must be sufficient time to allow the Trainee surgeon time for training in the specific competencies of surgical skills.

6.2 This of necessity requires "joined up" planning between those responsible for Service and Training and a real commitment to changing the patterns of care delivery such that the principles of MMC are met.

6.3 The critical factor in the redesign of service and education is the tension as to where the finances are held. Training budgets for doctors are not transferable within medicine or to other paramedical specialties or to the provision of "service" staff. This has lead to a type of "planning blight". If funding followed trainees then training Trusts would be rewarded and the trainee would be properly trained. Trusts opting out of training should be expected to subsidise Trusts who train as they will also be beneficiaries of newly trained specialists.

6.4 The separation of decision-making about varying aspects of the service into regional and service versus training silos has created difficulty in planning new ways of delivering the training and the service. National steers on strategy of training needs are essential and localities need flexibility to provide suitable training and receive proper funding to do so.

7. Summary

Trauma and Orthopaedic surgeons wish to ensure that their patients receive the best standards of care and their workforce is organised and trained for that purpose.

We would welcome the opportunity if asked to provide oral evidence to the Health Select Committee in its proceedings.

Miss Clare Marx
Vice President, British Orthopaedic Association
Chairman, Specialty Advisory Committee in Trauma & Orthopaedic Surgery

October 2007

Memorandum by NHS London and London Deanery (MMC 32)

MODERNISING MEDICAL CAREERS (MMC)

1. *Introduction*

1.1 NHS London (The Strategic Health Authority for London) was established on 1 July 2006. Prior to this there were five Strategic Health Authorities in London and the London Deanery was managed by the five SHAs through a lead SHA arrangement.

1.2 London Deanery manages the postgraduate education and training of doctors and dentists in London, through programmes that extend into Kent, Surrey, Sussex, Essex and Hertfordshire. London Deanery is the largest in the UK, responsible for the training of 10,000 trainees.

1.3 NHS London and the London Deanery would like the Inquiry to consider the following evidence about MMC and national recruitment through MTAS. The evidence provides an over view of the role of the London Deanery with the implementation of MMC and in particular the challenges faced by London with the highest volume of training posts and applicants. The evidence then turns to respond to each of the questions posed by the Health Select Committee where there is specific relevant input from London.

2. *Key Points: Executive Summary*

2.1 The principles of MMC are sound, although there are tensions between the desire for more flexibility and more structure; more trainee-centeredness and more service orientation.

2.2 Implementation of Foundation Programmes was assisted by piloting, funding for a new infrastructure, and the fact that there were enough posts for all eligible applicants. The reforms to specialty training were implemented without those features. The recruitment to specialty training was always going to be more challenging as the transition year saw the transition of existing trainees into the MMC training programmes.

2.3 National electronic recruitment was not one of the principles of MMC, merely a strategy for managing a high volume of applications as trainees moved from one system to the next.

2.4 The principles of MMC are right and should be implemented. The view of NHS London and London Deanery is that modernising the structure, content, delivery and assessment of specialty training is urgently needed, and should now become the focus of attention. National electronic recruitment systems should be re-introduced only once the structural reforms are in place, processes are bedded down, and the technology has been thoroughly tested.

3. *Background*

3.1 London Deanery fully supported the MMC principles, and its team of postgraduate deans and directors were engaged in all stages of planning of the reforms.

3.2 In 1997, London reformed recruitment into specialist training, with the introduction of a competency framework; replacement of CVs with a structured application form; structured interviews and a transparent scoring system. The process was evaluated by applicants and panellists as fair and effective, and was commended by the Institute of Employment Studies. London's application forms were used by the Work Psychology Partnership as the basis for the MTAS forms. However, in the process of making them fit the requirements of PMETB, and to serve for multiple levels of entry, changes were made that altered their acceptability. These changes were not apparent until applications went live.

3.3 London Deanery expected a large volume of applications, and planned accordingly. The Dean Director spoke to every Trust Chief Executive, engaging support and agreeing a process for identifying the 1,200 consultants that would be required. A bespoke e-learning package was commissioned for those who had not had equal opportunities training in the past three years. A series of evening training sessions was held.

3.4 During these sessions, consultants said they preferred to score from paper, rather than on-line, especially as they could not score on-line from home. It was agreed the deanery would print the forms and courier them out. MTAS was informed and agreed.

3.5 Another consideration was whether to go for vertical or horizontal marking. Vertical marking meant the scorer could take a global view of the whole form, but with the disadvantage that some pairs of scorers might be kinder or harsher than the norm. It was felt to be fairer if each pair of scorers marked one section across all applicants. The decision was made to go for horizontal marking. MTAS was informed and agreed.

3.6 Finally, checking for eligibility (longlisting) was considered. With only three weeks for printing, sending out, scoring, and returning the forms, it was clearly going to be impossible to complete longlisting before the scoring started. MTAS was informed that we planned to carry out both processes concurrently, a deanery team working on longlisting while consultants scored, and this was agreed.

3.7 Plans were in place to download the forms from MTAS and send them to commercial printers to print off the required number of copies. Unfortunately, the reference number did not appear on any but the front page, so this number had to be copied onto each page of each form by hand and photocopies made. It took 90 people working throughout the weekend to prepare the downloaded forms for photocopying, and led to delay in getting the forms to those shortlisting.

3.8 Some London statistics:

— 4,500 vacancies, of which 4000 filled in Round 1
— 23,000 applications handled
— 8,700 interviews in Round1a
— 5,500 interviews in Round 1b
— 7,500 hours of overtime clocked up by deanery staff (late working, working at weekends and bank holidays).

3.9 In response to concerns raised about the recruitment process for 2007, NHS London put in place a Programme Management structure overseen by a Programme Board. The membership included representatives from London and KSS Deaneries (one unit of application), the SHA and London Trusts to oversee the recruitment process. The additional support to the London Deanery included the development of a simple but effective IT programme to replace MTAS once it was taken off line for the remaining tasks in Round 1 and Round 2, as well as providing expertise in information analysis and project management.

4. *What are the principles underlying MMC and are they sound?*

4.1 The 16 principles of MMC that are referred to are as appears on the MMC website and are detailed in Appendix 1

4.2 NHS London and London Deanery support the principles, although there are tensions in the desire for more structure and more flexibility; more trainee choice and more attention to the needs of the service.

4.3 Principles 5 and 7 point to the desirability of shortening the training period. Due to the expansion of SHO and Trust Doctor numbers that occurred as hospitals attempted to reduce junior doctors' working hours SHOs were increasingly spending longer in the grade before entering higher specialist training. In London it was taking as long as nine years for UK graduates to gain entry to higher training in popular specialties. Without extensive experience, a higher degree and a good publication record, it was not possible to advance in most of the surgical specialties. Progress was quicker in shortage specialties, although certain specialties such as public health, rehabilitation and general practice drew a substantial proportion of recruits from those making a late career decision.

4.4 Principles 12 and 14 encourage flexibility in the programmes. A common criticism is that flexibility has been lost. However this hides the opportunities that trainees have as once they have successfully competed for training programmes they then become eligible for inter-deanery transfers, time out for research or overseas experience, or transfer to another specialty. The relative competitiveness of the various specialties and geographies will affect opportunities for flexibility and attempts to address this will potentially adversely impact on service need.

4.5 It should be noted that the principles of MMC do not address systems of recruitment and selection. National recruitment and the use of a national IT system are not an integral part of the MMC reforms. However, selection methods become especially important if selection is to take place early and against global competition. London would favour the development of a single national invigilated test taken during the Foundation years, covering the broad knowledge, skills and attitudes desirable in a trainee within the NHS. Taking this test would be a requirement for all applicants whether from inside or outside the UK system. The results would be known to the applicant and would form the basis for short-listing for specialty selection, supplemented as necessary by interview or specialty specific selection centres.

5. *To what extent have the practical implementation of MMC been consistent with the programme's underlying principles?*

5.1 The first stage in the MMC reforms was the introduction of the Foundation Programme, which was done according to the principles of MMC. Three features made Foundation Programme implementation successful: 1. Pilots; 2. Funding to support the reforms; and 3. A match between the number of posts and the number of eligible applicants, so that all eligible applicants were appointed into the new structure.

5.2 The implementation plan for specialty training occurred during a time of financial stringency. It too depended on there being a reasonable match between the number of applicants and the number of training posts. This in turn depended on those without right of residence in the UK being excluded from the first round of application. When this proved not to be the case, and it became clear that over a third of applicants would be unsuccessful, including many UK graduates, support for the reforms evaporated even among those who had helped to plan them.

5.3 The problems with recruitment and selection should not overshadow the main thrust of the reforms. Each curriculum has been overhauled, in consultation with the service, to standards set by PMETB. New strategies for assessment are being developed. Educational technology has been used to develop e-portfolios and e-learning packages to support the curricula. New programmes have been forged from collections of standalone SHO posts and educationally unapproved trust doctor posts. The number of training posts available in England has risen by over 1,000. In London alone, 250 trust doctor posts were accepted for conversion to new training posts identified by Trusts to support current and future service requirements.

5.4 The problem of an excess of doctors in basic surgical training or surgical SHO posts was well recognised, and a good deal of effort was expended in career counselling services to persuade these trainees to seek a career change in Round 2 of the recruitment process if unsuccessful in Round 1. What was never envisaged was that competition from international medical graduates in non-training posts and those applying from outside the NHS would mean that many F2s and SHOs in training in July might be left without a training post in August.

6. *The strengths and weaknesses of the MTAS process*

Strengths

6.1 In previous years London hospitals had received up to 1,400 applications for a single post, and a comparison between two hospitals showed that 50% of their applicants were the same people. Hospitals resorted to considering only the first 100 applicants, or applying some other random way of reducing the numbers. Those known to the hospital were more likely to be considered. MTAS in contrast offered one national electronic portal; one standard application form per specialty/level; just 17 units of application, and a limit to just four applications per applicant.

6.2 Standard documentation helped to ensure consistency of standards across the UK.

6.3 The electronic application made it easy for applicants to apply, wherever they were in the world and ensured that data was uniform and could be collected and analysed effectively.

6.4 Both applicants and London Deanery staff found the interview booking system was excellent providing choice to the applicant and streamlining interview schedules.

6.5 Applicants with multiple offers would be offered their highest preference.

6.6 The linked application system was appealing to couples.

Weaknesses

6.7 The consequence of offering all applicants four choices, while interview capacity was limited, was that the highest scoring applicants were offered multiple interviews, while nearly half had none at all, and the fill rate for posts after Round 1 was predicted to be not more than 40%, wasting the time of consultant panellists and creating anxiety among those not selected for interview.

6.8 The original algorithm would have maximised the number of applicants getting their first choice, so that those unsuccessful in their first choice might well have been displaced in their lower choices by lower scoring applicants. This is what happens in Foundation. It is only effective if there are enough jobs for everyone.

6.9 Applicants who would normally have tried again for what they really wanted included "insurance" choices in their applications and were disappointed when they found that they had to accept them or be out of the system.

6.10 The system was intended to be a "national electronic portal with local implementation" but in reality was centrally controlled, with a tight national timetable, and very little freedom to respond to local problems.

6.11 There is some limited evidence that the "white space" questions on the application form were too easy to plagiarise, invent, or write according to formulae available on at least one guide available in the internet. Consultants in London who had scored the same question for hundreds of applicants complained of the formulaic responses and were not confident that they were able to select the best applicants on this basis.

6.12 NHS London commissioned external audits of both Round 1a and Round 1b recruitment processes in London. The audit reports found that the processes of longlisting, shortlisting, interview and integration of scores were carried out in accordance with national guidance and with no more errors than might be expected in any such large scale undertaking.

6.13 NHS London will commission a further audit of Round 2 recruitment once complete.

7. *The degree to which current plans for MMC will help to increase the flexibility of the medical workforce*

7.1 Flexibility within a managed programme is a feature of MMC as described in the Gold Guide. The practicalities have not yet been tested, but in London the breadth of opportunities means it should be achievable. However, flexibility will tend to increase rather than shorten the duration of training (please see para 4.4.).

8. *The roles of the Department of Health, Strategic Health Authorities, the Deaneries, the Royal Colleges and the Postgraduate Medical Education and Training Board in designing and implementing MMC*

8.1 We will confine our response to the role of the NHS London and the London Deanery.

8.2 The Deputy Dean Director was seconded as national clinical lead of MMC. London Deanery was represented on the COPMeD Steering Group. The Dean Director of London was Chair of COPMeD from July 2006, and in this position was a member of the UK Strategy Group and MMC Recruitment Board, and later of the Douglas Review Group.

8.3 The London Deanery managed local implementation of the national recruitment process and timetable, but was dependent on MTAS for documentation, application forms and reporting.

8.4 NHS London (the Strategic Health Authority for London) was in place from 1 July 2006. In the autumn of 2006 the SHA sought a London view of the impact of MMC. From this point the SHA became closely involved with the Deanery on how the 2007 transition year would be managed. In particular the SHA was concerned about the logistical problems London expected to face. A joint Programme Board of the SHA London Deanery, and London Trust representatives was set up to oversee the 2007 recruitment process in London in April 2007.

Dr Anne Rainsberry
Director of People and Organisational Development
NHS London

Professor Elizabeth Paice
Dean Director
London Deanery

October 2007

APPENDIX 1

THE 16 PRINCIPLES OF MMC

1. The end product of the training process, whether a hospital doctor or a general practitioner, should be a high-quality, well-trained and accredited doctor who can deliver the care and treatment patients need in the modern NHS.

2. Medical training will take account of the training and development of other health service staff. It will prepare doctors to work in multi-profession settings and employ shared learning and cross-professional training where necessary.

3. All postgraduate medical training should be organised in structured programmes (usually a series of co-ordinated placements) with progress monitored against clear curricula. In general, assessment should be competency-based and should he focused on outcomes with the ability to perform as the underpinning competence.

4. Training should be applied to clear, consistent UK-wide standards.

5. Programmes should be designed and managed to ensure that trainees complete them in the minimum necessary time. There should be explicit career pathways and explicit career goals.

6. Individual programmes should be available to meet individual needs.

7. Training should as far as possible be seamless and conducted within a grading structure which supports this process.

8. Training must be supported by strong educational management and underpinned by skilled trainers.

9. A clear structure is necessary to encourage and support the development of academic, research and teaching skills and to support those who opt for an academic career.

10. Programmes should be broadly-based at first and lead on to greater specialisation where appropriate.

11. The responsibilities given to doctors completing training should match their skills and competencies. Similarly, doctors in training should be able to take on progressively more responsibility as they are assessed as acquiring the competencies needed.

12. Training should be trainee-centred and programmes should reflect a variety of career choices, from those who decide on a particular career early on to those who need more time to do so and to those who want to train part-time. Individual programmes should be available to reflect individual needs.

13. Rigorous counselling and career advice should be available throughout training.

14. New training structures must allow trainees to change training programmes according to service need with the minimum duplication or retraining.

15. Programmes should be designed to suit the needs of overseas doctors who may enter training at a number of different levels and in a number of different ways.

16. The development of new training structures, programmes and the delivery of training itself must be effectively quality assured.

Memorandum by Professor Alan Crockard (MMC 33)

MMC

Executive Summary

— For generations, most of the day to day acute and routine patient care was delivered by junior doctors with variable training and uneven supervision within a Consultant led "firm".

— External drivers, such as the European Working Time Directive changed this structure and put at risk the "apprentice based" training system.

— Modernising Medical Careers arose from the NHS Plan (2000) and the Chief Medical Officer's "Unfinished Business" 2002 which identified the Senior House Officers (SHO's) as the work horses of the NHS and the "lost tribe" in terms of career structure. A small team under the direction of Deputy CMO was created in 2003 and successfully delivered a two year Foundation Programme in 2005 which exposed junior doctors to six specialities including for the first time general practice. The curriculum was competency based with explicit standards.

— Following this, a radical change in Speciality Training was inevitable and the Post Graduate Medical Education and Training Board (PMETB) adopted the some competency based framework for all speciality curricula to begin in 2007.

— The complex interrelations between standards, training methods and workforce requirements were underestimated. These included:

  I. Transition arrangements to cope with experienced SHO's in approved training posts in the old system.

  II. Eligibility criteria for doctors working with the NHS in non training posts, for the new run through training.

  III. There was an interdepartmental debate without clear policy on the future of International Medical Graduates (IMG) and the status of Highly Skill Migrant Population (HSMP) which potentially doubled the number of eligible applicants.

  IV. A new online recruiting system, Medical Training Application Service (MTAS) was rushed in, largely untried, and with a completely different philosophical approach to applicant ranking, which confused and frightened applicants. There were technical failures and security issues.

— There was no clear overall management lead in the Department of Health (England) DH. There were two separate Senior Responsible Officers (SRO's) for MMC and MTAS. In a United Kingdom context, there was a MMC UK Strategy Group run by the four nations CMOs, in England day to day input was from DCMO.

— There was wide consultation with stakeholders from the beginning, and, in the early days, acceptance of the proposed MMC reforms. The online recruiting system failure accentuated the many doubts about the original philosophy on which MMC was based. The whole system has been thoroughly examined by Professor Sir John Tooke.

Medical Training—The Need for Reform

1.1 Central to hospital healthcare delivery for several generations has been the work of the junior doctor. The original workforce model was one of relatively few senior "consulting" staff who were highly trained and experienced and who provided an undefined amount of junior doctor supervision. Most of the day to day routine patient care, including the bulk of active medical care, was provided by junior doctors. These doctors would be employed either in the grade of "SHO" or, more recently, as "Trust Doctors" who held similar levels of experience to SHOs, but received little, if any, training.

1.2 The original system was accepted by junior doctors as it allowed them a period in which they could use short term contracts to explore career and life style options before committing to a specialist career. The reality was that it allowed some to dream of being a cardiologist or a plastic surgeon without spelling out that their chances were less than one in 10. This meant that the majority would be forced to realign into a less competitive speciality in the following five to seven years. In these cases, only some of their previous training counting to their ultimate career pathway.

1.3 Senior medical staff also liked the system as it provided a huge pool of enthusiastic applicants from which to choose their support staff without any long term obligation. For employers, this system also offered advantages. It meant an abundance of staff prepared to work on short term contracts and easily obtained locums, all of which could be provided at the low end of the pay scale.

1.4 The obvious concern was that many of the junior doctors were not trained for the roles which they were being asked to perform, and an increasing body of evidence pointed to the simple fact that outcomes were better when patients were treated by a trained doctor. This was reflected in the public expectation that they would be treated by trained doctors, and in changes in the number of medical malpractice claims which has soared, 80% of which are aimed at the most junior medical staff.

1.5 As well as this clinical driver for reform, external factors also began to impact adversely on the existing system but the changes occurred too quickly for the "apprentice" training model to accommodate. These are:

1.5.1 The European Working Time Directive (EWTD) disrupted hitherto accepted long working hours necessary for "on call" rotations. So the employer appointed more SHO "look-alikes"—the Trust Doctor, for whom there was no obligation to train or long term employment.

1.5.2 The Hospital at Night initiative developed to counter 1.5.1 has undoubted benefits but disrupts the original "consultant firm" for patient care and training.

1.5.3 Medical demography shifted as the majority of UK Medical School output became female, driving different life style aspirations to previous generations.

1.5.4 Technology and changes in disease patterns impacted on the system. Open operations on the heart and blood vessels and urinary systems were being replaced by catheter techniques which are the domain of radiologists and physicians, not surgeons. These changes occurred faster than the slowly evolving workforce model could react, resulting in fully trained but unemployed surgeons.

2. *Origins of MMC*

2.1 The origins of MMC began with the realisation that SHO's were being treated as the "work horses" of the NHS and that this must change (2000). MMC was one part of a wider "Agenda for Change" which was intended to reform the NHS workforce, but it was never linked or closely coordinated to the main reform programme. Instead, the CMO's review "Unfinished Business" 2002 identified a "lost tribe" of SHO's and set out a series of changes to the early stages of medical training to ensure that all new doctors were assessed as being competent to treat patients, and that all doctors were given opportunities to explore different career paths without compromising their chances of being accepted into a competitive specialty or training location.

2.2 The MMC Team under DCMO came into being in 2003, to lead the thinking and spearhead the production of well trained doctors to treat patients in a world of rapid technological advances and altering disease patterns and a shift to female majority junior doctors.

2.3 The MMC Team's role was to raise awareness of the need for change, to consult widely and develop educational ideas within PMETB guidelines. New training and workforce rotas would be implemented through Royal Colleges and speciality bodies and the Post Graduate Medical Deans, with whom there was wide consultation and close collaboration.

2.4 The MMC Team delivered successfully the two year Foundation Programme allowing exposure to six specialities in a two year period and with a competency based framework. The training and assessment within the Foundation Programme shifted away from (implicit) opinion to explicit measurement of fitness to deliver care.

2.5 The inevitable "knock on" effect of this programme was that speciality training would also have to change. While intellectually accepted by all, it was apparent that there would be wider problems to resolve in order for a streamlined training pathway to be introduced. While the MMC team set about escalating the need for change, it was only as the deadline approached for August 2007 that the pragmatic and emotional implications were generally understood.

3. *Unresolved Issues*

In addition to the external factors (1.5) there were a series of unresolved policy issues which made workforce predictions very difficult for the MMC training pathway, resulting in double the applications for the planned training positions.

3.1 UK Medical School expansion was a policy to provide a largely self sufficient supply of doctors with the potential for doubling output by 2012.

3.2 EU Medical Graduates had the right of migration to the areas of best remuneration and conditions. Junior doctors here are amongst the best paid in Europe.

3.3 International Medical Graduates (IMG's) were part of a wider debate between the Treasury, Home Office and the Department of Health. Was the aim to train and then return to their country of origin? Was it a way of providing already trained doctors to fill vacant posts? Was it a means of driving down the wage bill?

3.4 Training (Specialist Registrar SpR) and non Training (Trust Doctor) posts raised issues for MMC; there were no instructions to consider all for training. Numbers of the former were regulated loosely by the number of predicted Consultant vacancies (Calman). Employers however could and did appoint Trust Doctors on short term contracts to fulfil clinical roles. The exact number thus employed were difficult to find (the number of part time trust doctor was not ever documented).

3.5 Transition (2007–12). The effect of a step wise change from the former system left many senior SHO's outside a run through system designed for the products of Foundation Training. This was particularly the case in the competitive specialities.

3.6 Another concern was the "four country" dimension. While it made sense to seek a UK wide approach, MMC was being developed at a time when the devolved administrations were exploring their own independence and specific local workforce requirements. This delayed decisions and adversely affected planning.

3.7 Centralisation or regionalisation is an ongoing debate with a major impact on the model of training.

4. *Personal Reflections*

4.1 DH leadership was late in appreciating this complexity involved with MMC.

4.2 I am uncertain as to when the DH Management Board even became aware of MMC; probably not before the Minister, John Hutton approved and backed financially, GP training in Foundation Programmes (late 2004). There was a clear dichotomy between the education/training role and workforce needs which resulted in two separate senior officers (SRO's) in charge of MMC and MTAS without close working of their teams. I am also uncertain how aware politicians and senior DH were of warnings such as the RED status awarded to the MTAS project by the Gateway review team (GATEWAY 331) in August 2006. I doubt they were also informed of the missed "drop dead" dates in December 2006.

4.3 In retrospect, I think that the role of the MMC Team was being reduced from late 2005 as the MTAS project grew. In the last few months of 2006 and early 2007, I considered that standards and educational principles had been subsumed in a workforce planning and rota crisis. It was with deep regret I tendered my resignation in March 2007.

Focus of Committee's Inquiry

5. *What are the principles underlying MMC and are they sound?*

5.1 Principles underlying MMC.

5.1.1 Improve patient care by:

- Aiming for more healthcare delivered by trained doctors.
- Moving from implicit to explicit standards of training.
- Adopting a competency based training.
- Incremental stages in the training journey.

5.1.2 Create a more relevant training system:

- To take account of changes in patterns of disease and medical technology.
- To work in multi-professional teams.
- Distinguishing the urgent and acute from longer term problems.
- Understanding care from community to specialist unit.

5.2 Are the Principles Sound?

5.2.1 The problems of the past were:

- The apprentice based training produced replica of the teacher. Some were brilliant; some far from good. A competency based system would produce a levelling up nationwide.

— The silo system of subspecialisation would blinker the trainee to developments in treatment for a condition from a different medical discipline eg endovascular catheter techniques by radiologists for blood vessel diseases might not be emphasised in surgical vascular units.

— The importance of prevention and a community healthcare approach might be missed in an intensive care teaching situation where only the end result of a 20 year pathological process is seen.

5.2.2 The principles in 5.1 would address these examples.

The approach was completely in line with developing the Medical Education approach of the Canadian system CANMeds which has influenced medical training in Australia and latterly in the US.

6. *Has the Practical Implementation of MMC been consistent with underlying principles?*

It is important to state that Foundation is well bedded in now. For many individuals and in some specialities eg general practice, the system worked well.

Foundation—The MMC Team made every effort to ensure a smooth introduction of the Foundation Programme (August 2005 and following years), by supporting and managing the implementation work of all the stakeholding groups. For example, coordination of the Academy of Royal Medical Colleges group produced the Foundation Curriculum; as a result, preliminary research by Sheffield has shown that the trainees were better versed in the Curriculum. In addition, the few "potential failing" trainees have been detected early. Work with the postgraduate deans ensured that opportunities were clear and all eligible UK Medical Graduates were successfully placed although initially there were problems with those students and teachers who did not get their first choices. The benefits of Foundation Training has been supported strongly by Hays from Queensland (BMJ 331, Sept 2005 456–6).

Speciality Training

— MMC (as the facilitator) and PMETB (as the legislator) worked very closely together.

— MMC influenced the standards agenda, competency based training and the development of appropriate speciality curricula.

— MMC working closely with many organisations including Postgraduate Deans, Royal Colleges, BMA Junior Doctors, Employers. MMC employed sessional basis representatives from the first two; it met on a regular basis with the latter in various committees. It is noteworthy, that a previous BMA JDC had campaigned for "run through training" 2001 (a discussion paper on an integrated training system for junior doctors). Alternative career paths were proposed by MMC, similar to the proposals that have now come out of the Tooke review, but the MMC team received little support from the profession to consider an alternative career structure.

6.3 Practical Implementation:

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

— Most of the organisations were used to the old ways of workings. For many the change was too fast and too large.

— While there had been very few objections to the principles, it was the effects of selection/recruitment problems which polarised huge numbers. The difficulty in reaching a consensus was too much for many to come to terms with and many significant issues were not resolved.

— It is important to stress that for many individuals and some specialities eg general practice, the system has worked well.

7. *Strengths and Weakness of MTAS Process*

The MTAS application system was not developed as part of MMC, rather it was developed in the workforce directorate in the DH under a separate Senior Responsible Officer. Once introduced, however, it was impossible for MMC to proceed independently and the MMC team did as much as they could to work with the introduction of MTAS. The ongoing problems with MTAS were a constant embarrassment to MMC, but beyond the team's influence to do anything. The eventual failure was placed at the door of MMC and damaged the programme irretrievably.

I think, but have no direct evidence, that DH viewed the introduction of MMC as an opportunity to include doctors like other healthcare staff in "NHS jobs". There had been various contracts with outside bodies for portions of this: this seemed to be a good opportunity for incorporating the doctors.

7.1 Potential Strengths. The idea of an initial application system being delivered online had many benefits and had been successfully implemented in the US. The idea has a number of advantages:

— National Recruitment to nationally agreed standards for each speciality.

— Impartial open and transparent recruitment and selection, removing all hint of patronage.

— Being able to plan the number of training posts nationally in a particular speciality.

— One electronic portal to many job opportunities in four countries.

7.2 Weaknesses. The greatest weakness were in poor management and control of the implementation by the SRO. As a result:

— The "Rules" governing selection occurred well after deadlines, with decisions being taken hours before the system went live.

— The selection criteria and design of questions was inappropriate and did not do enough to distinguish applicants at a key stage in their careers. Those with the very highest achievements, including PhDs, received little acknowledgement.

— The actual questions which might have been appropriate for selection from Foundation were inappropriate to many of the highly experienced and qualified SHO's in Transition.

— There were no obvious academic cross references in the literature to justify the particular format chosen.

— There were inconsistencies in the ability to "roll out" at individual deanery level.

— There were few direct links with MMC and little "joined up" working.

8. *Lessons in Project Management for DH*

— This was an extremely complex project, and more complicated than its instigators realised. Whilst it was conceived as a way of improving and streamlining junior doctor training, it was complicated by lack of clarity at DH Board level and ongoing confusion about wider government policy on immigration (IMG's), on costs (MPET), on central or a regional "roll out" (SHA) and the lack of a national management system for postgraduate deans.

— Never should a project have two SRO's overseeing two parts of the same project.

— Ensure the project is supported from the Top. It is my belief that DH management board had no concept of the implications of MMC.

— CMO and Director of Workforce (2004–06) saw the project from different perspectives. The latter, having been part of the Consultants contract and GP contract negotiations was clearly concerned about the resource implications of MMC.

— Intergovernmental (Treasury, Home Office, DH) discussions are essential to avoid confusion and delay.

9. *MMC and the supply and demand of junior doctors*

Unless and until DH Board and Senior Management had come to a view on these issues it was impossible to direct the MMC Team to design a training programme and then instruct the MMC Team of the general guidelines.

Many Trusts appeared to prefer well trained imported doctors who would be prepared to work at perhaps a lower wage, than setup a structured training programme for UK Medical Graduates.

Another factor has been that different specialities and Royal Colleges have very different views on IMG; some acknowledge that, without them, their service would collapse.

10. *Will current plans for MMC increase Medical Workforce Flexibility?*

This is a very difficult question and in the present state of affairs the short answer might be "No". All parties have retrenched and there is little room for compromise.

10.1 There are wider issues. For example, what is flexibility? To move around the country? To retrain in another speciality? To work at a lower salary? Flexibility of medical workforce might mean a rigid training programme.

10.2 The second issue is the main thrust of MMC. Is it better "fit for purpose" training to provide better patient care? Or is it a method whereby certain skills are imparted locally to plug a local knowledge gap.

Clearly, a properly instituted MMC plan could be enormously valuable to provide a "fit for purpose" workforce, but the open debate has yet to be had.

11. *Roles of DH/SHA/Deaneries, Royal Colleges and PMETB in designing implementing MMC*

The original MMC concept predated SHA and as they may have a short life it is difficult to see what their role should be. Also the central/regional issue needs to be addressed.

So the question might be, should there be MMC Mark 2? Or should MTAS be abandoned?

It should be stated that initially all Royal Colleges "signed up" to MMC. They have only reverted when it became clear that MTAS would not deliver.

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Former National Director, MMC (England)
Victor Horsley Department of Neurosurgery
The National Hospital for Neurology and Neurosurgery

October 2007

Memorandum by the Committee of General Practice Education Directors and the Society for Academic Primary Care (MMC 34)

MMC

What are the principles underlying MMC and are they sound

The underpinning principles of MMC are that education and training should be managed, systematic and provided in a safe clinical learning environment. We believe that these are very sound.

To what extent the practical implementation of MMC has been consistent with the programme's underlying principles

The Foundation Programme established the principle that all doctors need a defined set of generic competencies to form a strong foundation for their subsequent speciality training. The programme also enables them to start developing their professionalism in the real workplace.

The original intention was that all doctors should spend at least four months in general practice to gain community based competencies, to understand the patient's illness within their home environment and to experience the delivery of primary care and its interface with secondary care. Unfortunately this key intention has not been implemented across the country. The number of doctors who have the opportunity to take up such a post varies from 25%–95% across the UK. It is difficult to see how some of the primary care generic competencies are being achieved and assessed. Over half of all doctors graduating from the Foundation Programme are denied vital early clinical experience of caring for patients in their usual community based environment. As a result, they are denied the opportunity to see natural history, care pathways, multiple morbidity and chronic disease management.

A research study proposed by COGPED to MMC Foundation has faltered because of the breakdown of the old MMC team and funding stream. This work would have investigated the utility and effectiveness of foundation training in general practice. However, early feedback from the first cohort confirm the evidence from previous PRHO in GP studies, that GP is a good learning environment, FY doctors get higher levels of supervision and they gain the required competencies.

It is disappointing that the implementation of the Foundation Programme component of MMC has been only partially successful.

Run-through training has required all specialities to define the curriculum that will deliver a Certificate of Completion of Training confirming that the holder is competent to work in the NHS as an independent practitioner. The training curriculum for general practice was developed by the Royal College of General Practitioners and was one of the first to be approved unconditionally by the Postgraduate Medical Education and Training Board. It is based on an integrated three-year programme with placements in both primary and secondary care. It is a significant improvement on the previous patchwork of time spent in hospital posts in (often unrelated and sometimes irrelevant) different specialties and a year in general practice. Unfortunately it has not been possible to extend the period of training in general practice beyond the current three years—nor is it yet clear whether the general practice phase of training will be extended from 12–18 months in all deaneries. Failure to implement this change will undoubtedly compromise the implementation of what is widely regarded as one of the most complex and challenging of all medical disciplines—and may adversely affect future workforce requirements. In addition, European legislation allows more flexibility in specialty training for hospital specialties than it does for general practice. This legislation needs to change if we are to train GPs to be fully fit for purpose. MMC could have tackled these issues—but it has not and, from a general practice perspective, could therefore be seen as a significant failure.

In the past seven years COGPED developed Higher Professional Education to respond to newly qualified GPs reporting that they did not feel confident to manage many clinical situations in primary care and to manage health provision in the community. A two-year programme supported by DH funds was developed with newly certified GPs learning in supported systems whilst working in a substantive GP post. A formal external evaluation demonstrated the effectiveness of the programme just at the time the DH decided to withdraw funding. Responsibility for such training was transferred to the Primary Care Trusts—who were only expected to implement it if it fitted their local retention agenda (and this at a time when they were required to make savings in their budgets).The original proposal to the MMC team was that GP training should be for five years with three years leading to CCT and a further two years developing experience and wider knowledge and skills relevant to their own practice and local circumstances in HPE. The latter could also fit with local PCT objectives around the development of GPwSIs and Commissioning a Patient Lead NHS. These together would deliver the other principles of MMC, namely educational and clinical supervision, working within competence levels, judgement safe with a clear route to CCT and post CCT training; all within the environment of care being delivered by trained and competent clinicians. We still strongly support these principles and look forward to their being the basis of care and training in the NHS.

Run-through training for Academic General Practice

General practice academic training has benefited from being allocated Walport Academic Clinical Fellowships at six university departments. The framework for applications has used the model of hospital specialist training and this has produced several difficulties for general practice.

The original issue stemmed from the three years /25% model for specialist training. The fellowships have however been integrated into the clinical programme resulting in a CCT at the end of four years, by adding an extra year of training.

The Walport Clinical Lectureships enable more senior academic trainees to move on from their PhDs, consolidate their work and apply for higher academic awards. For general practice, those in the ACF grade gain their CCT when they finish and are thus no longer entitled to trainee status. They have to seek employment in practices or with local PCTs (the latter being very unlikely) to ensure the clinical element of the Clinical Lectureship.

These posts, if filled, will produce a significant proportion of the clinical academics for departments in the future. However, it bypasses a large group of GP clinicians who provide service but have academic interests in education and research: indeed, many of these are now in high academic positions especially in educational roles. The "In Practice Fellowships" are one way of bringing this group back into academic work, especially on the research side.

Recent changes in the research funding streams have focused funding into departments with substantial portfolios supported and delivered by researchers with the pre-requisite research qualifications. We feel this is creating a research/service divide and could potentially diminish the pool from which future educational academics are drawn. We would advise MMC and Walport to seriously consider the career pathway for medical education not only in GP but also in hospital medicine. Whilst this is not within the pre CCT MMC agenda it does impact on the post CCT agenda for GP and it has certain impact upon supplying educational leadership and delivery for the future.

The strengths and weaknesses of the MTAS processIt is important to distinguish between the principles of MMC, which included selection, and the selection process itself. We also would like to separate the process from the system that delivered it, MTAS. The principles and guidance for the selection process have been published by PMETB. General practice had started to develop its selection process (PMETB compatible) seven years ago. It is based on defined behavioural competencies that are required to train for and become GPs. The assessments of these competencies were then designed, tested and applied. Over the last few years each deanery has worked towards a UK national process which is described in detail on the GP National Recruitment Office website http://www.gprecruitment.org.uk/faqs/index.htm . The design and development continues as part of one of the COGPED work streams. Although a national process, we are trying to see how we can develop a degree of local ownership whilst preserving national standards. In 2006 we delivered the process through an online system, Konetic, which enabled deaneries to drastically reduce their administrative support and paper wastage. We are asking the DH to permit General Practice to return to Konetic while MTAS is piloted and made fit for purpose. Despite several rule changes within the MTAS system, the GP process was robust enough to deliver appointments into all vacancies across the UK. Whilst the GP process is not perfect, nor indeed fully developed, the principles of:

1. defining competencies,
2. designing appropriate assessment methods set to national standards,
3. piloting and validating, and
4. to be delivered online

are applicable to any speciality in medicine.

What lessons about project management should the Department of Health learn from the failings in the implementation of MMC

Design a process that will deliver an agreed outcome.

Pilot the process and validate the tools / methods of assessment.

Apply the process by the most appropriate system, if online ensure that that itself is piloted for system problems.

Be prepared to be patient to get the right result.

Appoint a project manager who is clearly identified as the responsible officer.

The extent to which MMC has taken account of the supply and demand of junior doctors and the number of international medical graduates eligible for training in the UK

Workforce planning needs to fit with national and local strategies. A major weakness of workforce planning has been that its periodicity for all of the medical specialties exceeds that of governments by at least a factor of two or three. The decentralisation of workforce planning takes no account of national strategy, small specialties, advances in medical care, new working patterns developed by professionals and educational requirements of UK wide regulatory bodies. Given its weaknesses a central process to collate and make sense of the complexity is vital to ensure at least partial strategic delivery and act as early warning for potential problems.

There appears to be a lack of commitment of some Strategic Health Authorities to engage in any process that takes account of national training or workforce needs. Although advised that the DH performance manages this activity by SHAs it is difficult to see any evidence of this.

The issue around international medical graduates is, frankly, a shambles—and serves no one's interests. The issue are well articulated by Winyard in the British Medical Journal 22 September 2007. This issue needs to be sorted out as matter of extreme urgency.

The degree to which current plans for MMC will help to increase the flexibility of the medical workforce

There are several ways of interpreting flexibility.

— Flexible, that is less than full time working, is more an HR issue than an educational one. If it is national policy to encourage more less than full time working then the employers rather than the educators will have to be encouraged to fund it. If there is to be less than fulltime working, it is obvious that more individuals are needed than the whole time equivalent number. With the increasing number of women in medicine this issue cannot be ignored for much longer.

— It is not easy to allow flexibility across training lines when each speciality has a defined curriculum. It is unlikely to increase until the service is delivered largely by fully trained professionals and the curricula are designed to work across specialities. There are some examples of this and more can be envisaged—but will require more work.

— A well educated workforce can as now adapt themselves flexibly to new ways of working, new advances in treatments and care and new professional regulation, this might not happen with such ease if they are just well trained.

The roles of the Department of Health, Strategic Health Authorities, the Deaneries, the Royal Colleges and the Postgraduate Medical Education and Training Board in designing and implementing MMC

All four Departments of Health should be designing the strategy and ensuring sufficient resources to allow the strategy to be delivered. The departments need to work much more collaboratively.

The SHA as the NHS in the regions in England are the bodies to facilitate the strategy by adapting their current plans and resources.

The deaneries in collaboration with the SHAs, PMETB and the Royal Colleges should operationalise the policies that will deliver the strategic aims.

Arthur Hibble
Chair of Committee of General Practice Education Directors

Amanda Howe
Chair of Society for Academic Primary Care

September 2007

Memorandum by the BMA (MMC 35)

The British Medical Association is an independent trade union and voluntary professional association which represents doctors from all branches of medicine all over the UK. It has a total membership of over 139,000.

EXECUTIVE SUMMARY

- The BMA responded to the Tooke Inquiry on MMC and encloses its response with this evidence.[31] The BMA also sits on the MMC Programme Board and communicates the views of doctors through four elected representatives that are members of the profession.
- The BMA has been appalled at the rushed implementation of Modernising Medical Careers in 2007 and called for a delay in implementation in 2006. However, the original principles behind the reform in specialty training are supported by the BMA. It is important to highlight that what was originally envisaged has not materialised and it is now necessary to assess, define and establish the training pathways of the future.
- The haste with which MMC was introduced severely hampered any opportunity to introduce any of the principles behind the reform. It is clear that despite the warnings from the BMA, the Department of Health moved forward with a programme that did not have the full confidence of the profession or other stakeholders. It is also important to note that implementation in the devolved nations was not as problematic; the reason for this has been attributed to strong professional engagement and the realisation that this should have been a transitional period. However, it was unfortunate that some decision makers in England ignored the impact that some of their policies would have on the devolved nations.
- The BMA is gravely concerned that the principle of flexibility has been eradicated from plans for the future of training and would like to see a greater emphasis placed on pathways for re-entry to training, whether it be from research, fixed term specialty training appointments (FTSTAs) or the staff and associate specialist grade, as well as more focus on flexible training opportunities for trainees.
- A national recruitment process can have its rewards; mainly it helps the applicant access more opportunities with lower levels of administration and reduces any local bias. The hurried implementation this year has highlighted the problems of an online system and has seen the profession lose faith in a computer system that failed to deliver a fair selection process. The recent consultation by the MMC Programme Board recognised that a computer portal could not be implemented for 2008 but is a possibility for 2009 subject to stringent piloting.
- The inclusion of the new Academic Clinical Fellowship posts in the MTAS system was a mistake that contributed significantly to the low fill rate of 57% and has further compounded recruitment to academic medicine. Academic posts should be disaggregated from clinical training posts, and recruitment should preferably take place before clinical training. Proper information should be made available to all trainees about an academic career.
- In future, as clearly pointed out by the Tooke Inquiry, the Department of Health must actively engage with the profession and heed constructive comments and advice rather than seeing them as a challenge to their authority, whilst effectively communicating decisions to those they affect.
- It is evident that ineffective workforce planning has hindered the implementation of MMC, and this was a principal finding of the Tooke Inquiry. The BMA continues to highlight the needs for effective workforce planning, where workforce patterns are based on need and not artificially restricted on the grounds of affordability. It is also essential to take into account current and planned medical school intake, coupled with future migration and immigration.
- The recent report by the Tooke Inquiry is an academic critique of the Government's failings this year. It has made many recommendations, all of which should be considered in the short and medium term, allowing us to reassess the future of the profession as a package. In order to do this, the BMA intends to conduct a survey and hold a conference on the recommendations which will assess the views of the profession on the future of medical training.

What are the principles underlying MMC and are they sound?

1. The original principles of MMC were first cited in "Unfinished Business: Proposals for Reform of the Senior House Officer Grade, 2002", a report by the Chief Medical Officer, Sir Liam Donaldson. These were that:

- training should be programme-based;
- training should begin with broadly-based programmes pursued by all trainees;
- programmes should be time-limited;

[31] Not printed

— training should allow for individually tailored or personal programmes;
— arrangements should facilitate movement into and out of training and between training programmes.

The BMA supports these original principles and has been dismayed that the current implementation deviated so widely from these.

2. In addition, the "seven pillars" of MMC were first written in "Modernising Medical Careers—the next steps, 16 April 2004". These stated that training should be:

— trainee centred
— competency assessed
— service based
— quality assured
— flexible
— coached
— structured and streamlined.

Whilst the principles outlined above continue to have strong support from the BMA, there is a need to reinforce, review and better define them and to ensure that more than lip service is paid to observing them.

To what extent has the practical implementation of MMC been consistent with the programme's underlying principles?

3. The speed of the introduction of Modernising Medical Careers has seen the majority of the principles ignored.

4. The BMA thinks it is utterly unacceptable that only two of the seven pillars remain standing. These are that training is service based and quality assured (by the Postgraduate Medical Education and Training Board). Through expediency, the other five have fallen by the wayside. Most concerning is the loss of the pillars stating that training should be trainee centred and flexible.

5. The concerns and needs of trainees have been ignored. Corners were cut despite several warnings from the BMA's Junior Doctors Committee. The supporting document "A Call for Delay" foresaw the problems that came to light. Unfortunately, these warnings were not heeded despite being repeated.

6. The most important principle that does not feature in MMC is flexibility. The possibility of movement into and out of training and especially between training programmes, a vital component of a settled and well-qualified medical workforce, has been eradicated.

7. Indeed, trainees have not been given the ability to change specialty—including a change to general practice—during their programme if they discover that the initial training path is unsuitable for them. A "one size fits all" approach does not suit every specialty and separate basic and higher specialist training could be of practical benefit for junior doctors and the profession as a whole. These avenues have not yet been explored.

8. There are many other factors affecting flexibility. Pre-eminent is the need for doctors to be able to train flexibly (less than full time training). The demographics of the medical workforce continue to change with more and more doctors favouring a good work-life balance. Therefore, this is of utmost importance to them.

9. There is also a need for support for re-entry to training. Many doctors are now in fixed term posts, others are undertaking research and many are staff and associate specialists hoping to re-enter the training grade. Routes for these doctors have not been fully defined despite the original aim of MMC to "open up more opportunities for doctors in other career grades to re-enter training and become a consultant"[32]. The continuing lack of such opportunity continues to be a major deciding factor in doctors' opinions of the shortcomings of the Modernising Medical Careers approach.

10. In addition, the limitations for those looking to embark upon Out of Programme Experiences (OOPEs) have been increased as opposed to removed. There is now little possibility to do this during training which will inevitably detract from the value of academic pursuits, by which evidence based medicine is underpinned.

11. This year doctors have been forced to accept posts in locations away from their family or social networks. This may be due to the restriction on application choices, accepting a lower offer for fear of not gaining a post in their preferred Deanery. The ability for doctors to move location during training for personal reasons has not been fully accommodated.

12. In order to reintroduce the original principles the BMA proposes:

— The ability to change specialty during training
— Access to flexible training should be improved

[32] Section 3.56, Unfinished Business: Proposals for Reform of the Senior House Officer Grade, 2002

— The creation of explicit pathways for re-entry to training

— Simple systems for those wishing to change geography during training

13. The BMA is also concerned that competency based assessment has not come to fruition. The ground work needed for a wholesale change in progression and assessment was not completed and the vision for a database of transferable competencies between specialties is far from being realised.

14. For a detailed description of how the BMA would envisage programme based specialty training programmes, please refer to the supporting document which includes the paper entitled "BMA JDC, The Shape of Specialist Training, 2004".

What are the strengths and weaknesses of the MTAS process?

15. The BMA supported the original idea of a national application process, whilst warning against possible issues that could arise using an un-validated computer system.

16. The benefits of a national system would allow:

— Applicants to complete one form.

— Applicants to remain anonymous.

— Applicants to access more opportunities at once.

— National data to be collected.

— National timetable to be implemented.

— Reduction in local bias.

17. The weaknesses of the MTAS system were:

— IT system could not cope with demand.

— The IT system was not secure.

— Some applications were lost / doctors could not submit applications due to the website crashing.

— The matching algorithm for posts was never tested and therefore not used.

— Long and short-listing criteria were not acceptable to the profession.

— Online short listing functionality was not available at launch.

— Plagiarism detection software was not available.

— Many details were not finalised before MTAS went live.

— Many details were changed after launch eg number of posts available, definition of one Unit of Application.

— Academic achievements and potential were not properly accounted.

— Academic Clinical Fellowship posts were made practically invisible which led in part to very low fill rates (57%).

What lessons about project management should the Department of Health learn from the failings in the implementation of MMC?

18. The BMA urges the Department of Health to actively engage with the profession and to heed constructive comments and advice, rather than perceive any advice as criticism to be treated with suspicion. This echoes the recommendations of the Tooke Inquiry.

19. It is also important for the Department of Health to realise that wholesale change needs timely and careful management and piloting and that reforms cannot be forced through without sufficient and realistic timescales in place and without the buy-in of all those involved in the process. The latter cannot be gained without the "breathing space" for reflection necessary for stakeholders to be assured of the efficacy of changes. At times, stakeholders have seen changes as expedient rather than being convinced of their worth by clear evidence and rationale.

20. Communication between the Department of Health and the respective departments in the devolved nations is vital. Policy decisions affecting all nations should be discussed in detail, and their implications fully acknowledged.

21. In addition, communication with applicants using multiple channels is essential; many doctors and stakeholders were often unaware of changes and/or information relating to the application process. This was compounded by the myriad of changes squeezed into an artificially compressed timescale.

22. A vital lesson is that the lines of accountability should be clearly defined. This prevents multiple conflicting decisions being made and also provides a contact for complaint or enquiry. Responsibility must be accepted.

23. Academic recruitment in 2007 was a failure in part because of the absence of a national co-ordinating body with the authority to provide information to candidates about posts, approve the application forms, devise shortlisting criteria and provide interview guidance. A detailed account of the problems and with academic training and lessons to be learnt about project management can be found in the BMA Medical Academic Staff Committee document entitled 'Clinical Academic Training—a lost opportunity', which was submitted as part of the BMA's evidence to the Tooke Inquiry (see appendix).

To what extent has MMC taken account of the supply and demand of junior doctors and the number of international medical graduates eligible for training in the UK?

24. It is crucial that the training structure under MMC is aligned with transparent medical workforce planning. However, evidence of effective Department of Health workforce planning has not been visible where MMC is concerned.

25. This is highlighted by the fact that over thirty thousand doctors applied for less than twenty thousand training posts—the latter a figure that ebbed and flowed over the course of the recruitment round. The lack of clarity about numbers reinforced in applicants' minds that the whole process was questionable.

26. The BMA believes that in order for the principles behind MMC to be achieved, training post numbers should be established through effective workforce planning, based on need and not artificially restricted on the grounds of affordability.

27. The BMA's workforce modelling suggests that over the period to 2030, the demand for doctors will be broadly met with current planned medical school intake and levels of overall immigration into the training grades. This is dependent on the assumption that doctors in training grades progress to Certificate for the Completion of Training (CCT) levels, and have the flexibility to move between training and non-training SAS grade posts as required to stabilise demand and supply for training and career posts and choice. The current training options put forward by the Department of Health make it likely that UK graduates will not all be successful in obtaining specialist training posts. This would result in a significant loss of investment which the BMA puts at £265,000 per doctor. No plans are apparent to allow for those graduates who fail to achieve specialist training posts to achieve skills and experience which would enable them to follow rewarding careers in medicine and safeguard the taxpayer's investment.

28. If it becomes a reality that the projected output of UK medical schools will not all be successful in obtaining specialist training, the undergraduate and post-graduate education environment should be closely studied to make sure that medical graduates have all the skills required to compete in the wider job market in order to retain their skills in the UK.

29. The impact of immigration of doctors from the EEA has simply not been accounted for or assessed in this process.

30. The BMA's policy on International Medical Graduates is clear; doctors that have been working in the NHS, with HSMP visa status, should be assessed on merit and not on immigration status when applying for posts. It is also the Government's responsibility to highlight the decreasing opportunities available to International Medical Graduates prior to them coming to the UK.

31. The recent change in immigration law has affected many doctors; it was appalling that the Government "offered no opportunity for organisations representing affected doctors to communicate their views about the changes, and failed to comply with its duty to examine the race relations issues involved", as stated in the High Court ruling on 9 February.

32. The change in this law caused extensive confusion for International Medical Graduates applying through MTAS and despite requests from the BMA, clear guidance for this group of applicants was not forthcoming until very late in the day. Even then, the guidance was open to interpretation by individual Deaneries. The current proposals to clarify Department of Health guidance, published on 8 October 2007, "Modernising Medical Careers (MMC) England Recruitment to foundation and specialty training—Proposals for managing applications from medical graduates from outside the European Economic Area" have been given a 10 working day response time in consultation. This is unacceptably short; such compressed deadlines suggest that the Department of Health have not learnt from the experiences of the last two years. Representative bodies such as the British Medical Association have no time to consult those affected, and this reinforces that the lack of reflection referred to above persists.

To what degree will current plans for MMC help to increase the flexibility of the medical workforce?

33. The Tooke Inquiry established that the main paths for flexibility have not been initiated.

34. It is worth noting that the amount of flexibility present within the medical workforce can be dictated by NHS Employers and, for this reason, full engagement of stakeholders is required. This is particularly important in the case of flexible trainees where there has recently been a downturn in the numbers appointed.

35. It is important to note that wider workforce issues are present here and so in addition to the suggestions made for improving flexibility in training for junior doctors, the impact on consultants, GPs, Medical Academics and staff and associate specialist (SAS) doctors should also be at the forefront of discussion. This impact is yet to be assessed, despite wide acknowledgement that junior doctors training cannot be considered in isolation. This has had a specific impact on the SAS contract negotiations.

Please comment on the roles of the Department of Health, Strategic Health Authorities, the Deaneries, the Royal Colleges and the Postgraduate Medical Education and Training Board in designing and implementing MMC

36. The BMA is disappointed that Royal Colleges have not finalised work on transferable competencies and noted the problems caused by the late submission of some specialty curricula and person specifications. Despite promises that work is ongoing, as yet there is little evidence of competency assessment methods or robust specialty specific selection tools. In addition some conflicting stances on workforce planning have exacerbated the numbers of FTSTAs in some specialties.

37. Whilst acknowledging the very tight timescales and high demands placed on Deaneries the BMA is concerned that many used local interpretations of guidance to different extents. This had adverse effects on applicants with multiple job offers, those applying within short deadlines for Round 2 posts, academic applicants and international medical graduates with HSMP and was not sufficient to cope with the demand of arranging the interviews and answering applicants' queries. The provision of careers guidance was also sorely lacking despite acknowledgement that this was desperately required. It has also been noted that deaneries were often inaccurate with regard to job descriptions and in some cases the allocation of rotations within a Unit of Application lacked transparency.

38. Applicants also complained that deaneries did not provide accurate job descriptions for posts and many felt they did not have sufficient information with which to make a very important decision. This led to a non-transparent approach to allocation to rotations within Deaneries. Despite the problematic implementation placing exceptional strain on applicants, deaneries were reluctant to introduce relaxed inter-deanery transfer schemes. A job transfer scheme was introduced but this was very rigid and it was doubtful that this assisted more than a handful of applicants.

39. The Postgraduate Medical Education and Training Board (PMETB) has been noticeably distant from the introduction of MMC, despite their compulsory involvement to reward or reject post approval. However, it is acknowledged that lack of information on the number posts by the Department of Health made even this task exceptionally difficult. It was hoped that PMETB would provide leadership on the standards of selection to specialty training.

40. Strategic Health Authorities were also removed from the process, it was also noted that employers lacked their support when the problems of MTAS emerged.

41. NHS Employers also contributed to the confusion by issuing guidance contrary to ministerial promises. This strengthens the requirement for consistent messages and improved mechanisms for communications.

42. As discussed above, and extensively in the Tooke Inquiry, the Department of Health has many lessons to learn from this episode. If the good will and morale of the profession is to be restored, our substantial, constructive and public warnings must be heeded and the involvement of the profession in any further discussions on subjects which affect us must be paramount.

October 2007

Memorandum by Dr J L W Parker (MMC 36)

This mess has come down to a lot of apologies and the abandonment of MTAS. Otherwise nothing much has changed and a whole cohort of doctors risk having their lives and careers ruined. In the past hospital doctors had competitive interviews every few years in order to gain promotion. This ensured that in general the best qualified and trained people became consultants. With MMC young doctors are being appointed to specialities too soon and will then progress to the top without any challenge or competition. It will lead to complacency and reduce drive and research. What is going to become of the thousands of experienced doctors caught in the middle of this debacle? My son is in his 30's and has a BSC in engineering, an MB.ChB and FRCS. He is now going to find it almost impossible to find a ST3 post in orthopaedics as they will be taken by younger less experienced doctors in MMC posts. MMC needs to be halted for a year to soak up the people who may be unemployed through no fault of their own. Professor Donaldson has primary responsibility, but has kept his head down and his mouth shut. It is now time for him to stand up and be counted or resign. He needs to stop the waste of these talented doctors for the their sake and the needs of the country.

Dr J L W Parker

15 October 2007

Memorandum by the British Orthopaedic Trainees' Association (BOTA) (MMC 37)

1. *Background*

1.1 We are the democratically elected representatives of 1,162 trainees in Trauma and Orthopaedic (T&O) Surgery. We constitute approximately 45% of the surgical trainees.

1.2. We would value the opportunity to provide oral evidence if asked.

1.3 We fully endorse the British Orthopaedic Association's view that ideal, safe and efficient orthopaedic care is best delivered by fully trained consultants.

2. *What are the principles underlying MMC and are they sound*

2.1 The principles of MMC should be, (and in Trauma and orthopaedics, are)

2.1.1 Less time in early years of training minimizing extraneous skill acquisition.

2.1.2 Defined curricula to clearly set out the goals at each level of training.

2.1.3 Rigorous assessment criteria to measure satisfactory progress enabling run through posts.

2.1.4 Produce safe, efficient, fully-trained consultants in order to provide the ideal treatment of patients in a consultant-delivered national health service.

2.2 We think they are sound and achievable.

3. *To what extent the practical implementation of MMC has been consistent with the programme's underlying principles*

3.1 The T&O curriculum has been published and approved in good time. It was the first surgical curriculum to do so, and this is a reflection of the fact that the specialty has been a leader in this matter over the last decade or more.

3.2 The introduction and implementation of the scheme was poorly thought out, and completely at odds with our recommendations over the last three years, which was to have a staged, gradual introduction, rather than the "big bang" that occurred.

3.3 Entry into MMC programmes should only have occurred from foundation years.

4. *The strengths and weaknesses of the MTAS process*

4.1 We welcome a computer based single portal and repository for application submission and distribution providing security is adequate.

4.2 The candidate's complete portfolio should have been available to all persons involved in selection.

4.3 The form used was designed for ST1, and was inappropriate for other levels. In addition, the questions used as the sole discriminators on the form were inadequate. They did not provide a complete picture of the candidate. We have evidence to show that minor inconsistencies in marking of the questions could lead to substantial bias against good candidates; however it is almost impossible to reliably gather numbers of good candidates who have not been offered posts. Anecdotally all of our committee are aware of good candidates who are without training posts at present.

4.4 Conversely, those selected are of good quality. This may be due to the fact that in T&O we had one of the highest competition ratios, and certainly the largest number of applications overall.

5. *What lessons about project management should the Department of Health learn from the failings in the implementation of MMC*

5.1 Careful selection of stakeholders and advisors. The "great and good" who have demonstrated their ineptitude and incompetence are still involved in decision making.

5.2 Transformational change rather than radical implementation may involve less uncertainty in improving the system.

5.3 A single unified system of postgraduate medical training does not satisfy the demands of different disciplines within medicine. It is unreasonable to expect training in Microbiology to be directly mappable to training Trauma and Orthopaedics and vice versa.

6. *The extent to which MMC has taken account of the supply and demand of junior doctors and the number of international medical graduates eligible for training in the UK*

6.1 MMC and MTAS does not seem to have been designed to cope with a large oversupply of candidates with similar qualities.

6.2 The fundamental difficulty at present is the enormous mismatch between the number of local graduates, who have been trained at the UK taxpayers' expense, and the number of training posts available. International medical graduates applying exacerbate this problem.

6.3 The number of medical students needs to be reduced.

7. *The degree to which current plans for MMC will help to increase the flexibility of the medical workforce*

7.1 MMC was said to enable junior doctors to demonstrate competences in a wide range of skills without completing a full training scheme, thus allowing them to dip in and out of training. In many craft specialties, however, trainees are not really able to deliver any useful service without supervision, and this model of training is one that will create a "lost tribe" in a worse limbo than both the Senior Registrars before Calman Training was introduced, and the SHOs that MMC was supposed to help.

7.2 Greater flexibility at a lower level of training does mean longer time is spent gaining these skills, which may be underutilised, and indeed lost, as the trainee progresses through the system.

7.3 We have defined the role of a consultant in Trauma and Orthopaedics in our submission to the Tooke Inquiry. We feel that this should be the end point of all training schemes. [5.4 Irrespective of the view of the present PMETB, we feel that a consultant post should only be available to candidates who have passed examinations in the generality of surgery, completed an approved training scheme, and passed an exit examination in that specialty. In addition, consultants must be capable of functioning independently within their chosen field (as defined by the relevant SAC) in the generality of that field and also have a good understanding of the entirety of medicine and surgery. They are capable of training others within their specialist field and have evidence of an ability to do so. They have a good understanding of the organisational aspects of their practice and play an active role in the governance and improvement of their practice. They may or may not have a subspecialist interest. They may or may not play an active part in research.]

7.4 "Alternative" models of practice by making the SAS grades more attractive may fulfil some as yet undefined role. At present the opportunity to enter these already exists. Uptake among trainees prior to getting their CCT remains miniscule, and in fact many of these staff are applying for entry to the specialist register, demonstrating that even for those within this grade, this is an unsatisfactory end point. Removing the carrot of progression to consultant will deter the best and most able students from entering medicine at undergraduate level, as well as deter postgraduates from entering hospital specialties. Already there is little financial incentive to do so.

7.5 There is little economic evidence in favour of providing an alternative service grade, as salary scales for this compared with new consultants must be similar in order to make them more attractive.

8. *The roles of the Department of Health, Strategic Health Authorities, the Deaneries, the Royal Colleges and the Postgraduate Medical Education and Training Board in designing and implementing MMC*

8.1 None of the above are blameless in the failure of implementation of a system that has the potential to work very well.

8.2 There exists a lack of communication between them, and many are blinkered to the views from the grassroots. This is best reflected in the difficulty of workforce planning, as demonstrated by this committee's findings in its March 2007 document.

8.3 Funding streams for training make little sense in their present forms, and have been an easy target during times of deficit. Despite Lord Hunt's promises (Q1006, minutes 25/01/07) and a projected surplus, training budget reductions have yet to be reinstated.

8.4 Funding for training, should follow the trainee. Trusts that train would then have an incentive to do so. Trusts opting out of training should still contribute towards this funding, as they would also be beneficiaries when it comes to appointments. Productivity reduction due to training must also be taken into account. It may also be useful to ally funding for training numbers to funding for consultant posts, thus minimising wastage, and providing an instantly available auditable tool for workforce planning.

8.5 Deaneries must understand that unfettered increases in training numbers will lead to a boom and bust scenario, as it has done for other NHS staff in the past.

8.6 In craft specialties, there are good arguments for expansion of the consultant workforce in order to provide a consultant delivered service for all patients. This is what patients deserve.

8.7 A degree of externality is welcome for regulators. More engagement is needed by PMETB in order to understand how specialties such as T&O had better safeguards of training in place, than the ones that they have instituted.

9. *Summary*

9.1 The orthopaedic trainees wish to ensure that patients get the best quality care through a properly trained National Health Service. Not only are we trainees, it is inevitable one day we will all be patients.

Mr Almas Khan MRCS Ed
President

October 2007

Memorandum by RemedyUK (MMC 38)

"MODERNISING MEDICAL CAREERS"

Background Information and Summary

1. RemedyUK is a pressure group established in 2006 to raise concerns about doctors training and workforce planning. It arranged the protest march in March 2007 at which 12,000 doctors expressed their frustration over MTAS and MMC, sought a judicial review of the process and has lobbied for change. It is now a subscription based organisation and has been recognised as a stakeholder by the MMC England Program Board.

2. We believe that:

a. The objectives of MMC were unclear. It appears to produce doctors that are less well trained than previously, as rapidly as possible, with a narrower skill base. The decline in educational standards has been exacerbated by the deleterious effects of the New Deal and Working Time Directive on clinical experience.

b. Reform of the SHO grade was necessary but was implemented badly. The new career structures are unrealistically rigid and are divisive. They require trainees to commit themselves to a specialist programme too early in their careers. A major underlying problem with the SHO grade—limited access to the higher levels of training—has not been addressed.

c. Flexibility for individual doctors to plan appropriate careers has been sacrificed in order to reduce time in the training grade.

d. We welcome the report by Sir John Tooke, and would like to see his recommendations fully adopted.

e. The MTAS project had many weaknesses. The original shortlisting worked so badly that it needed to be changed mid-recruitment. The Matching Algorithm, a fundamental component which should have allocated doctors to their job preferences, also failed. There were security breaches and failures of due process.

f. Manpower and workforce issues in medicine are an inherently difficult problem, because the delays involved in implementing change span many years. A few years ago there was a perceived shortage of doctors, yet we now expect to have a surplus. The number of doctors-in-training has been determined by the service requirements of the grade, rather than by the calculated requirements for future consultants.

g. The establishment of a pre-Consultant grade seems inevitable, and needs to be openly addressed.

h. The entire project was overambitious, poorly conceived and mismanaged. Objections were raised by those directly involved with training and career planning, but these objections were often ignored.

i. Few of the bodies concerned with introducing MMC can be proud of their achievements. We are especially unhappy that PMETB, a body set up to regulate training, has appeared impotent in preventing this disaster.

Underlying Principles of MMC

3. The aims of MMC were poorly defined, changed over time and were sometimes conflicting. We have considered the underlying principles of MMC, as stated in 2003 and examine whether they were conceptually sound and well implemented.

Creation of training programs

4. MMC recommended that:

> All postgraduate medical training should be organised in structured programmes (usually a series of co-ordinated placements) with progress monitored against clear curricula.
>
> Individual programmes should be available to meet individual needs.
>
> Training should be trainee-centred and programmes should reflect a variety of career choices, from those who decide on a particular career early on to those who need more time to do so and to those who want to train part-time.
>
> Programmes should be broadly-based at first and lead on to greater specialisation where appropriate.
>
> A clear structure is necessary to encourage and support the development of academic, research and teaching skills and to support those who opt for an academic career.

5. Prior to "Unfinished Business", approved SHO posts were often of short duration. Reorganisation into formal programmes provided more structured training and negated the need for repetitive job applications. Ten years previously the SpR grade had been successfully reorganised into formal rotations and many benefits were apparent. To extend this concept to SHO training was an attractive idea.

6. However free-standing short-term posts had provided much-needed flexibility for trainees who were unsure of their career aspirations or abilities. Nearly one quarter of SHOs changed their career preference during their SHO training. Figures from the BMA cohort study confirmed that that even five years after graduation 7% were still undecided on their career, and 17% had changed their career plans within the preceding 12 months. The Tooke review confirmed these findings, and indicate that any programme must offer trainees a simple route to change careers.

7. Flexibility for trainees to change, plan and tailor their careers was a laudable, compassionate and sound part of the initial design. It was largely lost in implementation, which became UoA-centred rather than trainee-centred. We believe this change occurred because of the perceived overriding imperative to shorten training.

8. The progression from general to more specialised training was also a good idea, but the manner by which this would be done was not developed. In Core Medical Training, doctors will be allocated to their future subspecialty by a mechanism as yet unknown. The principle of Acute Care Common Stem Training, an excellent idea in principle, was largely given up for manpower planning reasons.

9. Academic medicine[33] has been disadvantaged by the intricacies of the recruitment system and the rigidity of the training pathways.

Structure and flexibility of training pathways

10. MMC recommended that:

> Programmes should be designed and managed to ensure that trainees complete them in the minimum necessary time. There should be explicit career pathways and explicit career goals.
>
> Training should as far as possible be seamless and conducted within a grading structure which supports this process.
>
> New training structures must allow trainees to change training programmes according to service need with the minimum duplication or retraining.
>
> Rigorous counselling and career advice should be available throughout training.
>
> Programmes should be designed to suit the needs of overseas doctors who may enter training at a number of different levels and in a number of different ways.

11. There is a clear conflict here. A broad-based and flexible education is likely to take longer than the bare minimum. Yet shortening time in training was made an explicit requirement, probably as a deliberate attempt to flood the market with minimally-trained doctors.

12. The attempt to reduce training time to the bare minimum also required that there should be once-a-year recruitment, timed so that doctors leaving Foundation Year could immediately enter into specialty training. Once-a-year recruitment is disadvantageous because:

a. It makes it difficult to replace doctors in training who leave during the course of the year, other than with locums, and will create difficulties filling consultant vacancies that arise during the year. It presents program directors, HR staff and recruiters with logistical problems.

b. There is an impact on service provision in August when many trainees change jobs simultaneously.

c. It increases the stakes for trainees, who need to wait a year if their application is unsuccessful.

[33] *Modernising Medical Careers, The response of the four UK Health Ministers to the consultation on Unfinished Business: Proposals for reform of the Senior House Officer grade (2003)*

d. Trainees who enter a specialty for which they are unsuited need to wait a year before they can transfer.

13. We believe that MMC forced doctors to select their careers at an inappropriately junior level, when they have insufficient experience or knowledge. This view was echoed in the Tooke report.

14. Doctors entering a career for which they do not have the necessary skills or aptitude, or who take longer than the minimum to complete their training, need appropriate advice and support to pursue alternative careers. In an attempt to disguise these issues, MMC flowcharts and pathways showed no routes or destinations for drop-outs.

15. A second conflict arises between the interests of flexibility and the interests of job security. The offer of a seven-year training post[34] appeared to provide job security and was championed by the BMA[35]. But this job security comes at a price.

a. Run-through training is divisive and creates two tiers of doctors. Those appointed have job security, which encourages complacency; those that are not appointed are insecure and perceived as second-class doctors.

b. Trainees who wish to change programmes will find they are locked-in, even if they are unsuitable for the career they have chosen, because of difficulties in getting another appointment, and the lack of "discharge with honour".

16. Run-through Training was presented as a solution to the "lost tribe" of SHOs who got stuck in career bottlenecks mid-career and were unable to progress. The number of SHO posts exceeded the number of SpR posts that were available for creating complete run-through programs. These surplus SHO posts were still required for service provision. Rather than solving the problem, MMC covertly disguised it by renaming the "lost tribe" posts as FTSTAs[36]—the Modern Lost Tribe.

17. FTSTAs are dead-end posts from a career perspective. The opportunities for future progression are restricted, since future entry into training posts depends on filling "dead men's shoes". The original promise of MMC was that "Further work is needed to develop a framework to ensure that those who are not selected initially for their chosen field have opportunities to continue in training. It is not acceptable that they should at this stage fall out of the training system." These opportunities are still not apparent, and FTSTA post-holders have no reliable information on which to base future career planning.

Education of junior doctors

> Training must be supported by strong educational management and underpinned by skilled trainers.
>
> It will prepare doctors to work in multi-profession settings and employ shared learning and cross-professional training where necessary.
>
> Training should be applied to clear, consistent UK-wide standards.
>
> In general, assessment should be competency-based and should be focused on outcomes with the ability to perform as the underpinning competence.
>
> The responsibilities given to doctors completing training should match their skills and competencies. Similarly, doctors in training should be able to take on progressively more responsibility as they are assessed as acquiring the competencies needed.
>
> The end product of the training process, whether a hospital doctor or a general practitioner, should be a high-quality, well-trained and accredited doctor who can deliver the care and treatment patients need in the modern NHS.
>
> The development of new training structures, programmes and the delivery of training itself must be effectively quality assured.

18. No changes have been made to the employment contract of trainers, and trainers are still uncertain what is expected of them.

19. The concept of "Competence" is superficially attractive, since it requires trainees to demonstrate they have achieved the requisite skills to progress. The models which have largely been adopted break down the concept of "Competence" into a series of many individual "Competencies". Trainees need to get each of these Competencies signed off at appropriate points in their training. This model is unsatisfactory for the following reasons:

a. The Competencies model assumes that overall ability can be broken down into a series of individual skills that can each be tested separately. There is considerable evidence that attainment of separate competences alone does not imply the fluent, integrated, judgment-based professional performance necessary for independent practice. This requires experience over and above any basic competence.

[34] The majority of Run-through training programs are seven years in duration. A minority are of different duration.
[35] The BMA has a joint role as both a Trade Union and a Professional body.
[36] Fixed Term Specialty Training Appointment

b. Assessment of Competencies is carried out locally with no standardisation or consistency. Consultants are generally reluctant to give unsatisfactory assessments, except in the most extreme circumstances, since it harms the trainer-trainee relationship and can result in overt hostility or reprisals.

20. Unlike previous generations of doctors, who appeared to be thrown in at the deep end and given clinical responsibility that they were not ready for, recent changes have taken things too far in the opposite direction. Some doctors now feel they have been infantilised, and are not gaining adequate experience of hands-on clinical decision-making.

21. This problem has been exacerbated by the reduction in training hours produced by the Working Time Directive and the New Deal. Evidence from log-books confirms the reduction in case-workload that present trainees achieve. Reduced hours has also fragmented training, reduced contact between trainees and trainers, and complicated manpower planning.

The Tooke Review—aspiring to excellence

22. We welcome the interim findings of the Independent Inquiry into MMC, led by Sir John Tooke, and congratulate him and his team for a well-researched and positive review. We share his view that MMC suffered from a lack of clear objective.

23. We hope the corrective actions he recommends are fully adopted. We look forward to seeing details in the final report of the proposed recruitment methods and training program structures.

The Strengths and Weaknesses of the MTAS Project

24. It is apparent that the MTAS project was rushed, and was implemented despite widespread concerns that it was not yet ready for use. It is also apparent that these concerns were ignored by those in a position of power, presumably for political expediency.

Overall design of the selection process

25. In previous years, individual Trusts and training programs had recruited autonomously at different times in the year. Successful applicants who attended for interview were offered the job on the day of the interview, and were expected to accept or decline. Unsuccessful candidates were then able to apply for other jobs as they became available. Under MMC all jobs were recruited and appointed to simultaneously. This could have resulted in each applicant applying for large numbers of posts, and so a restriction on applications was introduced. Each candidate was limited to apply to up to four "Units of Application" (UoA), which they then ranked in order of preference.

26. Each UoA covered a much larger part of the country than in previous years. For example, applicants could apply for the whole of Scotland, or for a "London" program which included all of North London, South London, Kent Sussex Surrey and parts of the East of England Deanery. Candidates would have little control over where in this large area they were posted. This has been very tough for individuals given jobs far from home in the larger UoAs, and we consider it unreasonable to expect doctors to apply for jobs without knowing where they might be working.

27. The Preferencing process whereby applications were considered for different jobs simultaneously was conceptually flawed. It was likely to prevent good applicants from being considered for posts because they were "crowded out" by the very strong candidates who would receive four interviews.

a. Since the strong candidates would have gained more interviews than weaker ones, interview panels would have gained the false impression that they had attracted a strong field of applicants; there is good evidence that this occurred in the less popular UoAs exactly as predicted.

b. Less strong candidates would be denied any interviews and less popular posts would remain unfilled. Bizarrely, unfilled posts and unplaced doctors could arise simultaneously.

28. SHO Contracts of employment were prematurely terminated to facilitate the introduction of MMC. Doctors who had been appointed (sometimes against stiff opposition) into SHO posts were effectively forced to reapply for their own jobs. Some doctors were unsuccessful.

Shortlisting and interviewing

29. Questions on the application form, and the scoring system, made use of criteria which had been designed by the Work Psychology Partnership. The WPP had been given incorrect information regarding the likely levels of competition for jobs, and they designed the selection process solely for use at the most junior level. In the event, the same selection questions were used at all levels. The scoring did not give sufficient weight to academic achievement and past experience, and was a test of aptitude rather than skill, which consultants found difficult to mark consistently. The system had not been validated for selection into specialty training on this scale.

30. Justice Goldring summarised "As it seems to me, the evidence as a whole suggests fundamentally that even as envisaged, and apparently the product of wide consultation, the shortlisting process was flawed. The application form was unreliable as a measure of ability. It resulted in able candidates not being shortlisted when they should have been and less able candidates being shortlisted when they should not have been." (para 74).

31. Midway through recruitment, the rules were changed. The Douglas review, set up to address the unfairness and problems with the original shortlisting, made two important changes.

a. They advised that all interviews should be informed by the use of CVs, so as to strengthen the interview process. This meant that applicants who had already been interviewed were been disadvantaged in comparison to those interviewed later.

b. They also insisted that all candidates should have at least one guaranteed interview, regardless of their shortlisting scores. This decision can be criticised on the following grounds:

    i. The original interviews were not disallowed. A good candidate, who deserved four interviews, would still only receive one. Yet a weak applicant may have already had four interviews placing him at a considerable advantage.

    ii. It would be difficult for interview panels to maintain consistency in scoring between the original interviews and the later 1b "guaranteed interviews". These would be held at a different time with a different panel. The interviewers would have preconceived ideas about this cohort of applicants.

32. Following the announcement of the guaranteed interview scheme, both the National Director of MMC and the National Clinical Advisor to MMC resigned their posts. Alan Crockard acknowledged that "the overriding message coming back from the profession is that it has lost confidence in the current recruitment system". Shelley Heard confessed that "I find myself able to support few of the decisions that the Review Group has taken since they undermine principles which are at the core of MMC".

Computer and other failures of due process

33. There were numerous reports of handling errors by the computer system, given by both candidates and Deanery staff/assessors. This included reports of applications where the preferencing had spontaneously changed, eligibilities changed, candidates invited to interviews which they had already been to, lost applications and other errors. In a report by Prof Steve Field, Regional Postgraduate Dean for West Midlands it was stated that there had been, "Countless problems with data loss—we lost over 1,300 applications on the day before the closing date and had many separate episodes of data loss—candidates also appeared on the screen unannounced during the short listing period!—As a consequence, the staff have no confidence in the system."

34. Consultant recruiters witnessed many other failures of due process. For example, some forms were not scored by all panellists, or were scored in a great rush, there were inconsistent applications of standards and recruitment panels were improperly constituted. There were panels who resigned in protest; others threatened to follow suit. To dissuade them from doing this, Deans promised that Round 1 would only fill "the very best candidates" leaving substantial opportunities available in Round 2. This promise was reneged on, with up to 90% of posts in some specialties being filled in Round 1.

35. Applicants who tried to ascertain how their application had been scored by a Data Protection Act enquiry were blocked from so doing. The Department of Health claimed that MTAS was an examination[37] and therefore scores could not be divulged.

36. There were two security breaches, described by the Secretary of State as "utterly deplorable". On one occasion, an unprotected Excel spreadsheet containing the full application forms was placed in a publicly accessible folder. The risks of placing such highly confidential data into a publicly accessible area should have been recognised by anyone with a basic understanding of computer security. A second security breach came to light the following day, whereby visitors to the website could access other candidates' messages on the website messaging facility.

37. The evidence from Methods Consulting, who ran the computer system, suggests that in the early stages the technical performance of MTAS was within agreed limits. However they had expected that key inputs—such as the application form questions, person specifications, list of specialties and UoAs—would be provided to them in good time to be built into the system and tested. None of these inputs were finalised on time—changes to the application form were being made in January, for example. In addition there were a considerable number of late and unplanned changes which distracted development effort, such as the reconfiguration of UoAs while the round was open for applications. As a consequence the development work was delayed and testing time squeezed.

[37] Had MTAS truly been an examination it should have been considered by the PMETB Assessments Committee.

Matching and allocations to jobs

38. The Matching Algorithm in MTAS did not give the results that were expected and was abandoned. This is the part of MTAS that allocated individual applicants to their highest-ranking job offer. It was euphemistically described at the judicial review as being a "Work in progress". It is astonishing that MTAS went live before the most mission-critical component had been properly tested and debugged.

39. This failure, which came to light in late April, meant that there was no central process whereby the various job offers could be coordinated. Instead of the ordered and proper issuing of jobs that MTAS had promised, UoAs were forced to enter into a free-for-all, which resulted in candidates being offered jobs in a random order, rather than in the ranking that they had expressed.

40. Doctors were hastily placed in jobs that were not their first preference. They were pressurised into accepting these jobs, even when their first-choice job became available later, by being given a short time to accept or decline, no opportunity to change their minds and the threat of GMC referral if they withdrew.

Remedy's Oppostion to MTAS and MMC

41. On 17 March 2007 RemedyUK organised protest marches against MMC and MTAS in London and Glasgow. These were attended by 12,000 people; an unprecedented number. This gives an indication of the general opposition amongst doctors to the new scheme.

42. RemedyUK sought judicial review of MTAS. The case was heard by Justice Goldring in the High Court of Justice Administrative Court on 22 May 2007.

a. In summary, the grounds for the case were as follows. MTAS was unfair, both in its original conception and as a result of the modifications introduced by the Douglas Review (Modified MTAS). These unfairnesses amounted to an abuse of power. There were two possible outcomes that were sought if the judicial review had been successful—one was a complete re-run of the process. The alternative offered was that the process should stand, but that all appointments that were made were to Temporary Training Posts with short tenure. This would have permitted hospital posts to be filled in time for the August 1st deadline, but would have allowed those unsuccessful to compete in the near future under a fair system.

b. Whilst acknowledging that there were conspicuous unfairnesses in MTAS, which were recognised as having "disastrous consequences" the judicial review was rejected for the following groups of reasons:

   i. The application for judicial review was actively opposed by the BMA, the doctors' Trade Union.

   ii. The judicial review challenged the Douglas review, rather than the whole of MTAS/MMC. The Douglas review had the necessary expertise and representation to reach their decision, and had reached a decision which was rational given the circumstances.

   iii. It would not be appropriate to "don the garb of policy maker".

c. In his summing up, the judge suggested that given the circumstances a substantial number of posts should be held back for Round 2 so that those unsuccessful could be considered. As discussed in paragraph 34, this advice was not heeded.

Flexibility of the Workforce and Manpower Planning

The number of doctors in the UK

43. In March 2007 the Fourth Report from the Health Committee on Workforce Planning reported that "There has been a disastrous failure of workforce planning.". The UK is not unique in having such difficulties. The development of Foundation Trusts is likely to make workforce planning harder in the future.

44. In 1999, concerns were expressed about the low number of doctors in the UK, which stood at 1.7 per 1,000 head of population. This was the lowest figure in Europe; the average number was 3.4 per 1,000. A contemporary study[38] correlated this ratio with mortality rates. The NHS Plan aimed to reduce the reliance on doctors from abroad, and sought to create. A temporary and short-term expansion of recruitment of foreign doctors was necessary to facilitate this.

45. An increase in the supply of doctors was achieved by:

a. Increase in Medical School size/output. Over a 10 year period the number of British medical students has doubled: 3,949 qualified in 1997; by 2005 7,830 students entered medical school.

b. Increase in non-UK doctors. The number of doctors recruited from outside UK outstripped those graduating from the UK after 2000. This is demonstrated by the following figures:

[38] BMJ 1999;318:1515–1520 (5 June).

i. Between 2002 and 2005 there were 60,000 registrations with the GMC. Of these, 31% were UK graduates, 16% were EU graduates and 53% were non-EU graduates.

ii. The number of non-EU doctors has been increased[39].

Year	*1999*	*2000*	*2001*	*2002*	*2003*	*2004*	*2005*
UK	72.4	72.2	71.9	70.5	69.5	67.8	66.4
EU	5.6	5.4	5.4	5.5	5.5	5.6	5.7
Non-EU	22	22.4	22.7	24	25	26.7	27.8

46. Historically there have always been swings in medical manpower, and the peaks and troughs have been levelled by recruiting doctors from abroad often to fill jobs that are unpopular or difficult to recruit into. It appears that the Department of Health felt unthreatened by the short-term oversupply that it created, believing that they could easily discard tens of thousands of doctors recruited from overseas at will when they became surplus to requirements. This was both a cynical and false assumption. The government attempt to limit immigration of doctors from outside the EU was challenged by BAPIO in a judicial review; this is now awaiting appeal. The number of EU doctors wishing to work in this country was also underestimated.

47. Sir Liam Donaldson, questioned by the HSC[40] on oversupply of doctors stated his position clearly three times: "My own view is that I do not really accept the assessment that there is an oversupply of doctors." . . . "We are still behind and I do not see ourselves as producing an excess of doctors at all" . . . ."We have to evaluate the need specialty by specialty, but on the whole, given the position internationally, the trends in the burden of disease, the growth of technology, the feminisation of the workforce, I think we shall need more doctors."

The number of doctors in training

48. Doctors in training make a significant contribution to the service.

49. In order to plan the number of doctors-in-training that are required, there are two basic models which could be adopted. Whichever model is adopted, the end-result may be either a shortage or surplus, since the time scale between implementing and realising change is over 10 years, and unanticipated events can arise during this time.

50. These two models are:

i. An estimate is made of the predicted number of consultants and specialists that will be needed in the future, taking into account factors such as predicted retirements, international movement and changes in the future requirements for consultants/specialists. The number of training posts is then adjusted so as to satisfy these requirements, possibly with a small surplus so as to ensure competition and to compensate for any wastage.

ii. The number of junior doctors necessary to maintain the present or predicted service levels (and especially on-call rotas) can be estimated. This number will then determine the number of future trained doctors. Any surplus production of consultants/specialists will result in a cohort of fully trained specialists with no future career in this country.

51. The second model seems to have been largely adopted by MMC, which has given the larger number of training posts. The number of training posts has been further increased by:

i. Pressure to maximise the number of training posts created; some stand-alone trust-grade jobs were incorporated into training programs.

ii. The demands of the New Deal and the Working Time Directive resulted in an increased number of junior doctors in order to satisfy service requirements. Further reduction in hours may increase this number.

52. Modernising Medical Careers was not directly responsible for the issues described above, which are determined by national and international pressures. But it exacerbated the problem in the following ways:

a. The offer of a Run-through post to a doctor makes a commitment to them for the full duration of training. This makes it harder to fine-tune the numbers over a short time period.

b. Flexibility in the design of Training Programs has already been discussed in paragraph 11 above. There is an inherent conflict between flexibility and security. A rigid system such as MMC has provided job security at the expense of inflexibility.

[39] Department of Health figures (Fourth Report of the Health Committee session 2006–07)
[40] Minutes of Evidence (from 12 May 2006) Health Committee (Published 15 March 2007)

The subconsultant grade

53. We are now training more specialists in this country than we are likely to be able to employ as Consultants. The development of a pre-Consultant grade seems inevitable.

54. Terminology in this field is confusing and emotive, and there is a stigma attached to the phrase "subconsultant". We suggest the term pre-Consultant is more appropriate. This grade de facto exists as the "Locum Consultant"; a post which provides significant career development for doctors who have completed their training. This grade should be reviewed. Postholders should have some degree of tenure, and clear terms and conditions of employment. Some flexibility in job plan would be appropriate, and there should be adequate CPD allowance.

55. Development of this grade should reflect the changing nature of the population of doctors, especially the changing percentage of women in medicine. It seems likely that there will be an increasing demand from doctors to be employed less than full time or flexibly.

Who was Responsible for MMC and MTAS

56. One of the key roles for this Select Inquiry is to determine what went wrong, and how this can be prevented from happening again. The Tooke Report suggests that the failure of MMC cannot be blamed on any one person or body, because many bodies were involved. Had the project succeeded we could expect those taking major roles to have put themselves forward for commendations and awards. Instead the project has been a failure, and although the National Director and his deputy offered their resignations, other key players remain in post.

57. MMC was the brainchild of the Chief Medical Officer, and he was responsible for its conception. The BMA has repeatedly called for his resignation.

58. Although many different bodies and agencies were involved, MMC was largely driven by the Department of Health. There is good evidence that they consulted with other bodies but that the results of these consultations were not always heeded. The complex structure of the project made accountability difficult to ascertain. The MMC Board claim to have been actively distanced from involvement in MTAS by the Department of Health.

59. CoPMED were given operational responsibility for MTAS. As 2007 approached it became apparent that MTAS may not be ready in time for the launch; the 331 Gateway Review gave it a red status. It is unclear why CoPMED did not call for a delay, especially in view of the subsequent failure of the MTAS Matching Algorithm.

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

61. NHS Consultants spent a lot of time shortlisting and interviewing on behalf of the Deaneries. Some of this was done in weekends and during annual leave, especially over February half-term holiday. Many of them found this frustrating and an inefficient use of their time. The relationship between Deaneries and these NHS Consultants, and lines of accountability, needs to be more closely defined.

62. PMETB are one of the regulators of Medical Education. They were intimately involved in the design of MTAS. On 25 August 2006, it was presented to them by Sarah Thomas (CoPMED) and Fiona Patterson and Maura Kerrin (Work Psychology Partnership). On 21 September Mark Dexter, PMETB Head of Policy, wrote to thank them. In his letter he wrote: "The overarching strategy outlined broadly meets the relevant sections of PMETB Generic Standards for Training (Domain 4), including the Principles for Entry to Specialist Training, set in the context of the governing legislation and our duty to the service—covered in The General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003" He asked for further details, and informed them that PMETB "will wish to revisit and review the operation of the new system, once it has been established, against our Generic Standards for Training including the Principles for Entry to Specialist Training, and in the context of our statutory responsibilities."

63. Further evidence of PMETBs involvement came to light in evidence given to the judicial review by Nic Greenfield, who gave evidence that "the change in culture to a competency based system . . . was instigated by PMETB". He also gave evidence that PMETB had laid down specific requirements regarding the composition of appointments panels.

64. PMETB has issued Generic Standards for Training, which were intended to ensure that entry into Specialty Training was managed by an "open fair and effective" recruitment system. Remedy has been unable to determine whether or not, in the opinion of PMETB, MTAS was indeed open fair and effective. We contend that it was not. If MTAS fails this generic standard, we submit that PMETB should not have permitted doctors appointed through MTAS2007 to enter Runthrough training.

October 2007

Memorandum by Lindsay Cooke (MMC 39)

This is a personal submission from Lindsay Cooke, co-ordinator of Mums4Medics. My personal interest is that my senior surgical SHO daughter has left the NHS and will complete her training in New Zealand as a result of MMC 2007.

On 26 March 2007 a letter over my name was sent to the General Medical Council asking them to examine the conduct of Professor Alan Crockard, then National Director of MMC, in relation to his management role. The letter was drafted by a junior doctor who wished to remain anonymous at that time because of the climate of fear and anxiety surrounding the MTAS/MMC process. I felt the issues it raised were both relevant and important and was content that it was within the remit of the GMC to investigate the conduct of doctors in management roles as the GMC produces detailed guidance for that purpose; and was content to "front" this intervention as, because I am a lay person, I could not be "got at" by the medical establishment. Professor Crockard resigned as National Director of MMC shortly afterwards. I have no evidence whether my letter was a factor in his decision. His resignation letter will, no doubt, form part of the evidence the Committee has already received. Among other things, Professor Crockard went on record with the contention that "this project has lacked clear leadership for a long time".

I heard nothing from the GMC for two months. After an intervention from a Council member who was alerted by a senior colleague about the GMC's silence on this matter, I received a brief email stating that the issues I raised were outside the remit of the GMC. I protested, and also asked for a detailed response to the many points raised in my letter. I was subsequently informed by letter that Sir John Tooke would be examining the issues I raised as part of his independent review. It is clear from a cursory glance at the terms of reference of the Tooke Review that this would not take place.

MMC/MTAS 2007 has been a deeply damaging episode for the medical profession, and the human costs for doctors and their families are incalculable. It is difficult to avoid the conclusion that its imposition has been characterised by both arrogance and ineptitude. Yet its architects, of whom Professor Crockard may be one (until accountability is established it is difficult to identify responsible parties) largely remain in positions of authority and/or responsibility within the higher eschelons of the profession, which has "passed the buck" and failed to hold them to account. It is surely essential that responsibility and accountability be established. The Committee seems to me to be the only body now capable of doing so, and I ask it to do so not through any desire for revenge but in order that the profession, and junior doctors in particular, can draw a line under this disgraceful episode and move on for the sake of the profession, the future of the NHS and its patients, present and future.

16 October 2007

Memorandum by Margaret Demaine (MMC 40)

I am writing to you to draw your attention to a particular example of the plight of a medical student, our Grandson.

Having survived the extreme trauma and dare I say torture of the MTAS selection process, he has not found a proper training post placement.

He has taken an Honorary post as a demonstrator at a London hospital. His pay (approx. £10.50 an hour) is not payable until the completion of the six months duration of the job. Fortunately he has managed to secure some locum work at another group of London hospitals—otherwise he would have no income, and having to find accommodation in London on no income I suggest is impossible!

What will happen in Jan/Feb when this post comes to an end, at present this is an unanswered question. Surely having studied Medicine for seven years and with a real vocation this should not be his dilemma?

I hope that at the conclusion of your deliberations you will be able to re-assure me and many others that the futures of our Junior doctors are not to be so in jeopardy.

I endorse the submission from Mums4medics, and look forward to hearing the outcome of your deliberations.

16 October 2007

Memorandum by the Royal College of Physicians of Edinburgh (MMC 41)

MODERNISING MEDICAL CAREERS

Executive Summary

The Royal College of Physicians of Edinburgh is committed to developing a more responsive training system in the UK and several senior officers and many Fellows and Members have been involved in the design and implementation of the MMC and MTAS systems. However, the College cannot emphasise too strongly the disillusionment and distress caused by the failures of the system this year and the effort that will be required to regain the confidence of the profession.

The College is keen that the potential benefits of MMC are not lost in the rush to address the very serious deficiencies of MTAS, and agrees that any changes following the recommendations of Professor Sir John Tooke should not take effect until 2009. That said, it is imperative that doctors applying for foundation and specialty training in 2007 and 2008 are treated fairly and clear transition arrangements must be agreed quickly.

The main points of the College's evidence are as follows:

- The intended flexibility in MMC was more theoretical than real. Early selection and run through training limited future options.
- Medical workforce planning must improve and be aligned to training schemes. The position of international medical graduates must be clarified.
- Fixed Term Specialty Training Appointments must be used in the short term only.
- There should be a single medical regulator covering all aspects of medical training and registration.
- Selection procedures must take due account of academic and clinical performance, supported by structured CVs.
- Applications to a national system for 2009 must be managed through a computerised system and processed locally through deaneries. Any new system must be rigorously piloted and tested to avoid the practical problems of this summer and regain the confidence of applicants.
- Effective risk assessment and contingency planning must be applied to all future training projects and must operate within a sensible time frame.
- The departments of health in the 4 administrations must be committed to full consultation with relevant stakeholders throughout the design, piloting and implementation phases of any future changes.
- The role of NHS consultants in this important task must be recognised in consultant job plans.

Introduction

1 The Royal College of Physicians of Edinburgh (RCPE) has a long and tested history in the development of medical training in the UK, latterly through its partnership with other Colleges in the Federation of Royal Colleges of Physicians of the UK and the Academy of Medical Royal Colleges and Faculties. We have been campaigning since the mid-1990s for improvements in the training programmes for Senior House Officers (SHOs) and had identified many of the issues raised in Professor Sir Liam Donaldson's "Unfinished Business".[41,42] Many of the initial proposals within MMC were therefore welcomed as long overdue but with major caveats, primarily the need for more flexibility and the importance of maintaining standards.

2 However, professional confidence in the new training systems at all levels has been shattered by the disastrous implementation of the Medical Training Application Service (MTAS). These acronyms are used interchangeably which is both incorrect and extremely damaging as the undoubted problems of MTAS infect and undermine the positive aims of MMC. Changes to the systems are required urgently but there is an equally urgent "hearts and minds" challenge and a need to address the problems of those trainees who have been let down badly by the system this year.

3 Professor Sir John Tooke's report has captured many of the key strategic and operational difficulties and, in principle, the College welcomes most of his proposals. Flexibility and fairness must be enshrined in any changes to current systems and arrangements confirmed quickly for those doctors appointed to Foundation or ST posts in 2007 and 2008. The College will be providing a detailed response after further discussion with Fellows and Members.

[41] Training in Medicine for the Senior House Officer. A joint Report of the Royal College of Physicians of Edinburgh, the Royal College of Physicians and Surgeons of Glasgow and Royal College of General Practitioners.

[42] Review of Working Patterns, Training and Experience of Medical SHOs in Scotland. Royal College of Physicians of Edinburgh and Royal College of Physicians and Surgeon of Glasgow

The Principles Underlying MMC

Flexibility

4 Revisiting the College's response to "Unfinished Business" serves to emphasise the original and welcomed intention to establish a much more consistent yet flexible system of training, encouraging trainees into the less popular specialties, and addressing the unsatisfactory position of staff grade and associate specialist doctors. Such flexibility is essential to facilitate career change, progress at a pace consistent with acquisition of competences and be responsive to the changing needs of the NHS.

Moving towards a Trained Workforce

5 Trainees and many trainers have expressed concern that an unstated driver of MMC was to reduce training periods and create a new grade of sub-consultant specialist to meet the financial needs of the NHS. Young graduate doctors are among the brightest of their generation and the market for medical staff is global. They will seek better opportunities abroad if consultant jobs in the UK are limited.

6 Many of those within the system this year expressed the view that MTAS was designed to fill NHS junior posts rather than select those best suited into particular specialist training programmes. This perceived conflict between service and training focus need not occur if the training benefits of service delivery and recruitment methods are improved and better understood.

Quality Assurance

7 MMC was not to be accomplished at the expense of competence and the Colleges have introduced curricula-driven foundation and basic and specialist training programmes, supported by robust assessment systems. Significant investment is required in training resources, in the infrastructure to support the new training programmes, and in quality assurance. Perhaps the most underestimated investment has been in the time required of consultants in the training, supervision and assessment of trainees and how this will be managed against the background of new job plans and consultant contracts.

8 The track record of the Colleges generally in the supervision and assessment of individual trainees and the quality assurance of programmes has been questioned, although little of this has been supported with clear evidence. The Postgraduate Medical Training and Education Board (PMETB), established in response to "Unfinished Business" to replace the "regulatory" role of Colleges in specialist postgraduate medical education, has been slow to start and appears expensive. It has failed to win the support of the profession, and we believe a fundamental review of its role is required urgently. In particular, the College calls for a cost-benefit review of retaining two medical regulators (GMC and PMETB) and would prefer to see regulation integrated into a single organisation supporting safe and effective practise from medical school to retirement. The GMC seems ideally placed to assume this cradle to grave role, and we note the Tooke recommendations in this regard.

Practical Implementation of MMC

Foundation Programme

9 The Foundation Programme, as the first component of MMC to be established, has had a mixed reception with our trainees. Those who are undecided about their future career are more positive towards a two year general programme with increased opportunities to try different specialties. Trainees with firm career aspirations can be less impressed, particularly if their attachments take them away from their preferred areas and they are discouraged from specialty work or study. Trainers report that this is evident from their attitude and performance, and deaneries must be innovative in their programme development to engage the attention of these ambitious young doctors. The College recognises that Tooke has recommended further changes in the structure of the Foundation programme.

Transfer of competences/shared training

10 The generic core of general medicine, felt to be essential to all medical specialties, was retained after a forceful defence by the three Colleges of Physicians of a two year Core Medical Training (CMT) programme. The development of an updated curriculum for this programme will improve the consistency of training. The College welcomes the implication in the Tooke Report that a longer period of general training in medicine will be reinstated for a wider range of trainees, before further specialisation. This will facilitate choice and selection into the specialities, allowing trainees to experience more options before determining their career choice and to demonstrate aptitudes. The College is well placed through its internationally recognised MRCP(UK) qualification to assess the relative performance of trainees and support selection into specialty.

Run Through Training (RTT)

11 What has become known as Run Through Training (RTT) has resulted in a rigid career path for doctors with early selection and very limited opportunities for change. Whilst helpful for delivering predictable numbers of trained doctors within set programmes, RTT has significant disadvantages, namely:

- A highly pressurised selection environment where candidates compete for what they perceive to be their only chance to enter the speciality of choice and with only four choices. This was particularly marked for trainees already in medical SHO posts and therefore committed to medicine.
- Early selection, forcing premature choice for many doctors and often before they have had the opportunity to demonstrate competence or aptitude and limiting options to change thereafter.
- Less opportunity to experience work in the less popular specialities to encourage recruitment.

12 Allocation into specialty after CMT reintroduces the concept of competition and has led in this introductory year to major concerns about the detail of the "promise" in RTT. Trainees have been reassured that they will be guaranteed a specialist training place but not necessarily in their preferred speciality. In Scotland, it is clear that many specialities will have few or no training opportunities each year and career progression could become a real lottery unless some geographical flexibility is permitted. Equally, other trainees may prefer a deanery-specific training programme for domestic stability. A hybrid approach may be feasible, and some certainty is required urgently for 2008.

Strengths and Weaknesses of the MTAS Process

13 MTAS attracted such criticism with emotions running high, and it is all too easy to overlook what worked within the system. The previous system of open and uncoordinated competition across the UK for each post was neither fair nor efficient and had to change. There are some glimmers of hope for a better system in certain aspects of MTAS but it would be exaggerating to call them strengths at this stage. These include:

- The application system appeared to work better for GPs than consultants.
- Trainees could see all job opportunities simultaneously.
- An on-line system has the potential to make the screening of applications more manageable for consultants.
- The application system was well promoted, attracting interest from large number of UK and international trainees.

14 But MTAS had many serious problems, some of which can be attributed to the design of the system and others to implementation at a local level. None must be repeated in 2008. The main areas of concern include:

14.1 *Deficient short listing systems*

- The forms for short-listing failed to discriminate reliably between candidates. This College and others had been involved at the early design stage, but the MMC team responsible for delivery were driven to such tight timelines that full consultation with the clinical experts within the Colleges was not achieved and fundamental deficiencies remained unchallenged. Person specifications were insufficiently discriminating, perhaps driven by concerns about equity and diversity. In the future, standardised application documentation must be complemented by structured CVs.
- The application forms were not available to consultants in advance of MTAS going live to allow them to get to grips with the new system and support trainees applying for the first time.
- Some deaneries had local implementation difficulties, resulting in hurried assessments, compromised quality and disillusioned assessors. There were also anecdotal reports of non-clinical input into short listing.

14.2 *Deficient interview information*

- Structured CVs and portfolios at interviewing are essential to allow assessment on merit. Information on clinical and academic achievements is essential to discriminate between candidates.
- There is now clear evidence to support the long accepted differences in the ability and knowledge of graduates from different medical schools and a growing need to calibrate medical degrees or test knowledge and competence during the Foundation Programme to support the selection process.
- Interview processes were inconsistent between and within deaneries, leaving applicants dissatisfied and employers vulnerable to appeal.

— The restriction on applications to four posts per trainee would inevitably result in some excellent candidates failing in their first choices and entering round 2. Interview panels were advised strongly by the review team to restrict offers to excellent candidates in round 1, as there would be other high quality candidates in round 2. The timing delay and pressures to fill posts no doubt discouraged panels from this approach and, as a result, some excellent candidates were at high risk of unemployment.

— The GPs' experience of incorporating structured assessment stations to assess knowledge and aptitude was helpful and could be usefully applied to other specialties.

14.3 *Unreliable computer system*

— There were many examples of defective functions which eroded the confidence of trainees and trainers. In addition to the well publicised security breaches, this College has anecdotal reports of trainees losing data from their applications, being unable to input data in some sections and many expressed the fear of the system crashing denying them the opportunity to complete applications within very tight deadlines.

— The promised plagiarism detection components failed.

— The system was developed quickly and went live with inadequate piloting. It was a new IT system, supporting a very new application process, for all UK trainees simultaneously. There was no obvious risk assessment or recovery plan for when the system failed.

14.4 *Ineffective communications strategy*

— The web-based communication and e-mail alerts may have worked effectively if the application process and IT system had not also experienced serious problems. Emotions were running high, media reports were inflammatory and deaneries were giving different messages to their applicants. The result was confusion and significant stress for trainees and anger among consultants who felt powerless to support their distressed junior colleagues.

— The lack of accurate and timely information about application and competition ratios made it difficult for corrective action to be agreed and implemented and for candidates to review their choices. It is essential that careers advice, including information about future job prospects is available to trainees and their trainers to encourage realistic applications. This should be a high priority for all deaneries next year, who will require support from national workforce planning teams.

14.5 *Scale and timing*

— It seems incredible that a new training system with untested IT support would be introduced simultaneously across all specialties and deaneries in the UK. Compressing all trainee recruitment in this way is unwise, and a staggered approach would both allow trainees other opportunities to apply and the NHS to accommodate the loss of doctor time.

— The four nations took a different approach to implementation of corrective action, causing some disquiet among trainees eg for logistical reasons, candidates in England were guaranteed their first choice interview only, whereas the devolved administrations offered interviews for all four preferences.

— Better coordination of the timing of job offers is essential to avoid a race to grab the best candidates.

— The delay in appointing posts caused disruption for some clinical teams. In addition to the usual changeover pressure experienced in August each year, gaps appeared as appointed trainees deferred their start dates or employers struggled to achieve pre employment checks.

Project Management Learning Points

15 A common theme to all the listed learning points is more time to:

— Ensure effective consultation with experts and stakeholders during the design phase.

— Pilot the application system and the supporting IT systems.

— Correct faults discovered during the pilot phase.

— Clearly communicate in advance of the system going live and once problems emerged.

— Phase the applications process to limit impact on the NHS.

16 The apparent lack of risk assessment and contingency planning is inexcusable. The failure to appreciate the potential number of unemployed doctors, despite the clear concerns expressed by this College and others, and make provision for their on-going support has left many trainees and their senior colleagues demoralised and disillusioned.

Workforce Planning Issues for UK and International Medical Graduates

Inadequate Numbers

17 The transition period has brought significant problems in terms of post numbers which were well trailed by this College and others. The numbers of SHOs seeking specialty training posts reflected several years of SHO recruitment, and this bulge was not accepted as real by the Departments of Health when agreeing the numbers of training posts. This illustrates the critical importance of including experienced clinicians in national and local workforce planning teams. The College believes strongly that, had the recommendations regarding the required numbers of training posts been taken seriously, some of the anxiety over unemployed UK graduates in 2007 could and should have been avoided.

Fixed Term Specialist Training Appointments (FTSTA)

18 Under the previous system, doctors failing to achieve training posts often found themselves in staff grade or other hospital (service) posts at the end of their SHO rotation. MMC was intended to remove barriers back into training for such doctors, but the competition for training places is such that there will be few opportunities to enter an approved training system after ST1. During the transition phase, FTSTAs have been established, but these must only be a temporary solution to the bulge of SHOs competing for ST3 posts. They are dead-end appointments for 12 months only, and (currently) bring poor prospects of later transfer into a training post. If an increase in training numbers proves impossible, doctors in FTSTA posts must be encouraged to change specialty or look at other (non-training) opportunities.

UK Medical School Output

19 Recent expansion within existing medical schools and the addition of five new schools in England has now increased the supply of UK medical graduates, most of whom seek careers in the NHS. The UK must balance the output from our medical schools with our need for trained doctors. It makes no sense to attract our brightest young people into medical school, invest heavily in their medical education and then lose them to Australia or Canada due to a shortage of acceptable consultant posts 10 years on. These countries are making high profile appearances at medical careers fairs across the UK currently.

International Medical Graduates (IMGs)

20 Clear communication is required with our overseas colleagues who, for many years, have sent their young doctors to the UK for specialist training, some of whom return home but many have remained in the NHS. As the UK becomes self-sufficient in medical graduates, immigration policy should reflect this reduced dependence. However, there should be some flexibility to support developing countries where much of their training cannot be achieved locally, and where governments are keen to fund trainees through UK training programmes.

21 Clear messages and sensible notice periods are essential. The immigration changes which were introduced rapidly in 2006 resulted in outrageous injustices to some young doctors who had invested heavily in their UK training and yet were unable to stay and complete their studies. The contribution from overseas undergraduates and graduates enriches the NHS and our medical schools and reinforces the reputation of the UK as a centre of medical excellence. There must be more joined up thinking across government on these policy decisions.

Job Plans and Training/Assessment Responsibilities

22 There are clear workforce implications for consultant job plans as training, supervision and assessment responsibilities increase under MMC. Consultants must have a reasonable time allowance within their job plan, or recruitment and selection systems will be rushed and will fail.

Opportunities for MMC to Improve Flexibility of the Medical Workforce

23 Embedded within previous sections.

Roles of the Various Stakeholders in Designing and Implementing MMC

24 The roles of the different stakeholders were intertwined so closely that, although there was a clear commitment to work collaboratively, the sheer numbers brought co-ordination and consultation challenges that were compounded by tight deadlines and poor understanding of the medium and longer term impact. There was significant disconnection, resulting in lost opportunities to identify problems and disengagement, some aspects of which have been discussed in previous sections. In summary, difficulties resulted from the need to:

- Cope with suspicion about policy changes on workforce issues and the inadequacy of workforce data.
- Reconcile the different needs of the medical specialities, including the rather different perspective of primary care.
- Reconcile the different perspectives of the deaneries across the UK.
- Cope with implementation differences across the four nations and between deaneries for what was intended to be an equitable and consistent national system.
- Reconcile different perspectives on key policy issues eg the HR requirements of equality with the need to discriminate between candidates or the position of applicants from overseas.
- Consult quickly on the final outputs from development projects eg application forms or the MTAS IT system.
- Meet unrealistic deadlines.

October 2007

Memorandum by the Royal College of Physicians (MMC 42)

MODERNISING MEDICAL CAREERS

We are pleased to submit evidence to the above Inquiry. The Royal College of Physicians (RCP) plays a leading role in the delivery of high quality patient care by setting standards of medical practice and promoting clinical excellence. We provide physicians in the United Kingdom and overseas with education, training and support throughout their careers. As an independent body representing over 20,000 Fellows and Members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare.

The following submission addresses each of the terms of reference set out by the committee, and is based on the evidence we submitted to the Independent Review of MMC, led by Professor Sir John Tooke, which was developed following a process of wide consultation with Fellows and Members of the College, with our Trainees, and with representatives of our Patients and Carers network. The College is encouraged by the publication of the interim report from this inquiry, and we will be taking this forward to consult with our Fellows and Members over the coming months. We particularly welcome Sir John's strong support for helping junior doctors caught up in this sorry episode.

1. *What are the principles underlying MMC and are they sound*

1.1 The College supported the original principles of MMC defined in the CMO's document "Unfinished Business" (August 2002) and further elaborated in "Modernising Medical Careers" (February 2003). Unfortunately the College thinks that, in its implementation, MMC has become increasingly rigid and has moved away from these core principles.

1.2 The College supports the principle that training should be "broadly based to begin with for all trainees, be flexible in design and operation, and provide opportunities to leave and re-enter training" (Unfinished Business). This was confirmed as a core principle in Modernising Medical Careers: "training should be trainee-centred and programmes should reflect a variety of career choices, from those who decide on a particular career early on to those who need more time to do so".

1.3 Through its Training Boards (General Professional Training and Joint Committee on Higher Medical Training—JCHMT, and now merged as the Joint Royal Colleges Physicians Training Board—JRCPTB) it has developed the concept of core medical training (core medical training can also be delivered via the acute care common stem programme delivered in partnership with the Royal College of Anaesthetists and the College of Emergency Medicine). The Colleges have developed an innovative, broad based acute medicine curriculum, based around the 20 common acute medicine presentations and the competencies

required to manage these patients. This curriculum has three levels—level 1 would be delivered by a core medical training programme and lead to trainee doctors competent initially to manage patients admitted to an acute general hospital from the acute medical take.

1.4 All 29 medical specialties supervised by the Colleges wish to comply with MMC and see a period of broad based core training as described above. The specialities think there are major advantages for patients and the NHS in their specialists having a broad based general medicine training. Core medical training would be followed by greater specialisation within 29 higher training programmes, leading to a CCT in the specialty. The College thinks that flexibility and duration of training are key issues. Flexibility, so that trainees could shift between specialties, and, if need be, taking with them the competencies they had accrued; appropriate duration so that trainees could be exposed to many of the different physicianly specialties, and if need be gather additional competencies relevant to that specialty, enabling them to decide their eventual specialty.

2. *To what extent the practical implementation of MMC has been consistent with the programme's underlying principles*

2.1 We are concerned that, as currently implemented, the new structures have not adequately enacted the core principles of trainee centred flexibility in training. The principle of flexibility must be reaffirmed and be at the heart of the new model of medical training.

2.2 We think that the policy shift took place when "Next Steps" were published by the UK Strategy Board in April 2004; it stated that "single run-through training programmes were thought to be not only desirable but achievable". The Colleges expressed concerns about difficulties of run-through, in particular the problems of allocating a cohort of core medical trainees to the entry points of higher medical training. Run-through was interpreted by MMC and PMETB as a single curriculum for each of our 29 specialties from F2 to CCT, with the expectation that every trainee who was appointed to a core medical training programme would expect to obtain a CCT in one of the 29 specialties. Indeed, the view of the Postgraduate Deans, expressed through COPMeD, was that allocation from CMT to the 29 specialties could take place within each of the Deaneries. The Colleges have repeatedly pointed out that there are considerable difficulties in allocating within Deanery. There are marked year on year fluctuations in availability of specialist training within the Deaneries. Many trainees would be forced in this situation to continue training within a specialty that was not their first, second, third, or even fourth choice. Additionally, there were problems with allocation arising when some small specialties do not exist within all Deaneries.

2.3 We are anxious that a solution to this problem is found for trainees who have been appointed in 2007 to "run-through" programmes at ST1 and ST2. These trainees may not benefit from the "uncoupled" approach to specialty training that we are recommending. Maximum flexibility of career choice for these trainees should be made available outside their current Deanery.

2.4 To summarise, the College's view is that the implementation of MMC has led to the emergence of inflexible run-through training programmes within Deaneries. This led to the amalgamation of core and specialist training curricula in an inappropriate way and the loss of flexibility and choice for trainees within run-through programmes. In addition, the effect of strictly linking Core and Higher training in a run-through structure is to restrict access to core medical training to trainees within physicianly specialties and to exclude other specialties such as anaesthetics, radiology and general practice, where a period of core medical training might be helpful to some trainees in those specialties.

2.5 The College would like to see choice and flexibility re-introduced to specialty training, first by uncoupling core medical training from specialist training (previously known as higher medical training) and secondly, by being more flexible about the duration and outcomes from core medical training. Thus foundation trainees would apply for core medical training programmes in the expectation that a two-year programme for most would deliver level one competencies in acute medicine. In competence-based training, trainees who achieve these competencies earlier could apply for higher specialty training at this stage. Conversely those who took a longer period may achieve the competencies in three to four years, and then apply for higher speciality training. Others may wish to stay within extended core medical training programmes to develop yet further acute medical skills to level 2 competency, enabling them to leave the programme with competencies that they might subsequently use as a CCT specialist to oversee the acute medical take, or as stand alone competencies when they could be employed by Trusts to manage acutely ill patients (within a consultant led team). A further cohort might go on to achieve level 3 competencies and CCT as an acute physician and be consultant in charge of running an acute medical unit in an acute general hospital.

2.6 While some trainees may complete CMT in two years and move on, we believe that maximum flexibility and career mobility will be achieved on the basis of planning three years as the average duration of CMT. While detailed modelling would be required, early thinking suggests that sufficient posts for a third year could be derived from FTSTA and high quality Trust Grade posts in Medicine (or related ACCS Specialties) with some trainees electing to spend time out of programme abroad or in clinical research.

2.7 Uncoupling CMT from higher medical training would mean that trainees compete for selection to higher medical training in the 29 medical specialities, and enter a "run through" specialty programme to CCT. The minimum person specification would remain the same, ie the achievement of core medical training (in five specialties core paediatric training is an acceptable alternative and some specialties have wider person specifications, including core surgical or GP training). The advantage of this system is that trainees would still know what they had to do to become specialists, but they would have the time to make up their minds about their specialty, and the opportunity to compete for the specialities of their choice.

2.8 Uncoupling would also facilitate workforce planning with increased adaptability to demand and a shorter lead time for trainees in shortage specialties.

2.9 Lastly, uncoupling CMT would be of advantage to other Colleges' programmes of training since trainees wishing to embark on radiology, anaesthetics etc training could acquire additional acute medical skills in CMT programmes. They could do so in the knowledge that this would not only make them more competitive for entry to the best programmes, but also enhance their overall clinical skills. In this context the College would wish to work with other Colleges to achieve recognition of competencies common to our training programmes so that training is delayed as little as possible by changes in direction. We believe that there would be advantages in working towards common "primary exam" assessments to permit further flexibility of training.

3. *The strengths and weaknesses of the MTAS process*

3.1 The College shares the widespread dismay at the poor performance of the MTAS system. The single annual simultaneous appointment round has caused anxieties around the provision of service in early August and alternatives to this approach should be explored.

3.2 We are concerned about the needs of trainees with young children who wish to train flexibly. The rigidity of MMC run-through structures poses particular problems for flexible trainees who may wish to move between specialties or regions. Many trainees choose to follow their partner's career and may need to move specialty or region during the "run-through" period. There are particular problems for academic trainees, since European law suggests that part time training must consist of 50% direct clinical activity. This reduces flexibility still further and effectively prevents part time training of clinical academics.

3.3 Academic physicians were particularly affected by the rigid MTAS process as it ran counter to the way that trainees with research potential had been identified and mentored. The College would wish, acting through its Academic Medical Committee, to contribute to the implementation of the Walport initiative by ensuring an integrated approach to the assessment of academic and clinical competencies, and to assist with the development of new selection processes for academic trainees in the light of the difficulties in assessing academic potential using the current MTAS methodology. Furthermore opportunities for out-of-programme experience, such as research, should be encouraged.

3.4 The following extracts, which form the remainder of our evidence for this section dealing with the strengths and weaknesses of the MTAS process, and broader issues concerning the MMC process as applied, are from the report from the RCP Trainees Committee, which formed part of our overall submission to the Independent Inquiry into MMC. This provides in more detail our concerns around the MTAS/MMC process:

3.5 Entry, Progression and Exit from Medical Training Grades

Application into Specialty Training via the Medical Training Application Service (MTAS) in 2007

3.5.1 The problems with MTAS in 2007 have been well documented, but they can be grouped into three key shortcomings:

1. A web-based application system that was insecure and difficult to use.
2. An unvalidated and flawed application form/mark scheme which failed to shortlist the a small but significant number of excellent applicants.
3. A huge discrepancy between the number of applicants and the number of jobs available.

3.5.2 The valuable advice of the Royal Colleges and BMA was not taken sufficiently seriously by the MMC organisation and Department of Health (DH) in the run-up to the implementation of MMC and MTAS. There was also a lack of engagement with the "grass-roots" junior doctors and consultants which compounded the gross system failures.

3.5.3 Many trainees applying to core medical training jobs had general practice as two of the four choices often with GP as their third and fourth choice. Initially trainees had been told that deaneries would not be aware of the candidates ranking preference. The decision that trainees applying to GP would only be considered if they had GP as their first choice made a mockery of the system of four choices and if further systems allow multiple choices the ranking must be confidential from those appointing.

3.5.4 One of the concerns of introducing a new training system is the transition period. It is crucial that good doctors are not punished for being in the wrong place at the wrong time. This is most evident at entry to ST3 level. Previously there has been a bottleneck at entry to specialty training with some trainees stuck in senior SHO posts with poor supervision and poor career progression. However this is not always the case and many senior SHOs are at the correct level for their career progression. In addition to this there are a number of trainees in research or LAT/LAS posts who have shown not only good career progression but also commitment to their chosen specialty. Below (Table 1) is a small sample of the data published by MTAS on numbers of applicants per post for a selection of medical specialties. With a single window of entry into ST3 a large number of excellent trainees are being denied any chance of progressing with their training.

Specialty	*Number of Posts*	*Number of Applicants*
Acute Medicine	121	678
Cardiology	100	1,501
Dermatology	30	274
Gastroenterology	50	658
Haematology	54	368
Renal Medicine	44	339
Respiratory Medicine	89	925
Rheumatology	27	211

Table 1. Numbers of posts and numbers of applicants for a selection of medical specialties. (MTAS)

3.5.5 We understand that there is a rescue package that may include an expansion of posts in specialties that have significant numbers of trainees applying to ST3 and have the workforce needs to support an expansion of consultant numbers. We await more information on this proposal with eager anticipation. However we would like it noted that this problem was self evident and made apparent to MMC when the decision to launch run-through training as a "big bang" was suggested.

3.5.6 *Entry into CMT—2008 and Beyond*

Choices and Numbers of Application

3.5.7 There is no reason to restrict trainees to four applications and therefore only four potential interviews. A trainee should be allowed to apply for any deanery school of medicine that they want to enter.

Application Form and CVs

3.5.8 It is clear from MTAS 2007 that psychometric testing does not discriminate well enough between applicants. There is also little evidence to support CVs as a discriminator between applicants but experience suggests that CVs are better than the psychometric forms. In future an application form is required that is largely based on the CV but should also have some specialty specific 'white box' questions.

Examination

3.5.9 The idea of a generic exam to aid selection has been suggested and has worked for General Practice. However written exams can only test knowledge and are likely to be highly influenced by local factors including coaching. Focus within the foundation years must be on acquiring the core generic competencies. If an examination is used to aid selection for CMT then the MRCP part 1 examination should be used. This would mean that trainees have worked for an exam that would contribute both to their education and career progression.

Shortlisting

3.5.10 Shortlisting for a specialty against specific criteria can be carried out once for each trainee rather than duplicating it for each post. This assumes that the application form and short listing criteria for each job is identical. For CMT there is no reason why it should not be. This would dramatically reduce the workload and service impact on consultants performing the short listing. It should not be difficult to agree on shortlisting criteria as most Deaneries seem to have used very similar criteria this year. As a consequence most trainees were offered either one or all four interviews.

Assessment centres and interviews

3.5.11 If work-based assessments are performed properly and are similar across the country then portfolios should provide a good reflection of a doctor's ability. Portfolios combined with a CV would show a trainee's commitment to a specialty. The use of three ten minute stations, including a portfolio review and clinical scenario, appears to be a reliable way of selecting trainees.

Leaving CMT and entering Higher Specialty Training (HST)

3.5.12 The process of moving from CMT to HST by allocation has long been debated. In fact a decision on how this process occurs is long overdue as it is highly relevant to those entering CMT. The proposal by Dr Cadigan and Professor Burr was largely acceptable to trainees. The suggestion is:

— Specialties with less then 30 ST3 posts nationally each year will be nationally allocated.

— Specialties with between 30 and 70 ST3 posts nationally will have a combination of deanery and national allocation. eg 30% of ST3 posts will be allocated nationally while the rest will be kept in region.

— Specialties with more that 70 ST3 posts nationally will mostly be kept in the deanery. But 10% could be offered for national allocation.

3.5.13 However we propose that with little evidence to support run-through training there should be a separate round of selection into HST. In keeping with the proposals of "Unfinished Business"5 we would aim to limit time in CMT to a minimum of two years and a maximum of three years. This would increase the flexibility for trainees dramatically allowing them to move region easily, consider different career paths and would solve the problems of allocation into ST3. The optional third year would allow for those trainees who are slow to progress with assessments and give time for those failing to enter the sub-specialty of their choice to adjust.

3.6 The End of Training and Entry onto the Specialist Register

3.6.1 It is appropriate the doctors in non-career grade appointments be allowed to enter the specialist register if they can prove they have the experience, qualification and judgement to work as a consultant. However the already established college boards could have implemented this change in policy. It is worrying that the college boards and PMETB have differing views on who should enter the specialist register even based on the new criteria. The formation of the Post-Graduate Medical Education and Training Board has led to an extra unnecessary level of bureaucracy and stress for trainees. This is most apparent with the use of Article 14 to allow trainees from the run-through tracts entry to the specialist register. The fact that trainees entering in year ST2 to ST4 will leave training schemes with different certificates will create an artificial division between trainees trained to the same standard. The Certificate for Entry onto the Specialist Register (CESR) awarded to those entering via Article 14 is already perceived as inferior to the Certificate of Completion of Training (CCT).

The Sub-Consultant Grade

3.6.2 While the sub-consultant grade is not a concept of MMC it was originally introduced to trainees on the original MMC diagram of run-through training. Medical trainees strongly feel that all doctors who are on the specialist register should be consultants and those senior physicians providing service must be able to impact on service delivery.

Changes to Training under MMC

Run-Through Training

3.6.3 Many trainees are unclear of the advantages of run-through training and certainly there is little evidence to support this core change to training.

Advantages:

— Job security once appointed.

— Tailored training programs.

— Reduction in number of relocations.

— (Potentially) Standardised and streamlined paperless selection procedures.

Disadvantages:

— Fails to recognise the diversity of medicine and the importance of a varied and broad training. In the face of multiple pathologies in an ageing population this general training is increasingly important.

— Dramatic reduction in length of training (also due to EWTD) reducing experience.

— Less freedom to gain experience in different fields before making a decision.

— Less freedom to leave a programme because of having to re-apply a year later in a highly competitive system.

— No perceived facility to move jobs.

— Poor systems for career progression for those conducting research outside of the few available Academic run-through training programmes (which is likely to lead to less research being undertaken overall).

3.6.4 As suggested above we feel the disadvantages of run-through training out way the advantages and propose that CMT and HST are uncoupled.

Competency based training

3.6.5 This is the most important change introduced by MMC and quite rightly all doctors have welcomed this concept. The ability of a doctor to prove to both their patient and their employer that they are fit for purpose is essential. Not only is this the safest way to train junior doctors but it also allows trainees to work within a strict framework so that they understand exactly what is expected of them, their educational and clinical supervisors, their employers, and their Deaneries. A potential problem with competency based training is it can promote mediocrity. It is hoped that as competency based training evolves that it will become more discerning and other strategies will be found to promote excellence.

Experiential learning

3.6.6 Being assessed as competent does not automatically mean that a doctor will be confident or indeed excellent in that specific area. It must not be forgotten that training in medicine remains in many ways an apprenticeship and there is no substitute for experience. It is important that trainees have carried out enough supervised procedures and that they have experience in managing the common complications. While the importance of experiential learning is most obviously applicable to procedures, it is just as important in other situations. Leadership of a cardiac arrest team demands more than an Advanced Life Support attendance certificate. Attendance and participation in many cardiac arrest situations with leadership from more experienced doctors is required to develop the confidence and knowledge needed to address real-life situations.

3.6.7 We are already seeing the impact of decreasing hours on training and it is not surprising that the specialties with greatest one-to-one interaction (anaesthetics and GP) gained the highest trainee satisfaction score in the PMETB survey6. With shorter time for training, each educational opportunity must be used as a learning event as it may be the only opportunity. This change in focus will necessitate much closer supervision of trainees to allow one-to-one teaching. The Gold Guide7 states that "sufficient time must be identified in consultant contracts and job plans to allow senior doctors to undertake clinical supervision whilst meeting their service targets and objectives". There is little evidence that consultant contracts are being adjusted to incorporate increased supervision. There is also little evidence that clinical supervisors are "appropriately trained to teach, provide feedback and undertake competence assessment to StRs [specialty registrars] in the specialty" despite what the Gold Guide states.

Careers advice and career progression

3.6.8 Trainees must have appropriate careers advice at multiple stages of the training journey. This is a key concept of MMC but it is unclear how it will be implemented.

For trainees entering medical specialties, careers advice is important before and during both foundation level and core medical training. While many Deaneries and Colleges have produced publications (mainly electronic) for trainees, this cannot replace the face-to-face discussion with a trained advisor. If careers advice is to be allowed to work properly it must also allow trainees time to sample specialties that they may not have experienced. Time must also be allowed for consultants and other advisors to help trainees with decisions relating to their career.

3.6.9 In addition to the support given to trainees to make the correct choice of specialty or sub-specialty even more support must be given to those have been unable to enter the specialty they had wanted to enter. This situation will occur following application to ST1 and allocation into ST3. These trainees will be particularly vulnerable, some having failed to achieve a goal for the first time and being faced with the possibility of a career that they do not want to pursue.

Appraisal and Assessment

3.6.10 The majority of junior and senior doctors are unaware of the difference between appraisal and assessment despite both processes being key to progression within the foundation years. Appraisal may be time consuming but should form the cornerstone of a supported program for development and progression of a trainee.

3.6.11 Assessment of trainees is done in two different but equally important ways. Knowledge based assessments are essential for testing the factual knowledge of trainees. The college membership exams are well validated assessment tools and act as a benchmark for trainees to work towards. It is essential that trainees in any specialty know and understand the core information that their specialty is based on. This information needs to be known and not accessed in a book in a crisis.

3.6.12 Work based assessments evaluate a doctor's ability to practice in medicine in the work environment. If they are performed properly by trained assessors and in enough numbers then they will examine a part of practice that previously has not been assessed except by personnel reference.

Out of Program (OOP) activity

3.6.13 The Gold guide incorporates a section on out of program activity. This includes illness, maternity leave, career breaks, and educational activities such as research, education and management training. The perception of trainees is that Post-Graduate Deans will make the option of going OOP increasingly difficult. The very small number of academic tracts does not correlate to the number of trainees currently benefiting from time in research.

3.7 Flexible Training

3.7.1 Flexible training is essential with an increasingly female dominated workforce. It should also be available for wider reasons than caring roles. There is an opportunity that flexibly training be fundamentally incorporated into MMC rather than "slotted in" in an ad hoc way as in the past.

3.8 Quality Control (QC) and Quality Assurance (QA)

3.8.1 The loss if visiting to trusts under PMETB is a huge loss to quality assurance of individual posts at a trust level. The combination of the PMETB questionnaire and Deanery level quality control is not rigorous enough to ensure each individual post is up to standard. The results of the 2006 PMETB survey are still not in the public domain eight months after the survey questions were disseminated. The relationship between the Deaneries and the NHS trust is very different from the relationship to the colleges and trust. Trainees perceive the Deaneries as less impartial and more focused on maintaining service needs of the trusts and the individual training needs of junior doctors. Trainees feel that there is more benefit from the external visit of the Royal College. The reduction in visiting my PMETB to "macro" visits to Deaneries will do nothing to quality assure individual post but is completely inline with government recommendations on reducing the burden of visits to trusts.

3.9 Formation of Deanery Schools of Medicine

3.9.1 The formation of Schools of Medicine with each deanery has been an excellent advancement under MMC but we are yet to see whether they are used to their full potential. Schools could be used to co-ordinate wider teaching programs and should lead to a strengthening of the weaker training posts.

Core Medical Training (CMT)

3.9.2 The concept of CMT has a number of positive advancements over previous Senior House Officer (SHO) training. The introduction of new curriculum (both clinical and generic) with accompanying work based assessments is a large step forward as is the increased focus on appraisal and careers guidance. The rotation of CMT trainees between teaching hospitals and district general hospitals will improve the diversity of training but improve patient care with the increased standard of trainees in traditionally less competitive posts.

Study budgets

3.9.3 The recent decrease in study budgets has affected all trainees in medicine. Trainees understand the expense of courses but also have to attend some courses as a requirement of their curriculum and training. Certainly trainees understand that local courses can be run for less money and often just as well but commonly there is no alternative.

3.9.4 Recommendations:

1. New application system incorporating CVs.
2. Allow application to individual deaneries.
3. Abandon run-through training with uncoupling of CMT from HST.
4. Insertion of a third CMT year for those trainees failing to enter the specialty of their choice from ST2.

5. Recognise the importance of diverse training and allow trainees to go out of program if requested and justified.
6. Recognise the true impact on service of appraisal, careers advice and work based assessment and build time into the contracts of educational and clinical supervisors to allow these activities to be performed correctly.
7. Allocate time for trainees to meet with their supervisors.
8. Increase time allocated to teaching in the clinical situation.
9. Improve QA and QC of individual trust by allowing external college visits rather than internal deanery visits.

4. *What lessons about project management should the Department of Health learn from the failings in the implementation of MMC*

4.1 The College welcomes recent moves to secure more robust project management for MMC, including the formation of the Programme Board. The medical profession must be at the heart of decision making and not merely consulted. To complement this change, PMETB must, as originally planned, become a smaller, light-touch competent body with maximum delegation of accountable operational delivery to the Colleges. Furthermore, the process of bringing this body under the overarching regulatory leadership of the GMC needs to be accelerated. The professional accountability of the Postgraduate Deans to the centre also needs to be strengthened.

4.2 The College shares the view of its Trainees Committee (as detailed above) that Quality Assurance of Training Programmes has become less rigorous following the changes implemented by PMETB and that more robust processes with appropriate external professional input are required to ensure a satisfactory educational environment for the individual trainee.

5. *The extent to which MMC has taken account of the supply and demand of junior doctors and the number of international medical graduates eligible for training in the UK*

5.1 We have concern for the welfare of International Medical Graduates (IMGs) who have been caught up in the uncertainty of the immigration regulations. We understand, and agree with, the need to ensure that there are training posts for graduates of UK medical schools, but recognise the contribution that IMGs have made to the NHS. Whatever decisions and changes are made in the future to immigration regulations that effect IMGs, it is vital that clear and unequivocal guidance is issued to IMGs, Deaneries and employers and that there is adequate consultation with stakeholders prior to changes.

5.2 The DH is currently consulting on proposals for managing medical graduates from outside the European Economic Area, and we are considering our response to this.

6. *The degree to which current plans for MMC will help to increase the flexibility of the medical workforce*

6.1 We believe that the uncoupling of Core Medical Training and Higher Specialist Training with a further point of selection gives greater opportunity to respond to contemporary workforce conditions. The model of run-though training is inflexible and unresponsive to changing employment factors.

7. *The roles of the Department of Health, Strategic Health Authorities, the Deaneries, the Royal Colleges and the Postgraduate Medical Education and Training Board in designing and implementing MMC*

7.1 Our retrospective review of our College's engagement with the MMC team confirms that our serious concerns about many aspects of the proposed new arrangements were communicated directly to senior MMC personnel, but they appear to have received insufficient attention. The review has also identified serious concerns with the lack of clarity about personal and organisational authority and accountability.

7.2 In addition, the role and functions of other stakeholders in the medical training arena has lacked clarity and cohesion, and therefore effectiveness. Difficulties in strategic and operational relationships with the Postgraduate Medical Training and Education Board (PMETB) have been well documented in recent interactions between the Academy of Medical Royal Colleges (AOMRC) and PMETB. This College continues in its view, as submitted in response to the Chief Medical Officer's consultation document "Good Doctors, Safer Patients", that all medical education and training regulatory activity should be brought together under the overall authority of the GMC.

7.3 In England there is scope for better co-ordination of the work of Postgraduate Deans through professional accountability to the Deputy Chief Medical Officer (Professor Martin Marshall) who now has the medical education remit nationally.

7.4 The College is already working with other Colleges to agree shared elements of core programmes and related assessments. We wish to produce trainees who are empowered by a wide range of generic and specific skills that will benefit patients and facilitate self-determination in trainee career choice. We recommend that Colleges continue to build on this joint approach.

7.5 There are other practical ways that the RCP can contribute to the process of implementation of the new medical training model.

7.6 The College would be in a strong position to assist with the implementation of the changes that we have suggested working though its training board (JRCPTB), which delivers training curricula, and through its Specialty Advisory Committees (SACs) (whose core membership comprises Heads of Specialty Training from the Deaneries of the four nations). The JRCPTB and SACs need to work with PMETB and the Postgraduate Deans to agree any changes made to training. PMETB would need to approve changes to the curricula as described within their standards. We do not think that uncoupling CMT from HST would transgress PMETB standards. The Postgraduate Deans are accountable for the delivery of specialty training in line with the approved curricula. They would need to agree training posts with the providers of training, ie NHS Acute Hospital Trusts, and ensure that these posts are part of approved programmes.

October 2007

Memorandum by the Royal College of Psychiatrists (MMC 43)

MODERNISING MEDICAL CAREERS

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and the Republic of Ireland and is the professional and educational organization for doctors specialising in psychiatry.

EXECUTIVE SUMMARY

Background

a) The shortcomings of the system have been highlighted from many quarters. The College believes that MMC had a number of sound proposals. However, the implementation failed to follow those proposals and became rushed and over-ambitious. This occurred in spite of repeated requests by this College and others for a phased introduction for Year 1 of speciality training with others remaining in existing posts and training programmes, which would have been the most sensible beginning. This would have enabled new methods for application and selection to have been properly tested for fairness, feasibility, validity and reliability in a way which could have commanded the confidence of all both within and without the medical profession.

b) The College remains concerned that the rigidity of the system is already showing itself with regard to the difficulty in concluding training and employment arrangements for those seeking to train less than full time and anticipates problems in handling those who do not progress according to the prescribed schedule. It also means that the movement across specialties especially in early stages of training eg moving from General Practice to Psychiatry has become more and not less rigid which was one of the stated intentions.

c) The deployment of the National MTAS methodology was an unnecessary disaster. Again various concerns, eg about possible plagiarism, were raised with the Implementation group but were ignored. The College believes that there must be learning from successful systems that have operated outside the UK. The system lacked security and humanity. The former was well publicized in the press but the latter creation of a method that was not responsive to individuals, their unique backgrounds, career progression and life situations was equally disastrous.

d) To add to these problems, was the position over International Medical Graduates. This has a particular resonance in psychiatry, reliant as it has been on high numbers of such doctors. The inflexible statements from PMETB over training programmes, meant that large numbers of doctors were made to feel a combination of panic and helplessness. For this College at the last MRCPsych examination part 1 only 12% candidates came form British medical schools. Again this has been raised repeatedly with the Implementation group without a satisfactory resolution.

Possible solutions

e) In looking to the future the College believes that it is essential that Colleges and Deaneries be permitted to work together using their extensive knowledge and experience in design and management of postgraduate training. Certain specific aspects must be addressed in order for the situation to be improved. These include;

i) Flexibility in Career choice—The College believes that the ability of doctors to review career choices and maintain a degree of flexibility in choice during their postgraduate training is essential to the future of the profession as a whole. It continues to seem to the College that the expectation

that the overwhelming majority of doctors make a lifelong career choice upon graduation is more suited to a graduate entry medical school model. A flexible system with good career advice was one of the original visions of MMC. This vision must be realised.

ii) Less Than Full Time Training—In order properly to recognise the needs of an increasingly female workforce, including families' childcare needs (moving at short notice or frequently is not family friendly) and those increasing numbers of male doctors who wish to work and train less than full time, we recommend that close consideration be given to designing training on the assumption that a majority will wish to work less than full time. Thus flexible working patterns would be integral to training and workforce planning.

iii) SAS or Career Grade Doctors—The background and aspirations of these doctors need to be examined as a matter of urgency. These doctors need to be in "managed education". There must be explicit standards for employment including supervision and a curriculum must be developed.

iv) Career counselling—The delivery of new training structures and curricula must be accompanied by the proper provision of career counselling and guidance. This was an important feature of the early iterations around MMC but was lost in the rush to implementation.

v) Ring fencing of Training Budgets—Training money must be ring fenced by SHAs for training at all levels and all grades. The savage cuts experienced last year have severely damaged the infrastructure (including consultant time for education) required to successfully deliver new curricula.

The College is pleased by the opportunity to present evidence to the Health Select Committee Inquiry.

1. *What are the principles underlying MMC and are they sound?*

1.1 The key principles underlying MMC originate from "Unfinished Business", namely:

— that training should be programme-based,

— that training should begin with broadly-based programmes pursued by all trainees,

— that programmes should be time-limited,

— that training should allow for individually tailored or personal programmes,

— and that arrangements should facilitate movement into and out of training and between training programmes.

Further important principles outlined in Modernising Medical Careers include:

— clear reference to the end product or outcome of training,

— the environment of training (including its multi-professional nature),

— the need for strong educational management and the need for "rigorous" counselling and career advice throughout training as well as specific reference to the needs of overseas doctors are fully considered.

1.2 The College considers the basic principles (with the exception of the minimum time clause, see below) of MMC to be broadly suitable. We believe they provide a competency-based training in which the individual doctor develops in an incremental fashion whilst providing a clinical service at a level and under conditions of supervision commensurate with their clearly demonstrated (through workplace-based assessment) performance.

1.3 We believe that these principles have underpinned the conditions of service and training in psychiatry for some years. For last three decades and more, Psychiatry has trained doctors in organised programmes that have involved numbers of Trusts working together, pooling resource and expertise.

1.4 The best training would be a fusion of clinical, academic and personal development based on an outcome-based curriculum. The focus should be on performance including knowledge and its application. The place of local service based assessments must be within an overall programme of assessment that includes credible national examinations that serve as benchmarks and demonstrable levels of achievement (the public and patients would rightly wish to see this). Training and supervision of training itself must be properly resourced and professionalized. This means incorporation of the true time and costs of training into service business plans at Trust level.

1.5 In terms of principles within MMC, the College remains less than convinced over the principle that trainees should always complete in the minimum time. There is no argument over the hypothesis that training should be efficient but as a principle this appears to give the impression that development of a medical specialist can and should be rushed in some way. One of the fundamentals of specialist status is experience gained through adequate and supervised training. This can only be gained through sufficient time and clinical/patient experience as well as exposure to clinical conditions.

2. *To what extent the practical implementation of MMC has been consistent with the programmes underlying principles*

2.1 The College believes that the implementation of MMC was rushed, over-ambitious and lacked clear management and leadership. This contributed to a situation in which the principles outlined above have not been fully met.

2.2 The first three principles from Unfinished Business have been achieved in part. Training has been designed around programmes with time indications but frankly in psychiatry it already was. Broad based programmes in the form of the Foundation Programme have been introduced. However, the presence of psychiatry in these programmes across the UK remains very poor. This seems entirely at odds with the concept of a broad development for doctors, given the epidemiology of mental health problems in modern UK society where one in four is likely to suffer from mental illness of one kind or another.

2.3 The latter two principles (individual tailoring of programmes and flexibility) have singularly not been met. The system totally lacks flexibility for the individual. Indeed, for those seeking to work and train on a less than full time basis much of the progress made over decades has been wiped out at a stroke as individuals have to "fit into" a prescribed structural arrangement. Movement in and out of training or between programmes has been made virtually impossible. The anxiety-driven scramble to get aboard any programme, coupled with unhelpful messages from PMETB over programme approval and the perception for trainers and trainees of an inflexible production line system conspired to present a system that has become rigid beyond imagination.

2.4 If one considers further the principles that were added in MMC these could only be considered partially met. There is in new curricula a greater emphasis on the outcome or end-product in terms of description of a level of performance. However, the nature of professionalism is such that specialist medical practice does not reduce to a few statements or a summation of competencies no matter how well drawn these are. There is far more to professionalism and professional practice and a clear danger of reduction to the level of a technician.

2.5 Some limited attempts have been made to describe standards in education, particularly, by PMETB. Regrettably, for psychiatry, many of these represent a considerable dilution of previous practice, for example, with regard to educational supervision. In addition, there is a danger that run-through training may reduce some of the incentives for learning that have always served medicine well. The need to clearly demonstrate achievement through success at National assessments in the form of College examinations and to compete with peers at interview for higher specialist training was a strength rather than a weakness in the past. Assessment is a necessary lead in learning!

2.6 The strong educational management that is the sixth principle has not been achieved or indeed clearly supported. The resource base for training has been drastically reduced. This is the opposite of what is required at a time of change and the place of postgraduate education within service organisations at Trust level is under threat.

2.7 Career counseling and career advice were never more needed and were rightly one of the key principles, but these roles were scarcely developed until the picture dictated by the MTAS debacle became clear. Then the focus was perforce on the difficulties faced by those who were excluded or significantly displaced rather than those seeking flexibility or advice.

2.8 The needs of overseas doctors which feature as another of the key principles continue to be overtaken by events. This College is alarmed at the continuation of proposals for International Medical Graduates who currently make up around 80% of the junior training workforce in psychiatry.

3. *Strengths and Weaknesses of MTAS process*

3.1 A significant problem is now the perception of the entire system. Much of this stems from the MTAS system itself. The method of a National Portal with local interview could have worked. It is clear that other countries including the USA and Canada have operated the National Portal very successfully. There was potential advantage in a system which tracked applicants and their progress particularly if this was matched with credible workforce plans. From the employers' view the system would have prevented doctors holding multiple offers until the last minute which formerly created difficulties in finalizing plans for rotations and hospital rotas. However, the inception appeared to be flawed and again rushed. The College is surprised that greater efforts were not made to learn from International experience and no piloting was conducted in spite of suggestions to the Implementation Board.

3.2 The problems of security have been well highlighted from many quarters. These were inexcusable and have led to a continuing loss of confidence that will affect perceptions for future recruitment years.

3.3 The College continues to feel that the method of using a National Portal has distinct advantages in streamlining the application, shortlisting and interview processes and supports its use in modified form in future recruitment.

3.3 Crucially, the system lacked a human interface for applicants and those attempting to advise applicants. The system of an online application only was remote and anonymous. The lack for example, of a recognisable and generally local "face" such as a HR manager or Panel member, who could give feedback

or advice to the trainees and with whom individuals could interact, was a considerable loss in terms of the humane side of recruitment and education which must not be underestimated. In certain deaneries the trainees were told that if they had not heard the results by a certain date they had not been offered a job. This added to the alienation of trainees after a stressful process.

3.4 In almost all parts of the country there is evidence (from heads of schools of psychiatry) that timetables for the shortlisting process were undermined by the failure of the system to deliver information in a timely fashion. The application did not make available to assessors vital information (ie personal detail and employment history) and did not have a valid or reliable method for scoring potentially useful items of experience such as audit, teaching, research and team-working. It used untried and unresearched questions for other domains such as clinical judgment and commitment to specialty. Shortlisters were thus presented with a very difficult task and not surprisingly reliability scores suffered (eg for West Midlands the reliability score on shortlisting for first year applicants at round one fell below the acceptable level for examinations). When this lack of reliability is taken alongside the four choices granted to applicants (which meant that only around 20% or so of applicants could be shortlisted in round one) then it is not surprising that the "results" at times appeared random.

3.5 The foreshortened timescale left little time to prepare properly for interviews. The College staged pilots, which were presented nationally to medical education leads, but this was not equivalent to proper research work on fairness, validity and reliability and obviously could not therefore amount to a National blueprint for interview.

3.6 The problems extended beyond application and interview. Trainees were offered jobs by email and then 15 minutes later offers were withdrawn, without any explanation or face to face contact. The indication on some Deanery websites that if the candidate has not heard about a job offer by a fixed time they have not got a job appears to reinforce the perception of a remote and impersonal system that treated applicants in an inhumane fashion. The adverse impact of this (systems approach) upon the mental health of applicants continues to be the subject of review and publication as a letter (BMJ, 2007, 344, p1335)

4. *Lessons for DH from implementation of MMC*

4.1 The Royal College of Psychiatrists believes that a fundamental lesson to be learnt from the implementation of MMC is that the Department of Health must listen to those people who are trying to implement a process rather than decide what to do before starting. The DH made a serious mistake in ignoring the grave reservations of professionals about the changes.

4.2 It is apparent to the College from feedback that it has received from educators, regional advisors and trainees that the Department of Health did not appear to be listening even when potential problems were highlighted. The style of these comments was as follows; "The College arranged meetings at which consultation with those who had to implement the change took place. At these meetings strong attempts were made to get across to those representing the DOH the problems that might ensue. These warnings seemed at the time to be belittled and ignored." and "the Deanery also did its best to arrange consultations but as at the College meeting negative feedback was dismissed and ignored." and "both the Deanery and the College did all they could to support trainees and those involved in recruitment when things began to go wrong."

The perspective of the devolved administrations supports the argument over a lack of listening and flexibility from the DH. Feedback included the following; "in relation to the Department of Health in the UK, it is difficult to see this in a positive light in that most of the initiatives and comments which came from Scotland in relation to the problems of MMC/MTAS seemed to be ignored by the department of health and efforts made to force Scotland into a straightjacket proposed by the English Department of Health. This probably contributed to the need for Scotland to withdraw from the system and it is essential that we look at it very clearly before going back into any UK system. The review of the MMC/MTAS process overseen carried out through Neil Douglas from the Royal College of Physicians of Edinburgh has come forward with some helpful suggestions but the general view in Scotland is that most of the issues to do with MMC/MTAS were very much based on the English situation with little account being taken of other countries within the UK."

4.3 One particular example relates to the process of appointment at FY1 and FY2 level. This had been working well in the UK for a few years and in Scotland was working very well. There was a desire to extend this to the ST1 appointment system and then gradually move it through the system at other levels. This was not taken on board by the Department in relation to MMC/MTAS although it would have worked much better than the "big bang" system introduced against the advice of many people. The College understands that it was considered that the level of complexity in running two systems in parallel was too great. The example of trainees remaining on "pre-Calman" arrangements for many years was quoted. The College were not persuaded by this argument. We believes that those charged with responsibility and management of postgraduate medical education were capable of handling this.

4.4 Finally, the College believes that large scale changes should be piloted first, with attendant research, and introduced one at a time. In addition to the national recruitment mechanism, we have also seen the implementation of the run-through training grade and the new curriculum and assessment mechanisms this year.

5. *Extent to which MMC has taken account of supply and demand of junior doctors and numbers of IMGs eligible for training in UK*

5.1 Supply and demand is always difficult to measure precisely. However, there appear to have been major problems in this area. There has been a lack of clear consideration of the effects of increased output from UK Medical Schools, the output of European Medical Schools and the current employment picture of doctors in the EEA coupled with the impact of European law permitting freedom of movement.

5.2 The College does not believe that due account was taken of the needs and aspirations of doctors in SAS grades. Those with direct experience of recruitment at local levels previously were less surprised by the numbers of applicants from these grades than were those with central roles. SAS doctors were treated, if at all, as a homogenous group with similar backgrounds, achievements and experience when it is clear that across and within specialities these doctors are a most heterogenous group. As a group their desire for further education in formal training schemes was underestimated (and the attraction of CESR perhaps overestimated). In psychiatry over the past decade there has been a not uncommon practice of doctors spending a couple of years gaining further experience in this grade with the clear intention of returning to training.

5.3 The College believes that a somewhat simplistic view of human behaviour was taken in some of the assumptions around modeling for choice of speciality. There was, and is, a clear expectation that trainee doctors will make an accurate assessment of their abilities and potential. The data that will be available to them to make this appraisal was unclear (the College notes current discussions for "ranking" examinations of all Foundation Programme graduates which may fill some of this gap). The trainee was then to compute this against information on available opportunities and likely career outcomes in a rational manner without any access to competition ratios. However, we know that human beings are not so rational. Some over-estimate and some under-estimate their abilities; even in the face of overwhelming odds people will still "gamble" on unlikely outcomes It is not surprising therefore that many will continue to pursue "over-subscribed" specialities. The fact that they may never get the chance not to succeed but are diverted at source may lead to lingering feelings of failure and resentment.

6. *Degree to which MMC will help to increase the flexibility of the medical workforce*

6.1 The College is firmly of the view that current plans seem likely to reduce flexibility rather than to enhance it. Indeed, as presently described and implemented there is little doubt that this is a very rigid system. The rigidity is to no-one's advantage. The proposals force choice at a stage that is too early in career and indeed personal terms (with regard to the latter it must be appreciated that UK Medical School intake remains largely post sixth form ie age 18/19 and not postgraduate with the extra maturity the latter contains). The system forces early choice and has made it harder for trainees to change career plans and to move between specialties. They are expected to commit themselves to rigid six year training plans at a time in their lives when they are far from settled. Flexible training does not fit easily and the arrangements for those who do not progress at the expected rate are unclear. The proposals do not allow for unpredictable process or outcomes and seem to depend on everything working perfectly to time every time. Even at this stage reports from Heads of Schools and Chairs of STC suggest that we are already running into difficulties in planning training for trainees who have missed time due to sickness or who want career breaks or maternity leave.

6.2 The College can see that possibly in the long term MMC might help with flexibility under the broad umbrella of a given specialty. There should be a speedier response of training systems to changes in Health Technology and Patient/Service Need. Thus the ability to produce a different kind of specialist in response to these drivers could become timelier. In psychiatry, new service models such as Early Interventions are an example of new programmes that cross previous boundaries, which are well served by this flexible approach.

6.3 In addition, it could become easier for people to move from one sub specialty to another within any specialty and there would be more options for people moving through the system more quickly if they achieve the competencies and complete exams more quickly and for those who are working particularly on a part time basis to move through more quickly provided they are achieving the competencies. But, as indicated above the rhetoric of these potential advantages for competency-based training over time-based training need to be tempered by the consideration that development as a specialist takes a necessary amount of time (see 1.5); it is axiomatic that to become a doctor one needs to "do an amount of doctoring".

6.4 However in view of the great difficulties with the process over the last year it will take a little time for things to settle down and have this properly implemented. In psychiatry, as there is a need to sort out the issue of the competitive allocation process between ST3 and ST4 and how this works with different specialties, the change from the time based training will be helpful.

7. *Roles of bodies including College(s) and PMETB in design and implementation of PMETB*

7.1 It is clear that the system got some things badly wrong. How helpful it is for one organisation to blame another is questionable. In future the College believes that it should be centrally involved informing PMETB about speciality programmes, curricula and professional standards. Colleges should then work with Deaneries in co-ordinating and implementing the system following a National entry or portal. The example of good working relationships and what they can achieve is highlighted by the situation in Scotland where all the Deaneries are working under one system of NHS Education. Thus many of the processes set up by NHS Education have been helpfully used to oversee the work of the Deaneries and examine issues which can be dealt with on a Scotland wide basis, with the option of introducing new initiatives in a considered fashion. The fact that NHS Education deals with all professions in the Health Service has distinct advantages for psychiatry and mental health services and has allowed Scotland to take forward many multidisciplinary and multi-professional initiatives in the last few years.

7.2 The College has been disappointed by the performance of PMETB. We would echo the comments of others, including Professor Carol Black, on the working style of PMETB and its apparent difficulty in formulating successful working relationships with Colleges in spite of their best efforts.

7.3 The role of the Royal College of Psychiatrists has in the past been very helpful and the fact that the training in psychiatry was always much more highly organised and supervised than in other specialties was seen very positively. There has sadly been little evidence of PMETB providing consistent added value in many aspects of its work. The methods and procedures with regard to approval of training posts and programmes have represented a significant and worrying backward step when compared to the immediate past certainly in psychiatry.

The "visits" process has been a failure. The College is very concerned that the past two years have seen a complete loss of real external review of the educational process at local levels and the current proposals show little sign of filling a growing void. The disposal of visits with no clearly thought through strategy for replacing the function is little short of astonishing. PMETB does not appear to be a "listening organisation". They have, for example, repeatedly failed to understand or make use of the existing successful relationships between the professional groups such as the Scottish Division of the College (in fact all Colleges operating in Scotland), NHS Education Scotland and the Scottish Executive Health Department who agreed on a more sensible ways forward.

Moving from "listening" to "responding"—regrettably it has been our experience that PMETB appears to take several months and repeated requests to answer a simple question eg on clarification of a position or statement. This does not inspire confidence in their work.

7.4 With regard to the MMC and MTAS process, PMETB would appear to have abrogated its responsibility. PMETB stated that it "set(s) the overarching principles under which selection into specialist training must operate" and that it (PMETB) "is not concerned with the operational aspects of selection". There is clearly a separation of strategy and local operational management in selection as in other matters, but taken overall, these statements highlight much of the problem with PMETB. High-sounding strategic statements are followed, if at all, by evasion of the reality of daily operation.

7.5 Finally, there has appeared to be a serious problem in PMETB's attitudes to postgraduate medical education and training. The right principles are there but without any attendant activity and no evidence of PMETB acting as an advocate for medical education. The recently published outcome from the consultation on the Quality Assurance Framework however begins to show some inclination toward the vital agenda of quality improvement.

October 2007

Memorandum by the British Geriatrics Society (MMC 44)

MODERNISING MEDICAL CAREERS

The British Geriatrics Society

The British Geriatrics Society (BGS) is the only professional association, in the United Kingdom, for doctors practising geriatric medicine. The 2,200 members worldwide are consultants in geriatric medicine, the psychiatry of old age, public health medicine, general practitioners, allied health professionals, and scientists engaged in the research of age-related disease. The Society offers specialist medical expertise in the whole range of health care needs of older people, from acute hospital care to high quality long-term care in the community.

GERIATRIC MEDICINE

Geriatric Medicine (Geriatrics) is that branch of general medicine concerned with the clinical, preventive, remedial and social aspects of illness of older people. Their high morbidity rates, different patterns of disease presentation, slower response to treatment and requirements for social support, call for special medical skills. The purpose is to restore an ill and disabled person to a level of maximum ability and, wherever possible, return the person to an independent life at home.

The Society is delighted to be given the opportunity to contribute to this debate and would comment as follows:

1. *What are the principles underlying MMC and are they sound*

The Society fully supports many of the underlying principles. It is the implementation of new structures, the unrealistic timescales and the lack of inclusion of those most closely involved in delivering training that has caused most concern.

The Society strongly recommends that training of the medical workforce should:

- Occur in well-structured, managed, time-limited programmes, based on clear curricula, driven by educational objectives.
- Be supported by a robust framework of educational supervision (requires trained consultant staff with dedicated time to undertake this).
- Include communication skills as a vital aspect.
- Include effective team working as a vital aspect.
- Reflect the predicted needs of an ageing population.
- Be sufficiently flexible to accommodate a) changes in career choice, b) out of programme experience for research and other academic activities c) less than full time working at all grades.

There needs to be closer cooperation between deaneries, colleges, faculties and PMETB to allow a clear allocation of responsibilities for different parts of assessment. This is not straightforward with so many parties involved.

2. *To what extent the practical implementation of MMC has been consistent with the programme's underlying principles*

- Progress has been made with curricula and measureable educational objectives. We strongly support the move towards validated assessment methods but there is still some way to go. It will take time to develop these properly and implementation will require significant support if they are to be meaningful.

  However, it is clearly impossible to assess all aspects of the curricula. In addition, many important decisions in clinical medicine are judgement-based, strongly dependent on experience. There are considerable concerns that the reduction in training time (imposed by both the working time directive plus MMC) reduces opportunities for repeated exposure to clinical scenarios. The emphasis in MMC seems to be to gain a superficial breadth of exposure to a number of areas. This is not the same as acquiring a secure set of broad skills and the experience required to make sound judgements.
- The eportfolio/log book is insufficiently developed to be used as an assessment tool in the first run of MMC and to compare trainees from different deaneries.
- Communication skills and effective team working have always been promoted within geriatric medicine and we welcome the new emphasis on these skills across the other specialties
- we remain concerned that the changes in training are insufficiently linked to the workforce required to care for an ageing population. There are two components to this: a) Numbers of geriatricians will need to increase as more "Expert generalists" will be required b) most other specialists (including GPs, Radiologists, Anaesthetists) will require some training in the principles of care for older people. Opportunities to gain a breadth of experience in core medical training for these groups have been reduced by the shortened and restricted new career structures.

3. *The strengths and weaknesses of the MTAS process*

Strengths

A national online application system has considerable merit and could potentially be more efficient than previous systems.

Weaknesses

1. MTAS was not adequately piloted and was far too immature to be nationally adopted. Computer system was unfit for purpose. Adequate time to develop a robust and acceptable system is required.
2. Application system was fundamentally flawed—"reductionist approach". Many of the sections were open to plagiarism and copying. Many sections could only be assessed by face to face interview.
3. "One size fits all" concept inappropriate when trying to select for such a wide range of specialties. Insufficiently discriminating for the individual specialties.

   Although this type of application system had done well in General Practice, this is just one specialty.
4. Short-listing process was insensitive and invalid. Many reports of trainees who were not short-listed first time round then doing very well at interview and vice versa.
5. Scoring system insensitive eg common problem was joint scores, no agreed process as to how to manage this. Often random selection.
6. Scoring system failed to adequately reward academic achievements and experience.
7. Lack of sophistication re allocation of interview dates. Reports of trainees being called for three sets of interviews in different regions on the same day.
8. The issue of national vs deanery selection for training needs to be explored further. There needs to be close working across deaneries to allow flexibility for individual trainees who wish to move around the UK.
9. One appointment round per annum will be insufficient.

4. *What lessons about project management should the Department of Health learn from the failings in the implementation of MMC*

The views of trainees and those most directly involved in training should underpin any reworking of the application system.

Major changes in medical training should be implemented over a realistic timeframe. The timescales set to implement MMC (and especially MTAS) were completely unrealistic and was one of the fundamental flaws of the process.

Rigorous piloting of any proposed changes should occur before universal implementation.

5. *The extent to which MMC has taken account of the supply and demand of junior doctors and the number of international medical graduates eligible for training in the UK*

There is a lack of robust data regarding numbers of graduates UK/ EU / IMGs eligible for training.

In addition, the basis of the calculations for numbers of run through specialty training posts is unclear and appears to be inaccurate—ie inadequately reflects the demand for service requirements. Numbers for England, Scotland and Wales have been calculated differently.

This type of data is central to workforce planning and to give realistic career guidance (students and qualified doctors). At the last round most trainees (and educational supervisors) had little or no idea of their chances of achieving run-through training and CCT or conversely the proportion of trainees likely to enter "career posts". There appears to be a lack of basic accurate data on the number of CMT or FTSTA posts in the system.

At the last round more posts were suddenly "created". There appears to be a particular shortfall in numbers of run-through training programmes in hospital medicine.

There needs to be an explicit calculation of numbers, based on the service requirements of a changing/ ageing population eg the predicted increase in numbers of older people will require doctors trained in geriatric medicine and most other specialists will require some training in the principles of care of older people. However, the reality is that the workforce is being dictated by the ever- changing whims of local PCTs/LHBs. It is not linked to a central strategy regarding care of older people. Hence the "workforce re-profiling" that is much mentioned in terms of government's plans is unlikely to be realised via MMC.

6. *The degree to which current plans for MMC will help to increase the flexibility of the medical workforce*

Although flexibility is a stated aim of MMC, the reality appears to be a move towards less flexibility eg.

- Commitment to specialty occurs too early. The concept of run-through from ST1 fails to recognise the importance of a varied and broad training.
- Opportunities to move between specialties are severely limited. We know from previous surveys that doctors frequently change career direction.
- Reduced opportunities to gain breadth of experience in core medical training—important in Geriatric Medicine where we are training "Expert Generalists".
- Loss of opportunities for those outside medical specialties to access core training in medicine eg general practice, radiology, anaesthetics. This may negatively impact on the management of older people who are the most frequent users of such services.
- Out of programme experience at all levels is less easy to set up and more complex. This is a particular disincentive to research.
- Rule book is perceived as being too complex.

7. *The roles of the Department of Health, Strategic Health Authorities, the Deaneries, the Royal Colleges and the Postgraduate Medical Education and Training Board in designing and implementing MMC*

No acknowledgement that the new system will involve additional work for the current consultant workforce. Dedicated time is required within consultant jobplans for:

- Selection of trainees
- Educational supervision
- Assessments
- Appraisal
- Career Counselling
- Additional clinical work that less experienced trainees and newly qualified consultants will be unable to take on.

A consultant may have to supervise at least three trainees at any one time (FP1, FP2, CMT, Specialty Trainees) as well as non medical staff (eg Nurses, Pharmacists).

Trusts (and some Deaneries) appear to be oblivious to the implications of this newly created work. Many members of the Society report that there is no recognition for this work within individual jobplans (SPAs are being driven down). Educational Supervision is therefore either not done or will be poorly done (which defeats the object of delivering quality assurance) or it is undertaken in personal time (not sustainable). There is a growing frustration and a degree of demoralisation within the consultant body because of the time pressures to achieve Trust targets none of which are directly linked to delivering a training system as set out in MMC. This tension needs to be addressed.

To date there appears to have been no significant discussion between those involved in MMC, the Departments of Health (all nations) and those delivering services (Trusts and Heath Authorities), regarding the impact on Consultant time and hence service delivery. Needs to be far more joined up.

The Royal Colleges appear to have maintained a role in development of curricula and assessment methodologies. However there is considerable concern that there has been a loss of quality assurance/control of training programmes following the cessation of external college visits. New system is too broad brush to identify and deal with the complex and sensitive specialty training issues that arise. There are specific examples within our specialty where this has proven to be the case and we understand other specialties are in a similar position.

MMC, MTAS and PMETB should recognise the experience and competence of senior specialists in the processes of quality assurance and assessment of trainees. This is provided through the SACs and Educational Committees of Specialist Societies.

Professor Peter Crome MD PhD FRCP FFPM
President

16 October 2007

Memorandum by NHS Employers (MMC 45)

MODERNISING MEDICAL CAREERS (MMC)

Introduction

NHS Employers is the employers' organisation for the NHS. Part of the NHS Confederation, we provide support and representation to employers in England.

We welcome the opportunity to provide evidence to the Health Select Committee and will be happy to provide any further information to the Committee as the inquiry progresses.

We believe it is essential to have employer input into decisions being taken on changes to medical training and to provide employers with support and information in order to realise the benefits of MMC for both the profession and the service.

Getting the right doctors in the right jobs for the benefit of both patients and the profession is a priority for employers, and NHS Employers endeavours to play a full part in achieving that objective.

We have worked closely with national stakeholders and employers to help resolve some of the well-publicised problems which arose during the first recruitment to speciality training under MMC and especially with the new electronic recruitment process (MTAS). We have hosted a number of meetings on MMC over the past 12 months, had regular discussions with our Medical Workforce Forum and communicated extensively directly with NHS organisations to gather views and share information.

We had a seat on the Douglas Review and now have two representatives on the MMC Programme Board (England). Overall we feel we are well placed to give a balanced service view on MMC and the future training of doctors.

Executive Summary

We recognise that recent months have been stressful and difficult for many junior doctors as well as for key service staff in the NHS.

The focus has inevitably been on specialty recruitment but looking forward it is important to take a wider view of MMC. There is much that is good about MMC, despite the obvious difficulties that have emerged during the speciality recruitment process and it is important to look constructively at what needs to be learned in order to ensure the highest quality patient care as well as providing satisfying careers for entrants to medicine into the future.

We would also like to draw attention to the huge commitment and effort that has been put in by many to resolve the problems that have arisen in 2007. All indications are that trainees appointed to specialty programmes this year are of excellent calibre.

More flexibility, more involvement of employers in planning and more testing of new ideas are key, but we have cautioned strongly against further radical reforms in 2008, and were pleased to see health ministers agreeing to return to locally-based, deanery-led recruitment for specialty training next year.

Ensuring flexibility for doctors in training while achieving an effective balance between service needs and workforce planning is essential. This can only be achieved with strong engagement with employing organisations. It is vital to support a recruitment and selection scheme which gets the right people in the right training posts to produce the best qualified doctors for the future NHS.

The requirement for senior level HR support to MMC and effective employer involvement needs to be addressed. NHS Employers provided intensive advice and support to the DH throughout the period of the Douglas review. However, while representing the view of NHS organisations and their service needs at a national level, we are one of a number of stakeholder organisations.

We recognise that while the MMC project itself was under-resourced, the consequences of the problems resulted in very significant costs for the NHS.

We will gather the views of employers on the recommendations contained in the Tooke MMC report *Aspiring for Excellence* published on 8 October. We welcome much of Sir John's report and believe that, despite the difficulties experienced by doctors and employers over the last 12 months, many of the lessons learnt have been taken on board in his proposals.

His conclusions reflect many of the views expressed in our written and oral evidence to his inquiry and in a position paper on the future of the medical workforce published by NHS Employers on 9 October 2007.

In particular we welcome his suggestions of greater flexibility in training, the need to recognise the service contribution of doctors in training and the importance of improving medical workforce planning at both national and local level. We are also encouraged by his acknowledgement that there needs to be greater employer and service input into planning and governance of medical training.

What Are the Principles Underlying MMC and Are They Sound?

Trusts are generally very supportive of the broad principles of MMC. Structured training based on quality-assured national curricula with progress measured by the acquisition of competencies is broadly seen as the right way forward.

We believe that the introduction of MTAS caused many to lose sight of these principles as emphasis switched to navigating the complex recruitment process rather than what MMC set out to achieve.

As employers have gained a greater understanding of the full implications of the MMC training system and the recruitment cycle developed to support it, it has become apparent that a number of strands in the MMC policy needed more thorough thought and testing. While the underlying principles of MMC remain sound, having now experienced the first year of recruitment we believe that adaptations are needed to introduce greater flexibility during training.

Additionally, further discussions need to take place between employers and representatives of the medical profession about the future role of the CCT-holder whose training experience will be shorter under the MMC curricula.

NHS Employers has already engaged in these discussions, and will now refine these in the light of the Tooke recommendations for lengthening and changing the structure of training. In particular the concepts of core and higher training followed by a period of practise in the role of 'specialist' as distinct from that of consultant. The trust registrar grade should be made an attractive and viable option for many doctors who do not progress to higher training. Implementation of the Staff and Associate Specialist contract, negotiated between the BMA and NHS Employers, will be a key factor.

To What Extent Have the Practical Implementation of MMC Been Consistent With the Programme's Underlying Principles?

Employers have the same aim as the medical profession in ensuring that the best candidates are short listed and appointed to training places and that staff are treated fairly.

Patients deserve the best doctors with the highest quality training and there is no doubt the old system of training needed reform. In retrospect it is easy to see that some things could have been done differently. Clarity of objectives and governance, longer lead-in times, wider testing of some elements and better communications would all have made a difference.

However, it is worth noting that many aspects of recruitment to the Foundation Programme and to general practice worked well. Employers report that they have appointed excellent specialty trainees and that those doctors selected in Round 1 were generally of very high calibre. However, the longer term effect on the morale of doctors is yet to be assessed.

Anecdotal evidence suggests that selectors felt the selection process through a national online application form could not fully distinguish the best candidates. It was generally felt that the process lacked flexibility and that once candidates had been accepted to run-through programmes, they would be unable or reluctant to reconsider their specialty choice.

There was a general lack of understanding of the role and purpose of the fixed term (FTSTA) training option, and how that fitted the underlying principles. It was seen as a second-rate career path, unpopular and hard to fill.

As part of a more "career ladder" approach to employment and training advocated by employers, it is possible that the NHS will seek to employ fully-trained CCT holders in a different role to that of consultant. Such a role could provide an alternative career pathway for trained doctors not wishing to seek consultant posts and ensure that patients are being treated by trained doctors.

Initial discussions indicate that employers welcome the Tooke report recommendation that defines the role of the specialist and the further learning and assessment required to be eligible for consultant posts. However we need to explore the implications of these recommendations in more detail with employers before submitting our full response to the MMC Inquiry panel.

The Strengths and Weaknesses of the MTAS Process

Trusts are firmly of the view that electronic recruitment is the right way ahead for a modern NHS, reducing paperwork and administrative functions, and releasing resources. We have promoted use of NHS Jobs, the online recruitment service, as a cost-effective tool for advertising posts in the NHS.

We should add that MTAS worked very well for foundation programme applications with the vast majority of applicants being offered first choice postings, and with deadlines being met.

However, employers' experience of the far more complex rules and processes for specialty training devised for 2007 under MTAS was less positive. The process was felt to be rushed and decisions made (or reversed) too quickly to test the impact or assess likely risks.

NHS Employers made frequent calls for senior dedicated HR support to be provided for MMC transition. We believe the absence of that support has led to failings in recruitment design at both policy and implementation level.

This was also the first year of the process and the transition cohort was significantly bigger than it will be in future years. With no previous years' experience to draw on, doctors were also understandably nervous about the process. The key reported problems were:

- Shortcomings in longlisting were widely acknowledged, particularly in larger deaneries where there was a particularly high volume of applications, especially over the final weekend before the closure of Round 1. Two deaneries which failed to implement agreed processes correctly led to inconsistencies in shortlisting and longlisting. The delay to MTAS functionality to support the shortlisting process caused handling backlogs and a serious loss of confidence. This was caused by a major change in Unit of Application design in one deanery in the final weekend before the system went live.
- There was doubt in some areas over whether all shortlisters were well enough trained in both the new competency-based selection processes and use of the MTAS software. Not having sight of an employment history during shortlisting was a mistake.
- Some applicants were concerned that they did not have enough guidance in completing the electronic form.
- Eligibility criteria were confused and inconsistently applied. The decision to include overseas doctors added many thousands of candidates, increasing both the workload for recruiting deaneries and trusts and concern among doctors (and media) about competition for posts.
- The extent, consistency and timeliness of communications to doctors and employers at an early stage and then throughout the process could have been improved.

We believe that over time a national "fit for purpose" e-recruitment process can be successful in the NHS but this must be preceded by pilots tested over a realistic timescale which allows for software changes to be implemented without major jeopardy to the project as a whole.

What Lessons About Project Management Should the Department of Health Learn From the Failings in the Implementation of MMC?

Medical recruitment is a specialised area of expertise, and we believe the Department of Health (DH) and the MMC team could have made more effective use of the experience which was available to them from employers. Consultation with service stakeholders began too late in the day. The software requirements or limitations of MTAS were not properly managed and this was further hindered by some very late decisions on recruitment rules.

We felt that risk assessments were not always tracked adequately. There were a number of subgroups working on various elements but little evidence of an overarching national project plan. Governance was spread across a wide range of groups, both in England and UK-wide, and it was unclear who held ultimate responsibility.

It was difficult to identify which areas were priorities, assess progress on changes previously agreed, or who was responsible for driving these forward. There was at times a lack of clarity about the respective roles of the MMC team and the wider DH workforce directorate.

While the MMC website was used to provide updates to junior doctors, engagement with stakeholders and communication with the service was limited. It was because of this that NHS Employers initiated work in this area.

The Extent to Which MMC Has Taken Account of the Supply and Demand of Junior Doctors and the Number of International Medical Graduates Eligible For Training in the UK

The decision to include overseas doctors in the cohort of applicants for speciality training in 2007 was felt by employers to be the right one at the time. International graduates have valuable skills and some hospitals and specialities rely heavily on them, and patients want to be treated by the best doctors available. That said, applicants for the future need to have a realistic picture of opportunities in the UK. Better modelling on likely applicant numbers was needed for 2007, by entry level and by specialty.

Initial indications from 2007 Round 1 recruitment suggested that 70 per cent of training posts were secured by UK graduates compared with 30 per cent by graduates from EEA and non-EEA medical schools. This ratio is good but not good enough to exclude overseas trained HSMPs from applying for specialty and GP training in the near future. While employers agree that the decision should be based on competency rather than numbers alone, there is support for asking the Home Office to raise the bar on HSMP entry status for doctors as a way of managing applicant numbers in the future. We believe, however that the situation should be kept under review, as over time, this ratio may change.

The Degree to Which Current Plans For MMC Will Help to Increase the Flexibility of the Medical Workforce

It is critical to match service and employer needs with the need to provide satisfying and meaningful medical careers.

While agreeing in principle with the run-through concept, employers believe there is a need for much greater flexibility than the current model of run-through training provides. Trainees should have the ability to switch between specialties if they feel they have made the wrong choice or to take time out and then return to their specialty. Trusts need transparent processes for dealing with poor performance, enabling them to remove trainees who do not progress from programmes.

There is a strong feeling that committing to a speciality after only two years is too soon, especially if the trainee has had little or no exposure to the speciality in the foundation programme. "Mini-rotations" or "taster" sessions during foundation could help with career flexibility.

Many employers feel that some element of competition or "gateway" based on an improved and robust assessment model at the end of ST2 is preferable, meaning there are effectively two points of entry to speciality training and a new break point prior to ST3. This would ensure that the very best doctors progress to final training, while facilitating alternative career pathway options and enabling doctors to grow and develop at their own rate. However, there is no 'one size fits all' solution and such flexibility may need to be decided on a specialty by specialty basis.

We believe the Tooke inquiry recommendations for the introduction of core and higher specialist training may provide the desired break point at a time in training that is more appropriate than seen previously. However we will need to discuss these options in more detail with employers to assess their full implications.

There is some good careers information available for doctors in training and this year's experiences have given impetus to further developments.

NHS Employers has worked with the MMC team and the medical professional bodies on the development of a new national website NHS Medical Careers. The website will aim to provide consistent information to medical students and foundation programme trainees about the future training and career opportunities available. The website ownership was handed over to DH in October.

The Roles of the Department of Health, Strategic Health Authorities, the Deaneries, the Royal Colleges and the Postgraduate Medical Education and Training Board in Designing and Implementing MMC

It was clear to trusts from the outset of MMC implementation that this major change programme required strong leadership, and good risk management and project management. NHS Employers raised concerns about the lack of effective governance at both the MMC Programme Board and the MTAS Project Board.

We see PMETB's role as central to ensuring that entry standards are maintained. But those standards must also reflect the "employability" of doctors, making sure we are appointing doctors who are fit for purpose and possess all the necessary clinical skills and experience. PMETB could have been more involved in translating that into the processes of recruitment.

SHAs were in the throes of reconfiguration for much of this period and may have been unable to take full account of the significance of the impact of changes to medical training. With the benefit of hindsight it would have been important to have ensured they took a leadership role early on but probably few fully appreciated the full extent of the change that was about to happen. This was primarily seen as a change in education and the implications for service delivery were not realised by many until late in the day.

SHAs were subsequently expected to take ownership of problems such as guaranteeing employment for displaced doctors. Many found they no longer had the leverage, funding or staffing to ensure such policies could be fully executed.

Deaneries and their supporting trusts did not have the capacity, particularly in dealing with the huge volume of applications. The communication between deaneries and trusts was patchy. Undoubtedly deaneries and employers pulled out all the stops, with many people working excessive hours to make sure the recruitment process was completed. Employers have told us that the goodwill that saw us through this year may not be repeated in the future.

We have covered many of the DH issues already but it is important to stress again that there were a number of individuals who worked tirelessly to try to resolve the problems that arose in 2007. For the future we would emphasise the need for better engagement with key stakeholders and longer term planning.

16 October 2007

Memorandum by Georgina Wilson (MMC 46)

I am a Junior Doctor who was particularly impacted by MMC and on understanding that your deadline to submit evidence for your enquiry has been extended till today—have decided to let you know of my situation/express my particular concerns.

1. My situation

I was an applicant who enrolled but who didn't submit in the February MTAS Round 1 this year, but that was on the understanding that I might for what was originally going to be a strong April 2nd Round. would have for what was initially going to be a strong April 2nd Round.

The March Review group changed that—and despite my doing all I could to bring the Review Group's attention to the very small group of people in my position—who stood to be very impacted by the changes they were making—we weren't included in the interviews which all of our colleagues were given.

The jobs that were being held back for the April 2nd Round were then put into Round 1, and the 2nd Round was moved back until July/August—and became something very different to what was originally intended.

Hence—despite having worked hard, and done well my career is pretty much terminated at this point. I have a job until the end of October, but I don't know what will happen after that—or if I will have an opportunity in future to continue my training.

There were jobs in what became the July/August Round 2—but very much less—and none at my level in my speciality in London. I wasn't aware of this (despite having corresponded with a lot of key players in MMC) until the Round came out—and had a matter of days to decide if I was willing to potentially move out of London—which has been my home all my life, where I have trained and always worked—because of what ultimately has been a flawed and unfair system. I wasn't prepared to do that—to example move to Humberside, where I could have applied for a job.

Hence I have gone within the space of a year from being ranked amongst the very highest in both the fields I have worked in—to literally below the bottom—in that I wasn't able to apply for a job in order to have an interview in the area and speciality of my choice.

That in a nutshell is my situation.

Other points are:

2. Lack of information before on new system

3. Form—particularly unsuitable for the more senior of us

4. Difficult to find who the people were who were able to effect change—ie many letters written to people who I thought represented me—but in fact those people had very limited power to really do anything on my behalf. Ultimately the people I needed to be communicating with were within the Department of Health.

5. Run Through training is too limited too early

6. Reducing length of training.

7. Pursuit of excellence being sacrificed for "fit for purpose".

17 October 2007

Memorandum by the Association of Surgeons in Training (MMC 47)

MODERNISING MEDICAL CAREERS

1. Key Messages

1.1 ASiT supports the original principles of MMC but the current incarnation of MMC does not reflect these sound principles.

1.2 Concerns about the implementation and structure of MMC repeatedly voiced by ASiT have been largely ignored.

1.3 We must strive for a training process that fosters excellence, not just competence.

1.4 The lack of a meaningful transition period has greatly reduced the opportunity for highly qualified trainees to compete for higher surgical training posts.

1.5 Important selection methods in addition to a structured CV and interview have been developed by the surgical community, but remain inadequately resourced.

1.6 The selection process must account for the relative importance of an applicant's different attributes.

1.7 Realistic opportunities must exist for those in FTSTA posts to be selected into run-through training.

1.8 Final selection to surgical specialty should not occur directly from the Foundation Programme and a second point of selection after core training is required.[43]

1.9 A CCT indicates sufficient competence to work at the consultant level—MMC must not act as a pretext to reduce this level of competence.

1.10 The early years of specialty training should include a significant generic component.

1.11 The lack of flexibility to move between specialties can be blamed largely on overly rigid curricula for early training and a lack of coordination between speciality colleges on the identification of transferable competencies.

1.12 Provision must be made for doctors to move between geographical areas.

1.13 The development of important research skills must receive appropriate emphasis.

1.14 Accurate and realistic career advice must be available to trainees.

1.15 Trainers must be positively identified and have training time identified and included in job plans.

1.16 Strenuous efforts must be made to protect training budgets.

1.17 Assessment of training doctors is often inadequate and mechanisms for identifying individuals unsuitable to progress remain untested.

1.18 Accurate workforce planning is a prerequisite of any rationalisation in the structure of training.

1.19 No further expansion of NTN posts should occur without evidence of an increase in the number of prospectively approved training opportunities and a similar expansion in consultant posts.

1.20 Specific requirements exist in different surgical specialties, but these variations can be easily accommodated within robust global structures.

2. Introduction

2.1 The Association of Surgeons in Training (ASiT) welcomes the opportunity to submit evidence to the Modernising Medical Careers (MMC) Inquiry, with particular reference to trainees in surgical specialties.

2.2 ASiT represents trainees from all surgical specialties and with over 2200 members is one of the largest specialty trainee organisations in the UK. The opinions expressed in this document have been gathered from members and agreed by the ASiT Council. A consensus has been sought from the relevant surgical specialty trainee organisations.

2.3 ASiT support the principles of MMC, particularly in the form expressed in Modernising Medical Careers (February 2003).[44] The current incarnation of MMC does not reflect these sound principles and significant reform is required to correct this disparity.

2.4 The medical profession has endeavoured to try and make MMC work. Concerns about the process of implementation and the perceived short-comings of the wider project have been repeatedly voiced, and ASiT have issued a number of statements over the last year. These concerns appear to have been wilfully ignored by those directing policy, resulting in the chaos of the current selection process.

2.5 Overall, we must strive for a training process that selects for, cultivates and rewards excellence. A process designed only to ensure competence will engender mediocrity. Not only is this demoralising, more importantly it will disadvantage many patients and the NHS in the longer term.

3. Specific Questions to be Addressed by the Health Select Committee Inquiry

3.1 *What are the principles underlying MMC and are they sound?*

The key principles underlying MMC (Feb 2003)—of structured, curriculum based training with a clear and reliable career progression are extremely sound and fully supported by the Association of Surgeons in Training.

The current implementation of the MMC programme however, raises several areas of concern.

[43] There is no consensus within Trauma and Orthopaedics on this issue, but is accepted by the majority of other Surgical Specialties.

[44] Modernising Medical Careers: The response of the four UK Health Ministers to the consultation on Unfinished Business: Proposals for reform of the Senior House Officer grade. February 2003.

— Selection has been shambolic and both trainees and trainers have serious concerns over the validity of the process by which the first cohort of run-through trainees were appointed.

— Attention to adequate funding and timely implementation of a new selection system is not felt to have been adequate, with the current system "borrowed" from the assessments used for foundation year trainees and variable uptake in terms of web-registration. Appropriate and effective assessment is imperative if this is to represent the defining measure for progression through the career system.

— It is not felt to be possible nor appropriate to select and appoint trainees for higher surgical training at the F2 level and a separate round of competitive selection to the ST3 grade is required.

— ASiT remain strongly of the belief that the award of a certificate of completion of training should entitle a trainee to be eligible for appointment as a UK Consultant and the introduction of any form of the "sub-consultant" grade is unacceptable. In this respect, ASiT are concerned by the material on page 99 of the Tooke Review, which would appear to suggest otherwise.

3.2 *To what extent the implementation of MMC has been consistent with the programmes underlying principles*

As outlined above, selection to and assessment of run-through trainees has not been satisfactorily demonstrated and there are concerns about the availability of sufficient training opportunities to occupy the number of run-through training slots currently available.

3.3 *What are the strengths and weaknesses of the MTAS System?*

A single standardised application which is submitted centrally to be considered by a number of units is desirable. The significant weaknesses of MTAS were however, the lack of objective measures of "excellence" in the structured response sections, questions deemed by many to be irrelevant and the obvious failures of the IT system.

3.4 *What lessons about project management should the Department of Health learn from the implementation of MMC?*

Application and selection has been an unmitigated disaster and should be a priority for improvement. Communication with applicants has been criticised and the dissemination of information, both that relating to the availability of posts prior to the application system and during the selection process must be improved. Doctors have commenced in run-through slots before the necessary infra-structure and training of assessors has been put into place. Clear guidance must be put in place as to the opportunities available to foreign medical graduates.

3.5 *The extent to which MMC has taken account of the supply and demand of junior doctors and the number of International Medical Graduates eligible for training in the UK*

Changes to working time legislation has lead to a situation where more junior doctors are required to supply a compliant rota than can expect to progress to independent Consultant practice. It has always been, and remains the view of ASiT, that the majority of trainees completing a programme and obtaining a certificate of completion of training should expect to find employment as a UK Consultant in their specialty. Over-producing highly qualified surgeons to face the prospect of unemployment is a criminal waste of public money and, by equal measure, forcing such individuals into service in a sub-consultant grade is not acceptable. Future workforce planning is therefore imperative to the success of a streamlined training programme and high quality career advice must be made available to all trainees. With an increase in UK medical school places the recent exodus in home graduates cannot be allowed to continue. Equally, IMGs must be given clear advice on their prospects for securing recognised medical training and of their potential for career progression in the UK.

3.6 *The degree to which current plans for MMC will help to increase the flexibility of the medical workforce*

The current incarnation of MMC has severely reduced the degree of flexibility in medical career progression and young doctors are being forced into making important career decisions at far too early a stage. It must be recognised that a significant proportion of UK medical graduates will not have made a firm career decision at the time of completing their pre-registration training and that experience within several specialties may be required to ensure that the correct decisions are made for an appropriate and rewarding career. Equally, breadth of experience should be nurtured and remains a distinct advantage in a number of specialties.

Reduction in working hours and a more targeted training system will, inevitably, produce specialists with a more limited repertoire of skills.

3.7 *The roles of the Department of Health, Strategic Health Authorities, the Deaneries, the Royal Colleges and PMETB in designing and implementing MMC*

The Department of Health and the Strategic Health Authorities remain the major benefactors of medical training along with the British public. Both bodies have a clear obligation to ensure that training opportunities continue to be made available within the National Health Service and wherever NHS work may be sub-contracted. In return, the NHS should expect that fully trained doctors are equipped to the very highest standards, to provide good quality patient care.
The Royal Colleges have traditionally been responsible for maintaining professional standards in each specialty. The role of PMETB in overseeing postgraduate medical education must not be brought into conflict with the role of the Colleges and it is essential that a symbiotic relationship be developed between these two organisations. By a process of evolution, the Royal College of Surgeons have developed extremely experienced sub-specialty advisory committees (SACs) and the wealth of experience held by these committees must continue to be utilised to its very best effect in terms of curriculum development and accreditation of training posts. It is the individual SACs, with the support of PMETB, that are best placed to advise on the availability of training capacity and to ensure that universally high standards are being met.
The role of individual deaneries in the day to day management of regional training posts must be maintained and the deaneries must be able to ensure sufficient funds for training, including opportunities for professional development outside of the workplace. Again, by a system of evolution, individual deaneries have developed some extremely effective methods for selection to training rotations and a significant weakness of MTAS was that much of the appointments system was taken from the hands of the deanery. So, in addition to overseeing training programmes at a regional level, it is essential that the deaneries are able to play an active role in the selection process and receive the all information about applicants that they feel appropriate.

4. Selection to Specialty Training

4.1 While we appreciate that the process by which individuals are appointed to specialist training (Medical Training Application System: MTAS) and the structure of specialist training (MMC) are separate entities, the success or failure of the MMC is dependent on a selection process that is reliable, valid, fair, practical and cost effective.

4.2 The number of surgical trainees in senior house officer (SHO) jobs has historically far exceeded the number of higher surgical training places.[45] The much cited 5:1 ratio of qualified SHOs to national training numbers (NTNs) is a reasonable estimate, but higher ratios exist in some surgical specialties such as plastic surgery. The architects of MMC never got to grips with this "lost tribe" and how best to integrate them into the new training structure.

4.3 Despite what has been stated in some fora, trainees are well aware of the realities of job prospects in the highly competitive field of surgery. The "honesty" introduced by an improved correspondence between the number of basic training and higher training places is broadly welcomed, but well-qualified trainees who have "played by the old rules" have been unfairly penalised by an overnight change in selection criteria and the one-off nature of the new process.

4.4 ASiT and most surgical trainee groups called for a transition period of 2-3 years (and greater in some specialties) to ensure highly qualified trainees had adequate opportunity to gain a higher surgical training post, prior to the full implementation of new selection methodologies. These calls were largely ignored.

4.5 The lack of a meaningful transition has been compounded by the recent need to increase numbers of junior medical staff to create WTD/New Deal compliant rotas.

4.6 ASiT put forward proposals on how a meaningful transition period could be introduced, even relatively late in the process. The basis of this "inverted pyramid"" model required a reduction in the numbers appointed to ST1 and ST2 this year, creating space for ST3 level applications in future years. This has not happened.

[45] Galasko CS, Smith K. Ratio of basic surgical trainees to type 1 specialist registrar programmes 1999/2000/2001/2002. Ann R Coll Surg Engl. 1999; 81(3 Suppl):124-8

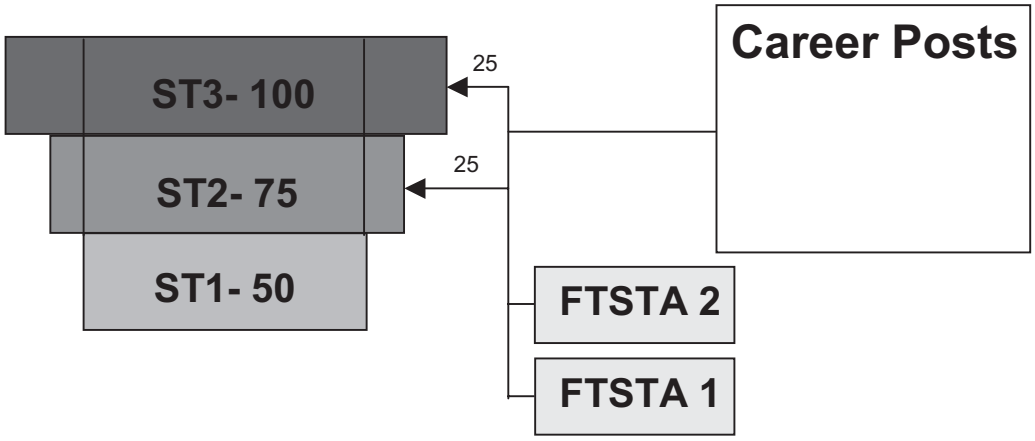

Figure 1. Inverted pyramid model. Worked example with 225 posts: rather than 75 per year at ST1, 2 and 3, this could be adjusted to have 50 at ST1, 75 at ST2 and 100 at ST3.

This creates 25 ST2 opportunities at each of ST2 and ST3 for 2008, and 25 ST3 in 2009. This avoids a huge increase in NTNs but creates a 3 year transition. (Personal communication to Dr Sarah Thomas, Postgraduate Dean, South Yorkshire and South Humber Deanery)

4.7 Any selection process has weaknesses and is prone to error. A process that uses a number of different validated methods to build a more accurate representation of an individuals attributes is likely to be subject to less error. Processes in addition to structured CV and interview are likely to be important. These have been developed by the surgical community in the past but have been inadequately funded and resourced.

4.8 Short-listing is a logistical consequence of a process where the number of applicants exceeds the number that can be practically assessed "face to face". It is our view that the ability to discriminate individuals on any application form is extremely limited. No evidence has been presented to support the apparent belief that the scoring of 150 word statements, in which an individual details their abilities in a certain domain eg team working, correlates with objective measures of that individual's performance in the given domain. There has been no piloting of this methodology or evaluation of its discriminatory ability. For this reason, the application form must assess objective criteria, rather than the more nebulous measures common to the MTAS process.

4.9 The weighting of scores in the selection process and particularly the short-listing took no account of the relative importance of different attributes. Hence, these statements used to assess various domains were given equal weighting to more objective measures of achievement, such as prizes, higher degrees and publications. It is accepted that the correlation between any of these selection criteria and what may be regarded as a "good consultant surgeon" remains difficult to determine, and we have to rely to a certain extent on face validity.

4.10 The desire for an online national application process has been significantly tainted by the failure of MTAS. Any rationalisation of deanery-based selection methods is based mostly on pragmatism and cost effectiveness, at the expense of individual flexibility. In some smaller surgical specialties, eg paediatric and plastic surgery, a national process is desirable due to the limited number places available.

4.11 There is no consensus on whether a national application process should be pursued, and if so, whether the number of applications an individual can make should be limited. Any future online application system must only be implemented following sufficient piloting.

4.12 There should be realistic opportunities for those in FTSTA posts to be selected into run-through training.

5. Structure of Specialty Training

5.1 A career structure allowing continuous progression without time spent "treading water" awaiting entry to higher training is welcomed. While this appears to have been a major driver behind MMC, a number of problems now exist:

- difficulties in selecting at such an early stage of training,
- a lack of candour regarding the future of the consultant grade,
- loss of generic/multi-specialty training,
- loss of flexibility in career and geography, and
- loss of research training.

5.2 The majority of trainees believe selection should not be directly from the Foundation Programme. In order to select those with a genuine aptitude and the skills required for a career in surgery, a second round of competitive selection following a period of core surgical training is essential. However, this is not a unanimous view, as within Trauma and Orthopaedics there has been no consensus amongst trainees.

5.3 Selection to specialty relies on:

- individuals having sufficient knowledge of a specialty, a) to wish to commit to a lifetime working in it, and b) to judge themselves capable of the specific requirements of that specialty,
- individuals having the opportunity to demonstrate (potential) capability and a commitment to that specialty, and
- selectors having access to sufficient information be able to make an accurate assessment allowing comparison of individuals.

We do not believe that Medical School and Foundation Training provide sufficient experience to fulfil the above criteria.

5.4 The Department of Health report A Health Service of all the talents: Developing the NHS workforce (April 2000), highlighted the concern that career decisions by doctors in training were often made too hastily, which has been used as an argument for the creation of the Foundation Programme. However, specialty exposure in Foundation Training is extremely limited (and variable within and between individual rotations) and with applications to specialty training being completed within the first few months of FY2, significant specialty experience in this period is unrealistic.

5.5 There has been no frank debate on the future of the consultant grade. Some suggest the consultant grade will continue to be the end-point of training, while others predict its demise within five years. How can we design a structure of training when the goal remains so uncertain? Either way, the CCT indicates that a trainee has achieved sufficient competence to work at the consultant level—MMC must not act as a pretext to reduce that level of competence.

5.6 Generic training. The early years of Specialty Training should include a significant generic component. Many surgical specialties are now calling for a return to the development of generic skills in the early years of surgical training. Skills in trauma, critical care, post-op care etc., are requirements of all specialties and should form part of core training. Some training in a number of surgical specialties is beneficial to all trainees and will enhance final career selection.

5.7 Flexibility. MMC: The Next Steps, stated:

> "Overall training arrangements must . . . promote diversity and flexibility."[46]

The lack of flexibility to move between specialties can be blamed largely on overly rigid curricula for early training and a lack of coordination between speciality colleges on the identification of transferable competencies.

5.8 Curricula. Generic training and the identification of core/transferable competencies is lacking in many surgical curricula. This makes early transfer of an individual from one surgical specialty to another virtually impossible. This problem is not limited to surgery and that the ability to transfer between other areas of medicine is also limited.

5.9 Geography. It has been reported in the US that almost 50% of doctors are married to other doctors,[47] and an equally high figure is to be expected in the UK. Provision must be made for this group and those with other pressures requiring them to be domiciled in a given geographical area. Increased provision for inter-deanery transfer, particularly in the early years of training must be ensured.

5.10 Research. The requirement for an understanding of critical appraisal, research methodology, statistics, ethics and educational theory is universal, together with the need to develop aptitude in audit, leadership and presentation. Many of these skills are developed during a period of dedicated research prior to higher surgical training. With the loss of this period, it must be ensured that these skills receive emphasis within the curricula or that trainees are supported in posts offering appropriate "out of programme experience".

5.11 Accurate and realistic career advice must be available to medical students and doctors and mechanisms must be introduced that ensure high quality and consistent advice across specialties and regions. Active career management with identification and redirection of those failing to progress is essential.

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[46] *Modernising Medical Careers*: The Next Steps. April 2004.

[47] Sobecks NW *et al*. When Doctors Marry Doctors: A Survey Exploring the Professional and Family Lives of Young Physicians. Ann Intern Med. 1999; 130(4): 312-9javascript:PopUpMenu2_Set(Menu10364925)

6. Training Delivery

6.1 MMC will reduce the hours available for training, adding to the pressures of the European Working Time Directive. A number of changes must be introduced to ensure adequate training delivery.

6.2 Training is often linked to service, but specific time allocated to training must be identified and adequately resourced. Effective training will often be modular, themed and rely on adequate study leave arrangements and funding.

6.3 Training must be an active process and trainers must be positively identified. Trainers should complete courses in optimal training methods and must have training time identified and included in job plans to ensure full remuneration.

6.4 Strenuous efforts must be made to ensure the multi-professional education and training budget is protected and cannot be used (as it has been) to offset other NHS deficits. If UK surgical training is to continue to be of a world class, then sustained investment is essential.

6.5 Assessment of doctors within training schemes is often inadequate. Methods are variable and trainers reticent to recognise and manage struggling trainees appropriately. Suitably supportive environments where remedial training can take place in a non-threatening manner are lacking. Robust mechanisms for identifying individuals unsuitable to progress in surgical training remain untested and many fear they will be inadequate. The concept of failure is unhelpful in this regard and a mechanism by which individuals can "exit honourably" and move to other specialties is required.

7. Workforce Planning

7.1 Has consistently failed in its goal. Appropriate workforce modelling should ensure numbers of doctors trained match future service needs. Yet, a number of surgical specialties have CCT holders well in excess of consultant job opportunities.

7.2 No further expansion of NTN posts should occur without evidence of an increase in the number of prospectively approved training opportunities and a similar expansion in consultant posts.

8. Specialty-specific Concerns

Trauma and Orthopaedics

8.1 An opportunity for all trainees to apply for training posts at ST1,2 and 3 for the next three years, given certain restrictions.

8.2 A small excess of trainees is desirable to foster competition, however, in the presence of a monopoly employer, this notion of true competition is fallacious.

8.3 UK trained doctors should have priority in the appointments process in advance of recruitment from outside the country. This is true for appointments to ICATs and ISTCs as well.

8.4 Existing consultants hours should be brought in line with the EWTD.

Plastic surgery.

8.5 In terms of transition, the position in Plastic Surgery is extreme in many ways, though not unique amongst surgical specialties. The well worn traditional career path of seven years post registration training prior to higher training has led to a problematic situation due to the short period of transition. Indeed, it is likely that any abbreviated transition, be it three or five years will undoubtedly lead to some trainees being disadvantaged.

8.6 The current situation of five to seven years worth of trainees attempting to shoe horn into run through training at two different levels has caused much anguish this year. Firstly, with the expansion of ST3 numbers, some candidates may have been awarded run-through posts who may not have got them under the old system. Secondly, the best trainees at lower postgraduate years are not getting training posts and with the short transition many will be unlikely to get training places and be disadvantaged simply on their year of graduation.

Cardiothoracic & ENT surgery

8.7 Both specialties are seeing a significant over-production of CCT holders compared with consultant job opportunities.

Urology

8.8 Urology has been a pilot specialty for shorter training. Trainees on three year programmes are due to finish in March 2008. Training has not modified for this group, just shortened, and most are very unhappy with the standard of training. Competency based assessment on completion may result in extra training time being arranged. Other specialties will face this problem if competency based assessment/training is not carefully planned with very specific objectives.

Neurosurgery

8.9 There is strong support amongst current and "awaiting potential" neurosurgical trainees for genuine national selection with ranking of all 18 (or as many as have posts) training rotations, in order to remove the geographical lottery. It is widely accepted that this would be in principle the same process as that which has always occurred, simply occurring at one stage each year.

8.10 At the last British Neurosurgical Trainee Association meeting, neurosurgical trainees unanimously supported the suggestion of directly linking the new input of NTN or equivalent posts with the release of NTN posts which should only occur once completed trainees are appointed to substantive consultant posts (obviously with account made of the expansion in consultant posts). We accept that it is unlikely that we could win an indefinite extension to the duration of an NTN whilst consultant employment is sought, but given that a completed NTN should have passed all stages of assessment such that they are suitable for such appointment, there is little logic in casting such trainees onto the scrap heap for them to become deskilled whilst spending the same amount again employing someone who currently has no "specific neurosurgical value".

8.11 Under MMC there is increased recruitment to training posts year on year in spite of the fact of the predicted unemployment.

October 2007

Memorandum by the British Society for Rheumatology (MMC 48)

MMC

Executive Summary

1. The British Society for Rheumatology (BSR) is a medical society committed to advancing knowledge and practice in the field of rheumatology. We aim to improve awareness and understanding of arthritis and other musculoskeletal conditions and work at national and local level to promote high quality standards of care for people with these conditions. We have around 1,400 members in the UK and overseas; the majority of these are consultant and trainee rheumatologists. BSR also has a number of members who are allied health professionals, primary care workers, scientists and others working in the field of Rheumatology.

2. BSR has a well-established committee structure which specifically addresses the knowledge and skills needs of trainees and career staff.

3. As a relatively small medical subspecialty there is rather variable representation in undergraduate and postgraduate medical training programmes. There is often little exposure to rheumatology at undergraduate level and even less at Postgraduate level. We would want to ensure that any changes in medical training take this into account.

4. In the long run, it will not be conducive to force trainees to select their specialties at such an early stage.

5. We need a much more flexible system with a separation of the core medical training process and the specialist training.

6. There is a need for any new medical training structure to take into account out of programme experience.

7. The curriculum vitae should be reintroduced to the specialist training selection process.

8. There is a need for greater flexibility in terms of location and time out, to allow trainees to fulfill any caring responsibilities.

What are the principles underlying MMC and are they sound?

9. MMC was designed to streamline and hasten progression up the medical career ladder. One of the major themes of MMC is continuity of training and while this is an entirely reasonable principle, we do not think that this should be at the expense of being able to make informed choices about a future career. MMC has not fully taken into account the complexities that influence trainees' career choices. Doctors make this decision at different speeds and the lack of flexibility to switch between careers is made very difficult by the rigid MMC system.

To what extent the practical implementation of MMC has been consistent with the programme's underlying principles

10. We consider it to be of crucial importance that there should be an opportunity to decide, approximately four to five years before the end of post-graduate training, which subspecialty path a trainee wishes to follow within Medicine. It is an essential step. No young physician should be committed to a medical subspecialty without considerable relevant experience so that he/she can make a rational choice.

11. Although the practical implementation fell a long way short of expectations, in terms of matching applicants to jobs, the process achieved limited success.

The strengths and weakness of MTAS process

12. While it is right that the selection process should be fair and free of bias, it must be able to afford adequate weight to experience, educational and training attainment and ability. We therefore feel that the selection process must include consideration of a comprehensive curriculum vitae.

13. There was a sense of frustration on the part of those interviewing due to inability to see the application forms, the limited range of questions asked on the application form and the system for providing references. We also feel strongly that the multi-choice referee system does not allow referees to express subtle differences between candidates. The addition of a box to allow some free text from referees could overcome this.

14. Trainees wishing to gain accreditation in more than one specialty also need a clear career pathway. Many rheumatology trainees wish to achieve dual accreditation in general internal medicine. The newly established specialty of Sports and Exercise medicine is another in which future doctors may wish to seek accreditation alongside rheumatology.

15. MTAS should have been piloted before release; this might have avoided the implementation of inadequate software and compromised security.

16. The timescale for processing was so short that it consumed vast amounts of physicians' time and resulted in unrealistic deadlines.

What lessons about project management should the Department of Health learn from the failings in the implementation of MMC?

17. There needs to be adequate input from front-line staff. The Department needs to listen to advice from the Royal Colleges and Medical Schools. These bodies articulate the needs of all junior doctors, including the most able, who are those that will ensure high standards in the future. The DoH needs to learn from previous mistakes and (a) avoid rapid implementation (b) pilot new systems (c) engage end-user staff.

The extent to which MMC has taken account of the supply and demand of junior doctors and the number of international medical graduates eligible for training in the UK

18. To its credit the Government has considerably expanded UK medical school output with the intention of making the UK self sufficient in doctors. However, as far as it is possible to predict, it is crucial that medical schools do not train more doctors than there are jobs for. Although it could be argued that those not appointed to NHS consultant posts in hospitals could alternatively be employed by primary care trusts to provide a community rheumatology workforce, doctors leaving the United Kingdom due to a lack of jobs would be costly to the country and demoralising for trainees. There needs to be joined up thinking at the undergraduate and postgraduate levels to minimise these problems. Specialist societies need to be actively involved in this process and can guide the manpower planning process based on service developments and service demand.

19. From our specialty's point of view, in terms of recruiting trainees, there is often little exposure to the rheumatology at undergraduate level and this is something that needs to be addressed uniformly across the UK in order to aid career decision making. Postgraduate exposure to rheumatology is often even more limited and it is this experience that generally most influences doctors' career choices.

The degree to which current plans for MMC will help to increase the flexibility of the medical workforce

20. It is undesirable to force young doctors to make ill-informed choices about their career at a very early stage. The outcome will result in unhappy doctors and an unhappy service to match. The system also needs to be more flexible to permit changing a career choice in the light of experience gained in clinical practice. A separation of the core medical training process and the specialist training would be desirable with selection for specialist training occurring as a separate process once the core training is complete.

21. The geographical inflexibility of MMC is a huge problem for trainees trying to combine a successful career with a successful personal life and is exacerbated if a trainee's chosen partner is also a medical trainee. Enforced separation will be good for neither them nor the service.

22. We have concerns about the breadth and depth of training that can be obtained in one Deanery. It is important that we return to the strong tradition whereby those who wish to may take time out of out of programme for research, education and experience abroad to provide that breadth and diversity which has been the strength of postgraduate medical training in the UK in the past. A prescriptive conveyor belt style of training removes flexibility and is not in the long term best interests of either our trainees or our patients.

The roles of the Department of Health, Strategic Health Authorities, the Deaneries, the Royal Colleges and the Postgraduate Medical Education and Training Board in designing and implementing MMC

23. We feel strongly that the Royal Colleges can be an independent voice and therefore should have a strong role in guiding postgraduate education and training. This is fundamental to the success of all future plans.

October 2007

Memorandum by the Royal College of General Practitioners (MMC 49)

MODERNISING MEDICAL CAREERS

1. The College welcomes the opportunity to comment on this Inquiry into MMC and its implementation through MTAS.

2. The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. It aims to encourage and maintain the highest standards of general medical practice and to act as the "voice" of GPs on issues concerned with education, training, research, and clinical standards. Founded in 1952, the RCGP has over 31,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline.

What are the principles underlying MMC and are they sound?

3. We believe that the underlying principles of MMC should be to provide a comprehensive, dedicated, supervised education and training programme that is managed in a systematic way. This should be provided in a safe clinical learning environment. MMC should be an outcome-base educational process that aids lifelong professional development.

4. We believe that these principles are sound and it is important these are adhered to in its implementation. The object of these principles is to produce doctors who are knowledgeable, task competent and equipped with sound interpersonal, resource management and organisational skills.

To what extent has the practical implementation of MMC been consistent with the programme's underlying principles?

5. The practical implementation has caused a number of problems that has not been in the interests of patient safety or trainees.

6. The Foundation Programme established the principle that all doctors need a defined set of generic competencies to form a strong foundation for their subsequent specialty training. The programme also enables them to start developing their professionalism in the real workplace.

7. It has been difficult to make a completely accurate gauge of the implementation due to major IT issues within the MTAS that have unfortunately hindered it.

8. The original intention was that all doctors should spend at least four months in general practice to gain community based competencies, to understand the patient's illness within their home environment and to experience the delivery of primary care and its interface with secondary care. Unfortunately this key intention has not been implemented across the whole country. The number of doctors who have the opportunity to take up such a post varies from 25%–95% across the UK. It is difficult to see how some of the primary care generic competencies are being achieved and assessed. Over half of all doctors graduating from the Foundation Programme are denied vital early clinical experience of caring for patients in their usual community based environment. As a result, they are denied the opportunity to see natural history, care pathways, multiple morbidity and chronic disease management.

9. A research study proposed by COGPED to MMC Foundation has faltered because of the breakdown of the old MMC team and funding stream. This work would have investigated the utility and effectiveness of foundation training in general practice. However, early feedback from the first cohort confirm the evidence from previous PRHO in GP studies, that General Practice is a good learning environment, Foundation Year doctors get higher levels of supervision and they gain the required competencies.

10. It is disappointing that the implementation of the Foundation Programme component of MMC has been only partially successful.

11. Run-through training has required all specialties to define the curriculum that will deliver a Certificate of Completion of Training confirming that the holder is competent to work in the NHS as an independent practitioner. The training curriculum for general practice was developed by the Royal College of General Practitioners and was one of the first to be approved unconditionally by the Postgraduate Medical Education and Training Board. It is based on an integrated three-year programme with placements in both primary and secondary care. It is a significant improvement on the previous patchwork of time spent in hospital posts in (often unrelated and sometimes irrelevant) different specialties and a year in general practice. Unfortunately it has not been possible to extend the period of training in general practice beyond the current three years—nor is it yet clear whether the general practice phase of training will be extended from 12–18 months in all deaneries. Failure to implement this change will undoubtedly compromise the implementation of what is widely regarded as one of the most complex and challenging of all medical disciplines—and may adversely affect future workforce requirements. In addition, European legislation allows more flexibility in specialty training for hospital specialties than it does for general practice. This legislation needs to change if we are to train GPs to be fully fit for purpose. MMC could have tackled these issues—but it has not and, from a general practice perspective, could therefore be seen as a significant failure.

12. We are very pleased that the recently published report into MMC by Professor Sir John Tooke supports this and recommends that the length of GP training be increased from three to five years to bring it in line with specialty training, as it is in other developed European countries.

13. Run-through training for Academic General Practice: General practice academic training has benefited from being allocated Walport Academic Clinical Fellowships at 6 university departments. The framework for applications has used the model of hospital specialist training and this has produced several difficulties for general practice.

14. The original issue stemmed from the three years /25% model for specialist training. The fellowships have however been integrated into the clinical programme resulting in a CCT at the end of 4 years, by adding an extra year of training.

15. The Walport Clinical Lectureships enable more senior academic trainees to move on from their PhDs, consolidate their work and apply for higher academic awards. For general practice, those in the ACF grade gain their CCT when they finish and are thus no longer entitled to trainee status. They have to seek employment in practices or with local PCTs (the latter being very unlikely) to ensure the clinical element of the Clinical Lectureship.

16. These posts, if filled, will produce a significant proportion of the clinical academics for departments in the future. However, it bypasses a large group of GP clinicians who provide service but have academic interests in education and research: indeed, many of these are now in high academic positions especially in educational roles. The "In Practice Fellowships" are one way of bringing this group back into academic work, especially on the research side.

17. Recent changes in the research funding streams have focused funding into departments with substantial portfolios supported and delivered by researchers with the pre-requisite research qualifications. We feel this is creating a research/ service divide and could potentially diminish the pool from which future educational academics are drawn. We would advise MMC and Walport to seriously consider the career pathway for medical education not only in GP but also in hospital medicine. Whilst this is not within the pre CCT MMC agenda it does impact on the post CCT agenda for GP and it has certain impact upon supplying educational leadership and delivery for the future.

The strengths and weaknesses of the MTAS process

18. It is important to distinguish between the principles of MMC, which included selection, and the selection process itself. We also would like to separate the process from the system that delivered it, MTAS. The principles and guidance for the selection process have been published by PMETB. General practice had started to develop its selection process (PMETB compatible) seven years ago. It is based on defined behavioural competencies that are required to train for and become GPs. The assessments of these competencies were then designed, tested and applied. Over the last few years each deanery has worked towards a UK national process which is described in detail on the GP National Recruitment Office website[48]. One of its strengths has been the time savings resulting from machine marked tests which there was not time to develop for MMC and the use of CVs only for long listing as these a poor discriminator for selection. Despite several rule changes within the MTAS system, the GP process was robust enough to deliver appointments into all vacancies across the UK. Whilst the GP process is not perfect, nor indeed fully developed, the principles of:

— defining competencies,

— designing appropriate assessment methods set to national standards,

— piloting and validating,

— to be delivered online,

are applicable to any specialty in medicine.
The online system is the best way forward, works in other countries and has worked by in large for General Practice.

It is important that the process is also transparent and fair and that there is a cohesive appeal and complaints procedure.

Some of the main weaknesses of the MTAS process have been:

— The lack of country specific flexibility in the logistical operation of the process.

— The lack of proper preparation and validating of systems.

— The lack of proper information and publicity about the system.

— Lack of a clearly defined feedback and audit system.

— Concern about the criteria used to select for jobs—some doctors have been found to not be to foundation standard.

— Lack of support for those who were unable to get jobs.

— Doctors feel that they are being asked too early to make career choices. In our view there should be more flexibility. Young doctors feel that they are being asked to choose a pre-determined career template with little room for adaptive decision making.

— Too many new arrangements were brought in simultaneously, making it harder to adapt.

What lessons about project management should the Department of Health learn from the failings in the implementation of MMC?

The implementation design needed more time for consultation and feedback from stakeholders as well as greater publicity. We are pleased that the recently published report by Professor John Tooke states this as one of its recommendations. Greater flexibility needs to be built in to the design of the system to allow for differences across countries and SHAs and to allow greater choice in careers options. It may be helpful to use the expertise of Occupational Psychologists to help advise the design of the process. It is important that the Department of Health provides adequate resourcing to allow effective implementation of MMC, lack of resourcing has been a particular problem with regard to the implementation of Foundation Training.

In addition we must learn to:

— Design a process that will deliver an agreed outcome.

— Pilot the process and validate the tools / methods of assessment.

— Apply the process by the most appropriate system, if online ensure that that itself is piloted for system problems.

— Be prepared to be patient to get the right result and not overreact to early bedding in problems.

— Appoint a project manager who is clearly identified as the responsible officer.

[48] http://www.gprecruitment.org.uk/faqs/index.htm

The extent to which MMC has taken account of the supply and demand of junior doctors and the number of international medical graduates eligible for training in the UK

19. Workforce planning needs to fit with national and local strategies. A major weakness of workforce planning has been that its periodicity for all of the medical specialties exceeds that of governments by at least a factor of two or three. The decentralisation of workforce planning takes no account of national strategy, small specialties, advances in medical care, new working patterns developed by professionals and educational requirements of UK wide regulatory bodies. Given its weaknesses a central process to collate and make sense of the complexity is vital to ensure at least partial strategic delivery and act as early warning for potential problems.

20. There appears to be a lack of commitment of some Strategic Health Authorities to engage in any process that takes account of national training or workforce needs. Although we are advised that the DH performance manages this activity by SHAs it is difficult to see any evidence of this.

21. It is important that the intake of doctors is matched by need. Whilst it is the ideal for the best candidates to fill posts in a competitive selection process, the intake of international medical graduates should not be such that supply greatly exceeds demand. We have a responsibility to graduates trained in this country and the healthcare systems in other countries to ensure in this regard.

The degree to which current plans for MMC will help to increase the flexibility of the medical workforce

22. There are several ways of interpreting flexibility.

23. Flexible, that is defined as less than full time working, is primarily an HR issue rather than an educational one. If it is national policy to encourage more "less than full time" working then the employers rather than the educators will have to be encouraged to fund it. If there is to be more "less than fulltime" working, it is obvious that more individuals are needed than the whole time equivalent number. With the increasing number of women in medicine this issue cannot be ignored for much longer, as women GPs are known to have a preference for "less then full time" working patterns over substantial parts of their careers.

24. It is not easy to allow flexibility across training lines when each specialty has a defined curriculum. It is unlikely to increase until the service is delivered largely by fully trained professionals and the curricula are designed to work across specialties. There are some examples of this and more can be envisaged—but will require more work.

25. A well educated workforce can, as now, adapt themselves flexibly to new ways of working, new advances in treatments and care and new professional regulation. This might not happen with such ease if the workforce is just well trained.

The roles of the Department of Health, Strategic Health Authorities, the Deaneries, the Royal Colleges and the Postgraduate Medical Education and Training Board in designing and implementing

26. All of these organisations have significant roles to play. The Departments of Health should be designing the strategy and ensuring sufficient resources to allow the strategy to be delivered. Other Government departments with a stake also need to work much more collaboratively.

27. The SHA as the NHS in the regions in England are the bodies to facilitate the strategy by adapting their current plans and resources.

28. The deaneries in collaboration with the SHAs, PMETB and the Royal Colleges should operationalise the policies that will deliver the strategic aims.

29. It is also important that consideration is given to stakeholder groups that operate within the other countries in the UK to ensure delivery is effective in all four countries and appropriate for those environments. This has been echoed in the recommendation made in the Tooke report on MMC.

30. I acknowledge the contributions of RCGP Scotland, COPGED, the RCGP Bedfordshire and Hertfordshire Faculty, Dr Neil Munro, Dr Bill Reith, Dr Andrew Spooner Dr Malcolm Thomas and Dr Martin Wilkinson to the above comments. While contributing to this response, it cannot be assumed that those named all necessarily agree with all of the above comments.

Dr Maureen Baker CBE DM FRCGP
Honorary Secretary of Council

October 2007

Memorandum by Fidelio (MMC 50)

MMC/MTAS

SUMMARY

1. *Philosophy*

Fundamental differences between MMC and previous systems cannot be addressed by mere modifications of the new structure. Democratic evolution of a free-market system is irreconcilable with a top-down ideology, driven by civil servants in the DH who have been unwilling to take responsibility for the consequences of their actions.

2. *MMC*

While not everything in Calman was good, and there was scope for what was good to be extended from the SpR to other grades, MMC as a big-bang solution for all doctors of all grades is an inflexible disaster. Run-through seemed attractive to the Juniors when assumed to apply to most applicants. Restricted to a minority, and the source of MMC's inflexibility, it should be abandoned in all but a few "shortage" specialties. Changes to medical training at grades already modified by Calman should have awaited a rigorous analysis of the Calman years. The Foundation years should return to the Universities, in part as protection from further inroads by EWTD.

3. *MTAS*

While hard to exaggerate the scale of this year's catastrophe, the failure of any individual or department to take responsibility underscores the need to transfer the process of selection back to local level. Centralisation should be limited to the possible unification of application forms, following the model of UCAS or the American matching scheme.

4. *PMETB*

Not fit for purpose—should be abolished, and its responsibilities either returned to those from whom they were misappropriated or incorporated within the GMC.

5. *Academic Medicine*

A barometer of the health and impact of any system upon future innovation and leadership is its support for the minority entering academic medicine. Many of the imperfections of Calman were compensated by the flexibility it introduced for OOPE, enabling externally funded research to be started at any time. This needs to be re-introduced.

> Any recommendations should be piloted and validated, and therefore cannot be implemented before at least one more round of selection has taken place. They cannot start with a clean sheet, but must take into account pressures on the job market both from this (and maybe next) year's victims, and the increasing number of applicants from the new medical schools and new EU.

1. FIDELIO: WHO WE ARE, AND WHAT IS OUR PHILOSOPHY

We are a body which has arisen spontaneously as a result of the alarm among senior members of the profession at what was being done to the juniors, and at the silence of the august bodies who should have expressed outrage at the unfolding disaster. For a long time we avoided taking a name, or even claiming to be a group, because the proliferation of groups representing doctors has been counter-productive. We saw ourselves initially as a "ginger-group" at most, who could be more outspoken in public than our distinguished colleagues holding elected or appointed positions in the various bodies; we hoped our outspokenness would help our leaders take a tough stance in negotiations, representing opinion of their rank and file members. It was the failure of prolonged pressure on the Colleges, AoMRC, PMETB and the Review Body, and our rejection of the view that it was better to be active on the inside of the DH than speaking out on behalf of the profession, which finally persuaded us to adopt an identity. Our "credo", and those who have contributed to our campaign as authors of our various letters and papers, are shown at www.fidelio.org.uk.

Our legitimacy arises from two factors. That we have no self-interest, either as individuals or a group; and that most of the views we have articulated are not actually ours, but were gathered by online polls. Now polls are two-a-penny. But only a few months ago, the DH, RCP, Review Body, and BMA all told us they could not find out whether the ludicrous single-interview proposal was popular, and that this country does not do single-issue votes. The senior DH members of the Review Body told us they were confident from Focus Groups and Deans that we were lone voices and that most people were happy. A senior College figure told us the 10,000

doctors who marched in March were just a bunch of complainers about everything and anything. In recalling these now clearly mistaken views, our aim is not to cast stones, but to remind you how rapidly the introduction of a non-democratic, centralist system corrupts the usual channels for aborting a potential disaster long before the denouement is reached.

While we will consider MTAS separately, we wish to emphasize that this year's MTAS experiment cannot just be dismissed as an unfortunate pimple on the otherwise beautiful face of MMC. Any review of MMC/MTAS which ignores this year's victims and seeks to impose a son-of-MTAS that quietly sweeps this year under the carpet would be anathema to us. A fundamental difference between a free market, and the top-down evangelism from which we suffered this year, is that only the former acknowledges that the situation at any point is determined by the conditions set by the immediate past.

We find it difficult to exaggerate the philosophical differences between the old and new systems.Previously we had a pyramidal career structure, a free market in job applications, and training was designed and assessed by the medical profession. By contrast, MMC offers a parallel ladder no wider than the top of the old pyramid, with (effectively) a single access designed and controlled by DH employees, the Deans. If no one at the DH accepts responsibility for this year's disaster, no future modification is safe in their hands. It will not be the Tooke inquiry which is responsible for implementing its recommendations.

The apparent need for a "ginger-group" of senior doctors during this year's debacle, and subsequent independent enquiry by Sir John Tooke, reflects lack of cohesion (and some conflicts of interest) among the various august bodies who are charged by statute or electorates with protecting the training of junior doctors. We strongly endorse the suggestion in the draft Tooke report that an overarching but representative College of Medicine be formed which allows the medical profession to speak with one voice on matters of training.

2. MMC

What was the problem MMC sought to address?

In finding robust solutions for the future, frank acknowledgement that medical training was not perfect beforehand is important.However these imperfections were not uniform across all grades or specialties.It is unlikely, for instance, that the accumulation of over-qualified SHOs in some areas of surgery required a change in appointments and training of most medical registrars. There have been pockets of problems but MMC smacks of single cases making bad law. Even opinion within the pockets is divided. The Plastic Surgery juniors themselves have said in their evidence to you: "The end of the lost tribe years is theoretically attractive, but one must not forget the advantages that such a system had—it allowed trainees the luxury of trying a few specialties, going abroad, carrying out research etc without the pressure to enter a specific specialty. It allowed young surgeons to better understand where their abilities would be best matched and the possibility of exploring specialties they may have previously had little experience. This is particularly so in Plastic Surgery where there is very little exposure both in Medical School and in many BST schemes. Also, we do not think it is possible to select trainees at ST1 level for any surgical specialty—they have far too little experience. Whilst it is true to say that all surgical specialties demand the same range of abilities they are required to different degrees between the specialties. We cannot see at present how one can select trainees for entry to Plastic Surgery at ST1 level."

Furthermore, we see a clear distinction between [i] the traditional objective of medical training in the UK, to create a cadre of Consultants who are perceived as among the best in Europe and likely to include many of the leaders and pioneers of medicine internationally; and [ii] the likely outcome of MMC as currently designed in which CCT holders have the minimum competencies to carry out service requirements in the UK, but not to contribute notably to future adaptation or innovation.

It may be that MMC was at some point driven by the manpower imperative of accelerating the output from training. If so, we assume this factor has now been eclipsed by the threatening tsunami of the increased input from new medical schools in the UK and the new EU. The CCT-holder of tomorrow may need more than ever to be multi-skilled in order to adapt to a rapidly changing environment in the medical market place.

Of course we have nothing against some of the motherhood and apple pie of the MMC seven pillars. But with typical dishonesty, we note that at some stage "flexibility" disappeared from these trumpeted pillars, and this exemplifies but one problem with imposed systems like MMC. It is a Rubic's cube wherein the players, lackingthe ability to put everything in place, simply wrenched out the bits which did not fit, or used glue to keep other bits together.

Run-through

RT was such a glue—rather literally, since it is the root cause of the rigidity that has undermined both MMC and MTAS. If either of these is to survive at all, competition for entry to training must be permissible at several stages. We understand RT was a late-entry to MMC; its inclusion illustrates the danger of introducing any apparently innocuous, even popular, modification without piloting and validation. Without RT, MMC remains as vacuous if not actually harmful, as many see the Foundation Years (see below). RT seemed

synonymous with security, and was therefore popular with the juniors when the proposed model was that all but 1,000 or so of applicants would enter run-through, and the rest would receive FTSTAs and be eligible in a vague way for subsequent transfer to ST posts.

In reality, RT has become a cage which keeps those inside safe from preying FTSTAs, but also stops those inside from getting out, or in hundreds if not thousands of cases, from seeing their loved ones for the next seven years except at weekend visits. In Medicine, many trainees will find themselves unable to obtain their specialty of choice at ST3 because the posts do not exist in their UoA.

Although RT from ST1-7 has been a windfall to some this year, and is unlikely to be repeated after such a bad press, it is not a new concept, having been introduced by Calman to link the previous registrar and senior registrar grades. Before embracing yet further RT, questions should have been asked about the evidence of benefit from the last change. Calman too brought forward the time for career choices and structured training. Many aspects of the latter have seemed better; but the source of improvement may have been as much to do with training and study-leave budgets—now all but collapsed since the DH's real interest in training was revealed by its £100Ms heist from training budgets.

Under Calman, some flexibility was lost, but this may have seemed a reasonable price for some necessary regulation of the market. And the OOPE possibilities within Calman—a casualty of MMC—were generally welcome. However, the majority of Calman trainees do not avail themselves of OOPE opportunities, and may be generally less motivated than their predecessors to do more than stay on the conveyor belt from entry to exit. General Medicine, in any meaningful sense, has been another casualty. And the routine practice now of SpRs in geographically large deaneries being forced to move house every year, or commute large distances each day, smacks of a London creation. It was this precedent which has let Deans these this summer play god with people's lives as many Juniors—a week before 1st August—still waited to find out where within a few hundred miles they would be working.

The CMO defended MMC on Channel 4 News in August saying "the previous system was old and needed changing". This was not an argument but an assertion, and neither half of the syllogism is self-evidently true.

Foundation Years

It is hard to disentangle the effect of EWTD from MMC on the devastation of the houseman grade. Fashionable 360 degree appraisals do not compensate for the disappearance of personal mentorship and the hours of apprenticeship many of us still assume to be a necessary part of acquiring skills. If either the application or educational processes of the Foundation years were considered successful piloting for this year's roll-out of MMC/MTAS, the evidence of such benefit should have been published.

3. MTAS

Our views on MTAS were well publicised in a series of articles and letters in The Times, Guardian, Independent, Lancet and BMJ (cited at the end of our evidence). If it were not for the DH press statement describing the outcome as "good news", one might have assumed—as did the Tooke enquiry—that no sane person any longer defended MTAS. The fact that DH is an exception is sufficient reason for us to be concerned about any aspect of medical training and selection remaining in its hands. The fallout has also undermined the credibility of Deans as regional superintendents, because the role of some of them in the introduction of MTAS inhibited the others from doing more than carrying out orders.

The "independent" Review Body—the epithet was variably applied in the weekly MMC announcements during March—became (as admitted to us by the PRCSEng) another quango in which the Royal College Presidents were used to front the DH's desperation to put service needs ahead of all else, in their self-fulfilling concern that 1 August would see empty posts in hospitals. It is incredible that, once the short-listing arm of MTAS was admitted to be flawed, the Review Body took more than 10 milliseconds to decide whether the whole process was flawed—and still made the wrong decision!

In trying now to look forwards rather than backwards, and to make points not previously covered in our writings, we wish to emphasise the inter-connection of MMC/MTAS, with one ill being the consequence of the other. Run-through removed flexibility, and created the need for indelible career decisions at a stage when insufficient assessable evidence is available to either the applicants or their scorers.Hence the need for mindless tests of basic mental fitness, rather than competition by markers of excellence. MTAS mirrors the 11 + in its rigidity and unfairness of selection, with the new lost tribe of FTSTAs being the secondary moderns of MMC.

It will be tempting to dismiss this year as a special circumstance—bad planning of the process, and the need to shoe-horn several years into one, as the old lost tribe of SHOs and IMGs were decimated with the same ruthlessness as colonial Britain has applied in the past. However every year from now on will have special circumstances—particularly the manpower consequences of bulging outputs from medical schools and Europe. But the philosophy and source of problems remains unchanged. If MMC seeks to produce minimally competent doctors, then every competitively chosen medical student who finishes medical school should be fit to meet competency, and son-of-MTAS can legitimately remain the lottery it was this year. Over-trained, thinking doctors might be seen as an expensive and dangerous luxury by the DH! If, on the other hand, MMC

seeks to produce the outstanding doctors and innovators of the future, (a ferociously difficult task—like trying to predict the 5% of research projects which will make groundbreaking discoveries. This vision is incompatible with discarding an ever-growing proportion of our graduates just two years out from medical school.

A central system for handling applications: lessons from the American system of medical applications

One of the problems of previous UK systems was the often enormous number of individual job applications that Foundation Year doctors had to make to SHO posts before securing an interview and, subsequently, a post. MTAS attempted to address this problem by restricting the number of applications to four—indeed to only one in a given, large region of the UK if applicants were already committed, eg through research or LAT experience, to a particular specialty. This restriction must, we believe (with some legal advice) be an infringement of human rights, and has led to the miseries of partner separation discussed in section 2 (MMC).

In the USA, two centralised processes greatly facilitate the process of allocation of post graduate training positions for doctors at a similar stage (ie those looking for residency positions).

The first, the Electronic Residency Application Service, (ERAS) allows all relevant personal documentation including the CV to be sent to a single central site, from which it can be forwarded to residency programme directors. This is run by the US equivalent of the Academy of Medical Royal Colleges. The second, the National Residency Matching Programme (NRMP), has, since 1952, operated successfully as a private, not-for-profit corporation to provide a uniform date of appointment to positions in graduate medical education (GME) in the United States. The NRMP has a very successful module that allows couples to match in the same geographical area, a striking contrast to what is proposed for this country.

These systems were highlighted as a potential model for MTAS. However there was a clear failure to distinguish between the purely administrative functions of the ERAS and NRMP schemes, and the use of a centralised process to select candidates for particular posts. In the USA, house officers visit residency programmes in as manyUS centres as they wishover a period of several months every year (usually between August and January). They have several opportunities to visit any one programme. They interview the programmes as much as the programmes interview them, so that standards of training are kept high. The programmes rank the candidates who have visited, the candidate ranks the programmes, and this data is sent to the NRMP which distributes residency posts according to mutual suitability. Unfilled posts and unemployed candidates are then put in a pool for "clearing". The Matching Scheme has NO involvement in the assessment of the candidates' qualities. This is the responsibility of the Residency Programme Director. Programmes and individuals must complete their rank ordering by late February. By 20 March—"Match Day"—the centralised system has completed its allocation of all posts. NRMP essentially provides an impartial venue for matching applicants' preferences for residency positions with program directors' preferences for applicants.

There is no a priori reason why the best elements of this scheme could not be adapted for use in the UK . It would require an increased time commitment by those providing Specialist Training to multiple interview days between August and December. With the increased sense of personal involvementby trainers that such a scheme would bring, this commitment should not be difficult to achieve.

4. PMETB

We entirely agree with the comments of the British Orthopaedic Trainees Association: "The present PMETB is an organisation that lacks any reason for its existence. It has succeeded only in reducing the quality of training so far, and introduced nothing but hurdles in trainees' quests for excellence. It has replaced SAC visits with a poor substitute of visits by its own department, which lacks any experience of the actual specialty that they are trying to assess. The result is a complete fiasco. It has also reduced the ability of trainees to obtain further Out of Programme Experience in order to learn new skills, and placed an enormous amount of bureaucratic red tape in a system that previously worked well and efficiently. This organisation must evolve, or be disbanded. It has been given unreasonable powers beyond its abilities."

The establishment of PMETB was a direct attack upon the medical profession, and in particular its Royal Colleges, and should have been resisted. Arguments by individual members of PMETB about what exactly their statutory duties may be, while thousands of young doctors were having their lives ruined, betrays a vacuum at the heart of the present system. Neither Fidelio nor RemedyUK had any statutory right or need to speak out! Fear to say what is true, lest lawyers or political masters serve a writ, are features of a totalitarian system of which MMC/MTAS will remain a part until returned to democratic institutions for their implementation and supervision. PMETB should be abolished or incorporated within the General Medical Council.

5. Academic Medicine

This may be considered to represent a minor part of the processes of training and selection. Yet even those furthest removed would concede that there is likely to be a strong correlation between the overall health and excellence of UK medicine and the strength of academic medicine. Leaders in academic medicine have traditionally accepted responsibility for leadership well outside academic matters. As the rest of this

submission, and our previous publications, will attest, the academic leaning of Fidelio has not been a bar to our speaking out on behalf of all the Juniors caught up in this year's disaster. In concluding on the issue of academic training, our concern is in part to illustrate how badly wrong a top-down ideology can go, by overlooking an apparently small but vital piece of the jigsaw.

As remarked above during our comments about Calman, one of its positive features was the flexibility of OOPE, that enabled SpRs to obtain externally funded research fellowships at any stage, and be replaced by LATs for upto three years. The introduction of Walport Fellows, while welcomed, does not account for more than a fraction of all research posts. Moreover, we are clear that many trainees do not perceive themselves as academics of the future at the stage of their training when Walport posts must currently be sought. Indeed, in some ways the creation of academic F1/F2 years—which need to be applied for by medical students—creates the concept that academics are a quite different breed of doctor who must define themselves at an extra-ordinarily early stage; whatever you recommend for the future must allow individuals to make that career choice late as well as early.

The LAT system had much to recommend it, both for the LATs and for those whom they replaced. If LATs cannot be accommodated under MMC, this raises serious questions about its nature and flexibility. One alternative might be a substantial increase in the number of training posts in each specialty equivalent to the number of LATs required in the previous five years. A mechanism would then need to be found for regularly reviewing this number, so that new areas—geographically and scientifically—are not excluded from representation.

October 2007

Annex

Glossary of Terms

AoMRC	Academy of Medical Royal Colleges
BMA	British Medical Association
BMJ	British Medical Journal
CALMAN	Former CMO; name given to current system of training specialist registrars
CCT	Certificate of completed training
CMO	Chief Medical Officer
DH	Department of Health
EWTD	European Working Time Directive
FTSTA	Fixed Term Specialty Training Appointment
GMC	General Medical Council
IMG	International Medical Graduate
LAT	Locum Appointment for Training
MMC	Modernising Medical Careers
MTAS	Medical Training Application Service
OOPE	Out of Programme Experience
PMETB	Postgraduate Medical Training Board
PRCSENG	President of Royal College of Surgeons (England)
RCP	Royal College of Physicians
SHO	Senior House Officer
SPR	Specialist Registrar
ST(n)	Specialist Trainee (year . . .)
UCAS	Universities and Colleges Admissions Service
UOA	Unit of Application (alias Deanery)

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Memorandum by Dr Alan Bosley (MMC 51)

I have read the Tooke report and largely agree that the original MMC and MTAS application system was flawed beyond belief. I support Professor Tooke's recommendation for local application; by local I mean to individual trust not local deaneries. Trust pay the bills, work with the appointees and trust staff should appoint junior staff. Otherwise we have army type "postings".

I must strongly object to non training "service only" appointments. All work in the NHS is training all jobs have a service commitment be they junior or senior. There is not a day go by that each of us at consultant level and below does not "learn a lesson". All jobs in the NHS should be training jobs, and all jobs should be subject to open competition. No first class (training) and second class (trust) jobs. Then the best and most suitable character wins. The old style interview had much to commend it and the "gut feeling" has been shown to be as accurate as any other method. Modern interview regulations should ensure equal opportunities and fair treatment for all with accountability. A good and working system was ruined by the ill informed rush to reform with no clear evidence of outcome. A hallmark of modern government. A vast amount of money was wasted on this project and that could have been effectively spent on clinical care and educational improvement. (Note the limits on study leave in many trusts).

I doubt those really responsible will be identified but the lesson of "if it is not broke do not fix it" needs to be learnt centrally. Good government has always been least government.

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