House of Commons
Health Committee

Modernising Medical Careers

Third Report of Session 2007–08

Volume III

Oral and written evidence

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The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

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Witnesses

Thursday 15 November 2007

Sir Liam Donaldson KB, Chief Medical Officer, Professor Martin Marshall, Deputy Chief Medical Officer, Ms Clare Chapman, Director General of Workforce, and Mr Nic Greenfield, Deputy Director of Workforce, Department of Health

Thursday 6 December 2007

Professor Sir John Tooke, Dean of Peninsula Medical School, Head of the Tooke Inquiry, and Sir Jonathan Michael, Deputy Managing Director, BT Healthcare, Member of the Tooke Inquiry Panel

Dr Richard Marks, Head of Legal Team, and Mr Matthew Jameson Evans, Press Co-ordinator, RemedyUK, and Professor Steve O’Rahilly, University of Cambridge, member of Fidelio

Thursday 13 December 2007

Professor Alan Crockard, Former National Director, MMC (England), and Professor Shelley Heard, Former National Clinical Advisor to MMC

Dr Jo Hilborne, Former chair, Junior Doctors Committee, British Medical Association, Dr Ian Wilson, BMA Consultants Committee and MMC Programme Board member, British Medical Association, and Dr Ramesh Mehta, President, British Association of Physicians of Indian Origin

Mr Mark Johnston, Managing Director, Methods Consulting

Thursday 17 January 2008

Professor Dame Carol Black, Chair, Academy of Medical Royal Colleges, Mr Bernard Ribeiro, President, Royal College of Surgeons, and Dr Bill Reith, Chair of Postgraduate Training Board, Royal College of General Practitioners

Professor Elisabeth Paice, Dean Director, London Deanery, and Chair, Conference of Postgraduate Medical Deans, Professor David Sowden, Dean, East Midlands Healthcare Workforce Deanery and Senior Responsible Officer for MMC, Department of Health (from January 2008), and Professor Sarah Thomas, Dean, South Yorkshire and South Humber Postgraduate Deanery
Thursday 24 January 2008

Professor Peter Rubin, Chair, Postgraduate Medical Education and Training Board, Professor Neil Douglas, Head, MTAS Review Group, and Professor Sir Nick Wright, Warden, Barts and the London School of Medicine and Dentistry

Ms Anne Rainsberry, Director of Workforce, NHS London, Dr Moira Livingston, Strategic Head of Workforce and Deputy Medical Director, NHS North East, and Ms Sian Thomas, Deputy Director, NHS Employers

Monday 18 February 2008

Ms Lorraine Rogerson, Director of Policy, and Head of Profession at the Border and Immigration Agency, Home Office, and Ms Judith Macgregor, Director for Migration, Foreign & Commonwealth Office

Rt Hon Alan Johnson MP, Secretary of State for Health, Mr Hugh Taylor, Permanent Secretary, Sir Liam Donaldson KB, Chief Medical Officer, and Ms Clare Chapman, Director General of Workforce, Department of Health
List of written evidence

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3 Richard Cove
4 Graham Robertson
5 Professor David Curtis
6 The Royal College of Radiologists
7 Diana Morgan
8 The Academy of Medical Sciences
9 Dr Clive Peedell
10 Anna Peek
11 Dr Schramm-Gajraj
12 Catherine Macdonald
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21 Dr Gordon Caldwell
22 Association of Surgeons of Great Britain and Ireland
23 Queen Victoria Hospital NHS Foundation Trust, East Grinstead
24 Penelope Jane Berry
25 Alison Matheson
26 NACT UK
27 Postgraduate Medical Education and Training Board
28 Royal College of Paediatrics and Child Health
29 The Royal College of Surgeons of England
30 Roger Fox
31 British Orthopaedic Association and the Specialty Advisory Committee in Trauma and Orthopaedic Surgery
32 NHS London and London Deanery
33 Professor Alan Crockard
34 Committee of General Practice Education Directors and the Society for Academic Primary Care
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36 Dr J L W Parker
37 British Orthopaedic Trainees’ Association (BOTA)
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Oral evidence

Taken before the Health Committee

on Thursday 15 November 2007

Members present

Mr Kevin Barron, in the Chair
Charlotte Atkins
Sandra Gidley
Dr Doug Naysmith
Mr Lee Scott
Dr Howard Stoate
Mr Robert Syms
Dr Richard Taylor

Witnesses: Sir Liam Donaldson KB, Chief Medical Officer, Professor Martin Marshall, Deputy Chief Medical Officer, Ms Clare Chapman, Director General of Workforce, and Mr Nic Greenfield, Deputy Director of Workforce, gave evidence.

Q1 Chairman: Could I welcome you to the first session of our inquiry into Modernising Medical Careers and ask you, for the sake of the record, to give us your name and the position you hold.

Sir Liam Donaldson: I am Liam Donaldson, Chief Medical Officer for England.
Professor Marshall: I am Professor Marshall, Deputy Chief Medical Officer for England.
Ms Chapman: Clare Chapman, Director General of Workforce for England.
Mr Greenfield: I am Nic Greenfield. I am Director (Education, Regulation and Pay) Workforce.

Q2 Chairman: Welcome, once again. I will start with the general question. The implementation of the new MMC specialty training schemes, through the MTAS recruitment process, has been described as “the biggest crisis within the medical profession in a generation”. Do you accept that MTAS has been the disaster that people say it has been?

Sir Liam Donaldson: I think it was a very, very distressing experience for all the junior doctors concerned, and for those of us who care about people, which I and my colleagues do, it was a very distressing experience for us watching the process. The consultants, who did a formidable job in carrying out the thousands of interviews that needed to be carried out, also had a very difficult time, and the postgraduate deaneries, which carried the brunt of the details of the application process, did as well. It was a traumatic and highly unsatisfactory experience. I think there are some positives to come out of it as far as learning for the future is concerned, and in some specialties and in some parts of the country the problems were not nearly as great as they were in other parts of the country.

Q3 Chairman: There were demonstrations on the streets of London. Up to 30,000 doctors were caught up in this chaotic event and the demonstrators were arguing that these 30,000 doctors had been treated unfairly and inhumanely. Would you agree with that?

Sir Liam Donaldson: I have already said that the experience for the junior doctors concerned was dramatic, distressing, created a lot of anxiety, and I have publicly apologised for that in April. Patricia Hewitt, the previous Health Secretary, did as well. We deeply regret that. As far as unfairness is concerned, in any large-scale recruitment process there will be some examples of unfairness but, across the board, I would not agree that the outcome has led to wholesale unfairness, no.

Q4 Chairman: In terms of project management, what does it say about the Department of Health? It seems to me that MTAS has been about project management. Do you think it has damaged the Department of Health, in terms it being able to manage change on the scale that was envisaged?

Sir Liam Donaldson: Any central government department like ours is sometimes put in charge of big programmes of change but often those are developmental and do not involve detailed technical aspects of implementation. When you look at the causation of the crisis—and no doubt you will be asking us about our views on that later—having read myself thousands of documents and reflected on the experiences, I am quite clear what the main causal factors were. Certainly one of the main three was aspects of the application process itself, but the rationale for adopting that application process—given that aspects of it had been used in the foundation programme, which, on the whole, has been a pretty successful implementation process, and aspects of it had been used in other settings—and the principles underlying it, of trying to move away from vaguer systems of recruitment to more competency-based judgments, were sound and widely accepted. But the technical aspects of implementation clearly went badly wrong.

Chairman: We will be picking up some of those issues as this evidence session goes along. I will move on to Charlotte.

Q5 Charlotte Atkins: The original aim of the MMC was limited to reforming the senior house officer grade. How did the programme expand so massively to include the whole medical training system?
Sir Liam Donaldson: I know that some of this is caught up in language and terminology, but might I just clarify that to begin with. The original programme was not called Modernising Medical Careers. It was, as you rightly say, a reform of the senior house officer grade, which was, in my view, an educational scandal in this country and needed to be remedied. I produced a report, Unfinished Business, advised by members of an expert committee, which suggested reforms to the SHO grade. The Modernising Medical Careers programme then was a broadening out of that. We received representations that if you are going to change the first two years of training and make it completely different, then that creates a problem for the interface with the next phase of training, so arguments were made that we needed to look at the specialist training as well. Essentially, the Modernising Medical Careers programme—and you could argue that there were other elements of it as well—contained these two big blocks: the SHO reforms, which came from Unfinished Business, and then the broadening out, on the grounds that if you are doing the first two years afresh, then you really need to look at the specialist training as well. Each specialty, 58 of them, looked at their curriculum, they looked at the design of their training programme, and they made recommendations to the Postgraduate Medical Education Training Board about the reform of specialist training as well. These two programmes were run in synchrony but the foundation programme was delivered first.

Q6 Charlotte Atkins: Did it not mean that, because you had this so-called “broadening out”, this led to the project being rushed and also to some confusion about the aims of the overall project? Sir Liam Donaldson: I do not think there was any confusion about the overall aims of the project. Indeed, I think those were absolutely clear, and we can go into that if you like. As far as being rushed is concerned, it depends what you mean by that. Some would have argued that you cannot go on having old specialist training programmes set alongside a new foundation programme; that would have been dysfunctional and you needed to bring the two in together. The curricula were all revised and all were in place in time, which involved a lot of hard work by the Royal Colleges, the training bodies and others. If you then say, “Well, maybe the implementation could have been deferred,” there is an argument for that but the other side of the coin, of course, is that you would have then been having this problem with the interface between the two new schemes. With the benefit of hindsight, I think probably one thing that should have been done was that the implementation should have been phased or staggered over a period of time.

Q7 Charlotte Atkins: You used the word “dysfunctional”. Is that not what we ended up with? Sir Liam Donaldson: I do not think so. No. If you look at the design of the specialist training programmes, the accusation has been made that we should never have introduced run-through training, but a lot of professional bodies are in favour of that for their specialties and there are some advantages to it. Again, with the benefit of hindsight, there should be more flexibility, so that not all programmes are run-through training but for those doctors who want to progress their career more quickly and are absolutely clear what they want to do, then run-through training is probably still a good option.

Q8 Charlotte Atkins: We will be looking at that in more detail later on. Let me just ask you about the issue about the major changes to the specialist registrar grade which obviously was created by the Calman reforms in the 1990s. What evidence was there that this grade needed reform? Sir Liam Donaldson: We received representations from some professional groups and bodies. There was a lot of discussion about it. There was a groundswell of view that the curriculum of each specialty needed to be looked at again. For example, the urologists came to see me and maintained very strongly that their specialty had changed a great deal since the implementation of the Calman reforms, which were necessary to meet European legislation at the time. They said that the office-based urologist who did not do surgery had emerged as a very strong model of practice and was distinct from the surgical urologist and that their training programme just did not address that at all. Cardiologists were making points about the growth of interventional radiology. I think the principle of having a fresh look at each specialty was not a bad one. To move to more defined curricula, competencies explicit, is a good thing I think for patient safety, as well as for trainees knowing where they stand as far as their experience is concerned.

Q9 Charlotte Atkins: But this grade had emerged out of the Calman reforms just in the 1990s. Was there ever a proper evaluation of the Calman reforms or were they just brushed aside? Sir Liam Donaldson: I do not think they were brushed aside. They have served us in good stead for a period of ten years but, in Medical Workforce terms and in the way that medical technology changes and the content of specialties change, ten years is a long time. In some ways, it would have been cavalier to say, “Don’t let’s bother to review things after 10 years.” Charlotte Atkins: Thank you.

Q10 Dr Naysmith: Sir Liam, you mentioned the single run-through grade. That was not part of the original concept, was it? When and why was the decision taken to create the run-through grade? Sir Liam Donaldson: In the original proposal in Unfinished Business, my report, there was a mention of the need to look at specialty training and the design of specialty training and the concept of run-through training was aired in that report. The next major publication was by the four UK health ministers, a report called Modernising Medical Careers and, again, the need to look at the specialty training was addressed. The next major publication, again produced by the four UK health departments,
was called *Next Steps in Modernising Medical Careers*. It was at that point that the concept of run-through training was majored on and developed further. There had been a lot of discussion with professional bodies and others which led to that point. Mr Greenfield was involved in some of that and might be able to give more detail.

**Q11 Dr Naysmith:** Just to be clear, in *Unfinished Business*, it was envisaged, clearly, that there would be two separate specialist training grades rather than the one single run-through grade. That was a conscious decision to change it, in discussion in these later papers. Is that right?

**Sir Liam Donaldson:** It was a conscious decision to change it. The original *Unfinished Business* suggested a period of general professional training, followed then by the higher specialist training, yes.

**Q12 Dr Naysmith:** But as you have already said, the run-through grade appears to make the new training system very inflexible and you are suggesting having to introduce flexibilities into it.

**Sir Liam Donaldson:** Yes. It has some advantages over the old system, in that for people who are absolutely clear what they want to do it gives them the opportunity to get on with things. In America, you can move more or less straight from medical school to run-through training and it seems to work pretty well there. It also creates more stability for the trainees: rather than having to apply for another job every six months, they can move forward knowing what their career plan is, and it allows a greater integration of training. It has the downside that for people who want to change specialties, who change their mind about what they want to do, it is rather inflexible. Also—and this is I think relevant to the principal in general practice, the feeling amongst the graduates all the time.

**Q13 Dr Naysmith:** That is to do with the computer system and the way of organising the applications.

**Sir Liam Donaldson:** I do not think it was purely to do with the computer system. I think it was the fact that, because the run-through would then take people right through to becoming a consultant or a principal in general practice, the feeling amongst the junior doctors, many of them, was: “This is a once-in-a-lifetime decision. We have to make that decision at this one point in time.” Irrespective of the computer, it was rather inflexible and created a high-stakes situation.

**Q14 Dr Naysmith:** One of the stated aims of the MMC system was to increase flexibility. That was one of its main, stated aims, and it ended up doing the opposite.

**Sir Liam Donaldson:** As far as the foundation programme was concerned, I think there was much, much more flexibility as well as many, many other benefits. In respect of changing specialties, I think, yes, it did not improve flexibility.

**Q15 Dr Naysmith:** Also, in terms of the National Health Service, where there are some specialties where it is really difficult to get candidates and others where there is over application, it would be a good idea to have more flexibility.

**Sir Liam Donaldson:** I think flexibility is always a good thing. I think it is a difficult question to answer whether run-through training made specialty planning worse in the NHS. In some ways you could argue that it created greater certainty, because it was clear which numbers would be allocated to each specialty. It is not an argument I would particularly make, but it is a more difficult question, without really thinking about it further, to give you a clear answer to. But I absolutely agree that one of the things we have to learn from this is that there needs to be much more flexibility in the future.

**Q16 Dr Naysmith:** The MMC system has created a large number of one-year Fixed Term Speciality Training Appointments (FTSAs—there are lots of acronyms in this business). Doctors in these posts have no set career path and limited opportunities to continue in training. Have you not just recreated the “lost tribe” which people used to talk about?

**Sir Liam Donaldson:** I do not think so because these posts are in the minority. The number of full-blown training posts has increased, compared to the past, and many more doctors are in them than would have been the case in the past. The “lost tribe” accusation was because the old SHOs had no educational content to their job at all and were just beasts of burden doing Health Service work.

**Q17 Dr Naysmith:** What is going to happen to them now?

**Sir Liam Donaldson:** Even the fixed term posts have a proper educational content and, indeed, would prepare a doctor very well. I think, for entering the training rotations which are the longer term posts.

**Q18 Dr Naysmith:** If you start with the run-through system, there are not going to be any vacancies for these people, are there?

**Sir Liam Donaldson:** There will be a fresh round of applications.

**Q19 Dr Naysmith:** They are competing against new graduates all the time.

**Sir Liam Donaldson:** Yes, but they will have a considerable degree of experience from that one-year posting.

**Q20 Dr Naysmith:** We will make sure that the application forms allow them to put that down on the form.

**Sir Liam Donaldson:** The application forms have been redesigned.

**Dr Naysmith:** Thank you.

**Chairman:** Richard.

**Q21 Dr Taylor:** Thank you. Good morning. Talking about the supply and demand of training posts in the UK, the figure of 6,000 was quoted in the Tooke Review and appeared in your invitation to tender for
the design of MTAS. In fact, it appears that that was a gross underestimate, because there were something like 32,000 people looking to do these jobs. Which of the groups had you forgotten? You seem to have thought only of the people going from F1 and F2 to the specialist training, and not taken account of the huge numbers of SHOs who were having to move sideways. Is that were the discrepancy arose? How did it arise?

Sir Liam Donaldson: We can come back to the point about the SHOs, but the big picture point on the numerical discrepancy was the fact that the planning assumption going into this whole programme was that international medical graduates would not compete until the later stages when there were vacancies created.

Q22 Dr Taylor: Yes, we will come to international graduates in a minute. I am trying to get at the UK graduates of that 32,000. Six thousand, plus, presumably, many thousand SHOs moving sideways. Why were those forgotten?

Sir Liam Donaldson: I do not know that they were forgotten. Might I ask Mr Greenfield to comment on that.

Q23 Dr Taylor: Yes. How do we jump from 6,000 to 32,000? That is what I am trying to find out.

Mr Greenfield: The number of 6,000 is from the initial invitation to tender to WPP. Is that the figure you are quoting?

Q24 Dr Taylor: Yes. We presume that is the number of people moving up from F1 and F2 to specialist training.

Mr Greenfield: The original ITT was focused on the recruitment to ST1, the first level only. That was subsequently expanded. But it was 6,000 per round, not 6,000 in total.

Q25 Dr Taylor: I am still trying to get at where the other 26,000 come from.

Mr Greenfield: We commissioned WPP initially and MTAS to be designed for 30,000 applications.

Q26 Dr Taylor: You commissioned them to be designed for 30,000.

Mr Greenfield: I am trying to be clear if you are saying MTAS or WPP, because there were different figures for each. The MTAS system, the electronic system, we commissioned initially for 30,000 and that was subsequently increased to 40,000.

Q27 Dr Taylor: Did the people designing the computer system know this?

Mr Greenfield: Yes.

Q28 Dr Taylor: Why did we get into so much trouble then?

Mr Greenfield: It was not about the MTAS capacity. That was not the problem. There was not a capacity problem, except on two occasions when the system slowed down for a sum of around 11 hours. The MTAS system was sufficient for the demands that were placed upon it, and, for that 11 hours when it slowed down, we extended the recruitment window by a period just slightly longer than that to make sure that those who wanted to apply had an opportunity to apply.

Q29 Dr Taylor: I am sorry. I am completely foxed. The figure of 6,000 was in the invitation to tender for the design of the MTAS systems, is that right?

Mr Greenfield: The system that was originally commissioned for MTAS, which was by Methods Consulting, was for 30,000 in total. That was expanded to 40,000, is my understanding.

Q30 Dr Taylor: That is not what it says in our briefing at all.

Mr Greenfield: Would it be helpful if I provided the detail in writing to you?

Dr Taylor: Could you do that.

Q31 Chairman: This is probably something we could usefully come back to. I think it is crucial that we know exactly.

Professor Marshall: Could I add something to your specific question, Dr Taylor. The original commission to WPP was for the transition between F2 and ST1. That is where the 6,000 came in. The original commission was not for all applicants across the whole of the system.

Q32 Dr Taylor: Why was it not for all of them? This is where one of the huge problems has arisen. It seems to me that it was these SHOs who were moving sideways who have completely over-swamped the system.

Professor Marshall: It was because the commissioning was done in phases and the first phase, the priority phase, was that first transition from F2 to ST1. There were then subsequent phases and subsequent commissions that went to WPP to look at the transition between ST2 and 3, and 3 and 4.

Sir Liam Donaldson: Chairman, this is your first hearing. We will be able to get a letter to you quickly, so that it will be available for subsequent hearings.

Chairman: Could we do that. We will move on.

Q33 Dr Taylor: We have had so much paper and what really bothers me is the effect of the European Working Time directive on training. One of our experts has told us that, under the old system, junior doctors would have something like 30,000 hours of training and under the new system that training is cut to a mere 6,000 hours. How is the profession going to cope with that? Does that not mean that there have to be more training posts to make up for this?

Sir Liam Donaldson: It is a strong point that is repeatedly made by medical trainers that they are worried about the clinical experience that doctors get. On the other hand, the European Working Time directive is the European Working Time Directive and we have to abide by it. It is, to some extent, a consumer protection measure: you want to avoid tired, fatigued people treating patients. On the other hand, it does have this downside on experience. That
is one of the reasons why the competency-based approach to training was brought in, so that we can test competencies more easily. It is possible, also, in some specialties to intensify the training with modern methods of education. For example, in radiology now, rather than waiting for the trainee as an apprentice to see cases coming through the X-ray department, there are training programmes in which trainees are shown hundreds of digital x-rays and given the opportunity to interact with them on a computer. There are modern educational methods in some cases that can substitute for that lack of experience. But I agree with you: it is a problem that we need to continue to revisit.

Q34 Dr Taylor: Should you not really be looking at lengthening the training? Because you are shortening the number of hours, as it stands at the moment.

Sir Liam Donaldson: Lengthening it just without purpose is difficult. Again, that is why defining competencies is perhaps a better way of doing that. Obviously, if people do not achieve those competencies in the time that has been allocated then you would have to look at lengthening.

Q35 Sandra Gidley: I would like to come back to the 6,000 because I have here a copy of that Tooke Report Aspiring to Excellence, which I have obviously looked into very thoroughly. In appendix 5 it mentions the invitation to tender and goes on to say the scope of work stated, “The number of applicants expected to apply for entry into speciality training is approximately 6,000 plus. Applications will be via a single electronic national portal system. The original ITT was to deliver a short-listing process for ST1. The companies tendering were not asked to deliver the selection methodology for doctors in transition via ST2, ST3, ST4, nor for FT STAs.” It seems to me that history is being rewritten here.

Mr Greenfield: Not at all. The point I was trying to clarify but perhaps did clumsily was that there were 6,000 applicants at each of those levels. The first, ITT, only focused on ST1. That was subsequently increased with ST2, ST3 and ST4, which are the subsequent years of recruitment, and in total that was then increased so that MTAS in its final form was commissioned for a capacity of 40,000.

Q36 Sandra Gidley: How late did they get the final spec?

Mr Greenfield: I would have to go back and check those details and give them to you in writing.

Sir Liam Donaldson: An earlier paragraph on the same page does in fact mention the 30,000. The capacity defined in the DH invitation to tender was 30,000 candidate users. That is in the middle column, the third paragraph down.

Chairman: Could we have that clarified and we can all look at it. Let me move on to Howard.

Q37 Dr Stoate: Thank you. I would like to talk about the rather sorry situation of the international medical graduates. I am sure you would agree that without international medical graduates the Health Service would long since have ceased to exist, if it would ever have got off the ground in the first place. I think we owe a huge debt of gratitude over the years to medical graduates from other countries. However, they do seem to have been spectacularly badly treated with this current system. The Department made several attempts in 2006–07 to try to exclude IMGs from applying for MMC posts or, indeed, to ensure that the system discriminated against them. I have to say I have real concerns about this. Legal action, as you know, prevented that happening, but surely there must be a feeling in the Department that they were treated spectacularly poorly even above any other system that was being introduced.

Sir Liam Donaldson: I would 100% agree with you that the international medical graduates have been great servants of the NHS and we do owe a great debt of gratitude to them. I would say—and I say this quite neutrally, because it is simply a statement of fact—that the planning assumption going into this whole programme was that international medical graduates would not compete for posts in the early stages of the programme until there were vacancies at the end. That was the planning assumption and everything was geared towards that being implemented. When the judicial review was won by the Department of Health, the Secretary of State for Health at the time was advised that it was then too late to implement the existing policy of its excluding international medical graduates but that the rules would be applied in Round 2 of the competition. The situation was further compounded by the fact that the Douglas Review, for all the right reasons, created a Round 1B, which in fact made Round 2 a very, very small round. As a consequence, there were a large number of additional applicants, who were not anticipated or expected, competing for posts. You may say why was the policy there in the first place? The policy was there in the first place, notwithstanding the great service that the international medical graduates have been, because the Government had declared a policy of self-sufficiency wherever possible, because, with such competition internationally, particularly from the United States, to attract medical graduates, it is a very high-risk strategy permanently to decide you are going to base your Health Service on doctors who might be attracted to go and work in other countries. That is why new medical schools were opened as a result of this policy of self-sufficiency. In my view, had the numbers not been as they were in the implementation, we would not have had the majority of the problem that we had. So that is, in my view, one of the causal factors and I say that quite neutrally, simply as a statement of fact, and not with any intent behind it.

Q38 Dr Stoate: Sure, but it does leave a rather nasty taste, that guidance was issued to employers not to consider IMGs for posts unless there was no suitable candidate from within the EEA. Surely that must
have rung alarm bells that it was going to be illegal, and surely morally it is a pretty reprehensible position in which to find yourself?

Sir Liam Donaldson: It was consistent with a policy of self-sufficiency. I do not think I heard any particular criticism of that whenever it was first introduced. I certainly did not hear any criticism when we were expanding the medical schools—indeed that was welcomed. Many other countries have this policy. It is not to say that Britain would not continue with its tradition of training overseas doctors in this country. That could easily continue or would have continued to be part of the programme. It is just that the policy of self-sufficiency and the policy of open borders would be bound to lead to this. You say it is illegal. The subsequent appeal has said that, but, at the time, the judicial review did not say that it was illegal.

Q39 Dr Stoate: The Appeal Court has now ruled that this guidance cannot be applied in 2008 either. It has now been estimated that there will be three times more applicants applying for posts than there are posts available. Does this, also, not make a mockery of the selection process?

Sir Liam Donaldson: We have only just received the judicial review and have not been able to take account of the implications for 2008 but we are looking at that at the moment.

Q40 Dr Stoate: Your own evidence estimated that between 1,000 and 1,500 UK graduates will be unable to find training places in 2008 as one of the consequences of this ruling. That is a quarter of our indigenous output of graduates. Is that not rather alarming?

Sir Liam Donaldson: We have to look at what the implications of the Government are and the number of training posts, and that is something we have not had an opportunity to discuss with ministers yet.

Q41 Dr Stoate: Assuming those figures are broadly correct—and there is little evidence otherwise—what opportunities do you think can be available for that 1,000 to 1,500 UK graduates who will find it very difficult to continue their careers?

Sir Liam Donaldson: Again, I cannot commit myself to things we have not discussed as policy options yet, but I think every effort will be made to help those doctors, just as we did in the packages that were put in place in the 2007 recruitment.

Dr Stoate: Thank you.

Chairman: Lee.

Q42 Mr Scott: Thank you. My question is around workforce planning. The number of students graduating from UK medical schools is growing rapidly but you are unable to prevent doctors from applying from anywhere in the world for UK training posts. As a result, there will be a huge overspill of junior doctors for the foreseeable future. Do you accept that recent workforce planning in the NHS has been “disastrous”? If so, who is responsible for this?

Sir Liam Donaldson: Perhaps I could ask Ms Chapman to come in on that, as the Director of Workforce, but I would not accept the comment that the whole of our workforce planning is disastrous.

Ms Chapman: There are a couple of things I would say. One is that if you look back at the decisions that were made as part of the Douglas Review to make sure that the distress that the Liam talked about could be minimised, some of the workforce planning assumptions have really helped us work our way through the solutions to get a very high fill-rate for the doctor vacancies in the UK this year and perhaps one of the highest fill-rates for the hard to fill specialties. In terms of the short-term workforce planning, I think that good data, which certainly we have had through this year’s recruitment processes, has helped us make good decisions. With regard to the broader workforce planning, I think Sir Liam mentioned that thoughtful workforce planning has been done in terms of broad thinking around self-sufficiency, to make sure there are sufficient people coming through to cope with the European Working Time Directive, and also the significant increase in doctors since 1997 which has been in the region of 30%. So I think there have been some broad things done well. I do think—and the Sir John Tooke inquiry points this out—there are some elements of policy that are not clear and that does make workforce planning more difficult—particularly around the role of the doctor and the extent to which the service is consultant supported or consultant delivered, does make some of the elements of workforce planning more difficult.

Sir Liam Donaldson: There are 21 countries ahead of us in the latest OECD rankings in numbers of doctors per head of population, so we are still not “well doctored”.

Q43 Mr Scott: The MMC reforms mean that many more doctors will complete specialist training in the near future. Surely this is going to lead to heavy numbers of unemployed doctors.

Sir Liam Donaldson: It depends on the needs of the NHS. As I have said, I have not so far seen the NHS complaining that it has too many consultants and principals in GP. As I say, we are still relatively low compared to other OECD countries. The increase in medical schools which was introduced at the time of the MMC reforms mean that many more doctors will complete specialist training in the near future. Surely this is going to lead to heavy numbers of unemployed doctors.

Mr Scott: Thank you. My question is around workforce planning. The number of students graduating from UK medical schools is growing rapidly but you are unable to prevent doctors from applying from anywhere in the world for UK training posts. As a result, there will be a huge overspill of junior doctors for the foreseeable future. Do you accept that recent workforce planning in the NHS has been “disastrous”? If so, who is responsible for this?
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higher education colleagues are investigating that. That can have quite a dramatic shift, so, for every seven doctors that we have at the moment, we would have to provide 11 to provide the same level of service because they are working more part-time, more flexible hours. It is issues like that. I would go back to the CMO’s comment about the impact of international recruitment. It is very clear at the moment that we have, to develop and support the Working Time Directive, relied on international doctors and have expanded with their excellent support, but we cannot rely on that in the future because other countries, English-speaking countries, Australia, New Zealand, America, are only training somewhere near 75% of that to meet their own needs and those doctors will be attracted to those places and we could not afford to take that risk.

Q44 Mr Scott: Sir Liam, what numbers of extra consultants do you predict are going to be needed over the next decade?

Sir Liam Donaldson: I cannot give you an answer to that question at the moment.

Mr Scott: Thank you.

Chairman: Richard.

Q45 Dr Taylor: Thank you. I have been around quite a long time, as you know, and the whole business of workforce planning has gone in cycles. We have gone through one stage where we were training too many, then we were not training enough, then we were training too many. What can you do to stop that cycle, to get to a position where we really know the number of doctors we need and we do not go up and down, up and down?

Sir Liam Donaldson: The short answer is that for planning workforce over these long periods of time there are so many uncertainties that you could never get it 100% right.

Q46 Dr Taylor: Could we get it nearer than we have got it in the past?

Sir Liam Donaldson: I do not think so. No, I do not think so. There are so many uncertainties. If you look, for example, at specialties like cardiothoracic surgery, it takes a long time to train somebody, you put a training programme in place and then suddenly interventional cardiology takes off and you do not need so many. You are always going to have things like that. Without wanting to sound too positive, because I know that is sometimes criticised, you say there have been ups and downs, and I absolutely agree with you about that, about the accuracy of some of the planning, but I cannot recall a time when the NHS was seriously disadvantaged by any of those things, where patients were left untreated. At least we have the basics right, even though the precise numbers in particular specialties at any one time may have gone awry, as they did in obstetrics recently, as they have in cardiac surgery/cardiology and so forth.

Q47 Dr Taylor: I would agree in the NHS but this is the first time that a full cohort of trainees has been massively disadvantaged.

Sir Liam Donaldson: In what way have they been disadvantaged?

Q48 Dr Taylor: You only have to see some of the letters that I have received in hundreds.

Sir Liam Donaldson: Yes.

Q49 Dr Taylor: There are couples who have been split up because they have been unable to match their jobs.

Sir Liam Donaldson: I absolutely agree. I went to particular trouble at the beginning to explain my distress and regrets for that. We do not have, of course, any benchmark data with the previous system. It seems to be assumed now that those problems to which attention has been drawn now did not happen under the old system.

Q50 Dr Taylor: But at least they had another chance. Under this system they have one chance and then nothing else for a whole 12 months.

Sir Liam Donaldson: Absolutely. I think that is one of the inflexibilities but weigh that against the situation where SHOs were wandering the face of the earth, applying in ratios of 1:900 for jobs and being rejected, going back and applying for another job in a ratio of 1:500, totally uncertain about their future, having to make compromises about their choice of specialty, where they live, moving their children from school, perhaps having no career advice. The old system was not the rosy world that some people have portrayed it as.

Dr Taylor: I think we agree on that.

Q51 Chairman: In relation to workforce planning, I do not have a copy of our inquiry now, but I do recall that it was not the issue of under-recruitment as much as over-recruitment in some areas inside the National Health Service, leading on from the projection in the NHS 2000 Plan, and some of them over 300% over-recruited. We felt at that time that the NHS lacked the structure for that type of planning. Would you be able to estimate where the workforce should be geographically, as it were? Are you confident that we have moved on a bit since we published that inquiry? Presumably your SHA s are capable of doing that now, when we thought they really had not been capable of good workforce planning in years prior.

Sir Liam Donaldson: I think things have moved on. The SHA structure, the fact that they now involve the postgraduate deans as part of their management structure, I think things have moved on. Having said that, as far as the future is concerned, I am not sure where the philosophy of planning will come in against a devolved and more diverse Health Service which is based much more on decisions by individual organisations about their needs for staff.

Chairman: We will move on.
Q52 Dr Naysmith: Sir Liam, I would like to look at a little bit of the detail of the MTAS selection process and the timescale for implementation. All of the changes to specialty training were introduced all at once in 2007 and candidates were given only one main opportunity to apply for training posts. We are all agreed on that. Why was this “big bang” approach adopted? Surely this vastly increased the risk that something would go wrong, and we did see that this year things did go wrong.

Sir Liam Donaldson: With the benefit of hindsight, as I have said, it might have been better to have staggered the entry periods. It probably would have, as I have said, it might have been better to have transitioned all in one go as a matter of principle. Some people would argue that it was felt, on balance, it was better to do the numerical problem dominated everything. Had that not been a feature, then, as with the foundation programme implementation, which did have its bumpy phases but the numbers were matched more closely, it would have been possible to allow more flexibility at the implementation phase. But the decision was taken, I think, because it would have been difficult to have run for any length of time an old-fashioned system with the old SHOs and other posts, those doctors possibly being disadvantaged and held back while others were going forward, and it was felt, on balance, it was better to do the transition all in one go as a matter of principle.

Q53 Dr Naysmith: Some people would argue that there were doctors disadvantaged with what happened this year. You mentioned the foundation and a few bumps as it was being introduced, but it was introduced over a number of years and it seemed to have gone relatively smoothly. Also, with the changes in GP training, that took a few years to do and it seems to have worked very well. Why on earth did you not to learn from those two?

Sir Liam Donaldson: The involvement and the accountability was quite widespread. There were four UK health departments, many bodies and organisations involved with different roles: some educational, some standard-setting, some regulation, some responsible for detailed aspects of implementation, so I think it was a very widely participative programme. Everybody involved, I think, who has expressed an opinion, has expressed regret for the problems that occurred, but, if you look at the causation of it, I think it comes down to two main factors and then one which is debatable. The first is the numbers: the policy decision—and we have explained the background to that, about the international medical graduates and the unexpected nature of the turn of events on that, following the legal challenge. The second is the MTAS application form. Serious aspects of that were not fit for purpose, particularly for judging more experienced trainees. Then there is the run-through grade. I do not think you can condemn that as something that should have never happened because there is strong support for that in some quarters. It did lead to this situation of people having to make the decision on one day and the degree of anxiety and distress but the two main causal factors were the international medical graduates and aspects of the design of the application form. Although there were problems with the computerisation, they were not as major and they have got muddled together, I think, in some of the coverage with the design of the application form.

Q55 Sir Liam Donaldson: The BMA called on a number of occasions for the introduction of ST training to be delayed by at least one year because recruitment systems were not properly ready. They drew your attention to it. Why did you ignore these pleas? With hindsight was the BMA not exactly right?

Sir Liam Donaldson: In any programme of implementation there will be many, many different views expressed. It is very easy with hindsight to pick out one and say, “That was the shining torch we should have followed,” but at the time many, many different voices were involved, different opinions, and—

Q56 Sir Liam Donaldson: The BMA are an important voice but they are not the only professional body or the only interest involved in this. Indeed, the BMA expressed other opinions. They argued, for example, that we should give the trainees four choices instead of two. If you want to get forensic about it, I can show you how that, in itself, although it was done for the right reasons, also compounded the problems of numbers and interviews.

Q57 Sir Liam Donaldson: They were the voice of the people you were trying to get on board.

Sir Liam Donaldson: The inclusion of training programmes is quite widespread. They are not the only professional body or the only interest involved in this. Indeed, the BMA expressed other opinions. They argued, for example, that we should give the trainees four choices instead of two. If you want to get forensic about it, I can show you how that, in itself, although it was done for the right reasons, also compounded the problems of numbers and interviews.

Q54 Dr Naysmith: Could there not have been some element of piloting in the system, selecting maybe one area and developing it there? Pilots have been very useful in other parts.

Sir Liam Donaldson: In retrospect, I think that would have been helpful, yes.

Q55 Dr Naysmith: You were not on your own in this: the Royal Colleges were involved and other professional bodies as well. At what stage did they draw your attention to the fact that it was not working? Are they as culpable as you are for this disaster?

Sir Liam Donaldson: The involvement and the accountability was quite widespread. There were four UK health departments, many bodies and organisations involved with different roles: some educational, some standard-setting, some regulation, some responsible for detailed aspects of implementation, so I think it was a very widely participative programme. Everybody involved, I think, who has expressed an opinion, has expressed regret for the problems that occurred, but, if you look at the causation of it, I think it comes down to two main factors and then one which is debatable. The first is the numbers: the policy decision—and we have explained the background to that, about the international medical graduates and the unexpected nature of the turn of events on that, following the legal challenge. The second is the MTAS application form. Serious aspects of that were not fit for purpose, particularly for judging more experienced trainees. Then there is the run-through grade. I do not think you can condemn that as something that should have never happened because there is strong support for that in some quarters. It did lead to this situation of people having to make the decision on one day and the degree of anxiety and distress but the two main causal factors were the international medical graduates and aspects of the design of the application form. Although there were problems with the computerisation, they were not as major and they have got muddled together, I think, in some of the coverage with the design of the application form.

Q56 Dr Naysmith: Were they the only voice saying that or did any of the colleges say that they wanted a delay as well?

Sir Liam Donaldson: There were concerns expressed in a number of quarters. There were also many people who were saying, “This is a great idea. The
principles of modernising the education system are very sound. Let’s get on with it and let the trainees have the benefit as soon as possible.”

Q59 Dr Naysmith: So it was project management really that was at fault?
Sir Liam Donaldson: Yes, I think that is a fair summary.
Chairman: We will now move on to Robert.

Q60 Mr Syms: Why was responsibility for implementing MMC divided between two separate parts of the Department of Health? Was this not a fundamental and basic mistake which made problems with coordinating the project very much more difficult?
Sir Liam Donaldson: In retrospect, yes, the governance—and Sir John Tooke has commented on this, we have in our own evidence and I have as well in my evidence to the Tooke Report. Yes, we acknowledge that the governance needed to be changed. It was in fact more complicated than that because it was not an England-only programme; it was a UK programme, so there were eight different elements: the medical elements and the workforce element in four different departments. I agree, the governance structure needs to be simplified, but it is difficult to put weight entirely on one element: the workforce versus the medical.

Q61 Mr Syms: Your submission states that the governance system for MMC and MTAS evolved over time. Why was the system just left to evolve? Why did no one take responsibility for ensuring proper governance for this complex project?
Sir Liam Donaldson: At the time, the concern was to ensure as wide a participation and consultation as possible, so there were a lot of extra committees and fora created for trying to ensure that participation and consolidation, and that led to a lot more complexity with the governance. To simplify it to a single management strand, I think, would have led to the accusation that people were not having a fair opportunity to influence things. In other areas of policy and implementation this can be a problem as well. Balancing the need for widespread external stakeholder participation and clear-cut management decision-making can lead to dysfunctions and problems and misunderstandings. Might I ask Ms Chapman to comment further, Chairman?
Ms Chapman: I would support Sir Liam’s view that it was trying to get the breadth that added to the complexity. When I joined, and in March, as we were working on the Douglas Review, we wanted to simplify governance and also put in simpler project management, we looked back to see what learnings could be pulled from what had gone before. I think there was a review done the year before that pointed to the benefits of breadth and a lot of involvement in sub-committees, but actually, given the tightness of time, one of the recommendations was to narrow down the focus of various groups, and I think that one of the things we therefore saw was that you had numerous silos of groups working to a much tighter focus, as per the recommendation, but one of the things which that led to was elements of the system really not joining up to deliver us the type of solution that we wanted.

Q62 Mr Syms: You started off with the specification in the tender documents and then you had an evolution, so there must have been changes as we went through the project. Would you be willing to share with the Committee the tender documents and the evolution we went through in terms of the specification?
Ms Chapman: I will need to ask my colleague, Mr Greenfield, to comment on that because I was not around at the time.
Mr Greenfield: The tender documents for the MTAS project were covered by one of the SROs. I was not that SRO, so I would need to go back and change what the arrangements. I am happy to write to you about that.

Q63 Chairman: You could share them with us under open circumstances or part closed circumstances.
Sir Liam Donaldson: If we are allowed to, we would be very pleased to share them.

Q64 Chairman: We would look at that, if you feel there are issues of commercial confidentiality that may compromise that, but I think it is important that we do look at the detail.
Sir Liam Donaldson: Yes.

Q65 Mr Syms: Could I pose another question for Clare Chapman. You came to the Department from the private sector in early 2007. What was your view of the governance and project management arrangements for MMC and MTAS? Would the private sector have used a similar approach?
Ms Chapman: In hindsight, we recognise that because it was very complex and because there were so many stakeholders involved and multiple countries, the governance system was too complex. My experience from the private sector, sitting down with my colleagues and going through that, that is what led us to take the decision earlier this year to significantly simplify it, to set up a single line of governance and a single line of accountability, particularly around implementation, whereby we could bring in a chief operating officer to bring all of that together. One of the factors that is different from the private sector is that we had a lot of partners—Royal Colleges, union partners—who wanted to be part of the solution not part of the problem when the Douglas Review started, and I do think that one of the benefits we have had is the involvement in the solutions for this year from those partners. I do think that the internal governance that was set up within the Department learned from best practice, both within government and private sector, but I do think that one of the characteristics of why the Douglas Review has helped us get through this year is because of the close involvement of other partners. That is what the programme board has achieved and that is what
Professor Marshall has led in going through the solutions for 2008, so that we have used a very similar approach in doing the design for next year.

**Mr Symns:** Thank you.

**Q66 Dr Naysmith:** I was going to ask this question of Sir Liam, but in view of what Ms Chapman has just said it has made me decide to ask her this question, because she was saying that since she has been in she has been having a look at these things. What specific project management resources in terms of funding, staffing and expertise did the Department have to support the implementation of MMC and MTAS? In your opinion, having looked at them now with hindsight, do you think they were adequate?

**Ms Chapman:** Dr Naysmith, I think I spend more time looking forward than looking back.

**Q67 Dr Naysmith:** That is okay, but I am sure you have an opinion.

**Ms Chapman:** Indeed. In March, we dramatically changed the resources in three areas. We brought in a single line of project leadership, with strong experience of doing that, so there was a programme office that could look at the various elements of implementation and make sure that that all came together with the absolute intent of making sure that that worked for junior doctors and worked for consultants. It was very much looking at how it would land as opposed to how it would be designed. That was one thing. The second thing was a much tighter set of milestones and review mechanisms. When we looked back, those did exist in each of the elements, so that was not something that was missing.

**Q68 Dr Naysmith:** But not clearly enough.

**Ms Chapman:** What was missing was across the entire programme, with all the various contributors and making sure that that worked across countries. As Sir Liam pointed out, one of the complexities was multiple countries. The programme board mechanism gave us one place where everything came together, so decisions could be taken. The third thing we did was to make sure we increased resources on things like communication, particularly around how to make sure that messages are got out, because we did recognize, in retrospect, that there were consequences to a number of the things that Sir Liam pointed out, particularly the four preferences. If those had been communicated sooner, people would have been more likely to accept that in Round 1, although there were 40,000 interviews being scheduled, the likelihood would be that the best candidates would get an interview first and, indeed, therefore a lot of people would not be getting interviews until Round 2.

**Q69 Dr Naysmith:** I will switch back to the one person who was around in all of this, Sir Liam Donaldson. The Tooke Report shows that progress on developing the MTAS computer system and on resolving the status of IMGs were both given a red-risk rating by officials from mid-2006 onwards. I am not quite sure what “red risk” means, but it obviously draws attention to something that might happen disastrously if something is not done about it. Why did this not persuade you to delay implementation for a year? That is the question I have already asked you. Why were these problems not escalated appropriately?

**Sir Liam Donaldson:** On the first causal factor, the extra numbers of international medical graduates, it was not foreseen that the Department would not be able to continue to implement its policy of excluding them until later rounds. That came in the judicial review challenge in which the Department of Health’s position was upheld. It was not anticipated that the timing of the judicial review would be such that the Secretary of State was given advice that it was too late to implement that policy, but, nevertheless, it was decided that it would implement it in Round 2. We could not have foreseen then that the Douglas Review would decide to extend Round 1, making Round 2 less significant. I think that would have been a very difficult situation to have foreseen. On the question of the MTAS, this was looked at. Indeed, Mr Greenfield will want to comment, I think, but he did, himself, commission an audit of that and took account of the concerns that were raised and with his team addressed them. He might, with your permission, want to say bit more about that.

**Mr Greenfield:** The issues of governance were very important to me when I became SRO. I commissioned a health check that is reported in the Tooke Report. That was about August 2005 and there was a subsequent report that was undertaken in September 2006. It was quite right that in the Tooke Report on page 50 they identified the risk we attributed to MTAS but also in the Tooke Report they identified that we received repeated assurances that it was going to be available on time. We had contingency plans for the foundation programme when that was recruited and we kept an MDAT system in the West Midlands running until we were sure we could take our foot off one steppingstone and put it on the next. For the specialty recruitment, our contingency was always that we would go to a paper-based system. You will appreciate that the massive gains from having an IT-based system, the savings, the reduction in administration, the simplicity of having one application for individual applicants, these were very attractive things and we were probably overambitious in trying to achieve them, but MTAS was delivered broadly on time. The report said that, whilst timing was tight, the key elements should be deliverable. That was the assurance that we took and so we progressed with it because we felt it would be effective.

**Sir Liam Donaldson:** Dr Naysmith, it was not as if officials were raising points. Mr Greenfield, as the senior responsible officer for this part of the programme, did look at it carefully and took account of the concerns that were raised, but if you want me to say what the principal risk was that was in all of our minds, it was that at the time the NHS had serious financial deficit, the budgets had been devolved to the strategic health authorities and the
Predictions from those who were making gloomy forecasts was that the budgets would be raided, the training posts would be cut and the number of training posts would be quite small compared to what was needed. That did not happen. We made representations to ministers about the risk and I can remember discussions with Professor Marshall when we were both extremely concerned that this would be a showstopper.

Q70 Dr Naysmith: But this was designed when you were not expecting these cuts. Now you are saying they were proposed budget cuts and then they did not happen.

Sir Liam Donaldson: It was not that they did not happen.

Q71 Dr Naysmith: Are you sure they were not designed for—

Sir Liam Donaldson: No, no, the context was much, much more complex and serious than that. The risk was that when the NHS was threatened with not being able to afford patient care that it would move to removing money from other budgets.

Q72 Dr Naysmith: Which it did in some areas—training nurses, for instance.

Sir Liam Donaldson: We went to the Chief Executive of the NHS, to ministers, to the strategic health authorities, to say, “Training is still important and, despite the fact that you have your hands on these budgets, we want you to preserve them.” It led to more training posts being created than in the previous year. Whatever you want to say, the fact that out of this we got more training posts in place cannot be rubbished as a conclusion from the process.

Q73 Dr Naysmith: No one would rubbish it. It is not really a conclusion; it is a fact. There were more training posts available. But you should have been designing a system to cope with that, because you did not anticipate at the time the system was being designed that the effect would be fewer training posts, surely.

Sir Liam Donaldson: We did have the training posts in place.

Q74 Dr Naysmith: The system had been designed for that.

Sir Liam Donaldson: But we were worried that the funding would be taken away from them. That is what we were worried about. They were there, but we were worried that the funding would be removed because of the financial crisis the NHS was in. And the NHS managed to do both: to solve the financial crisis and to preserve the training—which I think is quite an achievement, especially given that a lot of people say that NHS managers do not care about education and training.

Q75 Dr Naysmith: I would never for one minute say that.

Sir Liam Donaldson: No, I am sure you would not but others do.
Sir Liam Donaldson: Nic, perhaps you can comment.

Mr Greenfield: There was no doubt that during 2006–07 SHAs cut their budgets, but particularly the areas which were probably more easy to cut and which they did cut were around the education commissioning, in the short term primarily for the non-medical professions. That was cut by around 6.5%—nurse commissions, et cetera. Some GP appointments may have been cut, because those too are made on a regular annual basis, but I do not think that any SHA, as far as I am aware—and I will check this—said, “We are stopping those in training.” As has been made clear by Sir Liam, on those four or five places—which was one of the issues that the BMA came to represent to me personally and which we took to our ministers, Lord Warner made a public statement that he would guarantee 18,000 places—we liaised with the SHAs and we delivered more than that.

Dr Stoate: Thank you, Chairman.

Q81 Dr Taylor: Short-listing. The process has been very widely condemned, as you know. The Royal College of Surgeons: “fundamentally flawed”; radiologists: “essentially random”. When you look at it more and more, your own answer about this is really quite odd. You say it is very difficult to short list from an application form for the first level of specialist training because the applicants have relatively little experience and yet, in the white box, they get asked questions, we are told. I have not actually seen a white box, but this is the question quoted to us—and this is to a chap or a lady who has done their first 12 months—“Describe a situation when applying your clinical judgement had a significant impact on patient health. What did you do and how did your judgement contribute to patient health?” I would have been terribly pushed to have answered that question after being qualified for five years or more. This really seemed to be a test of imagination and creative writing. You are allowed 150 words on this sort of question and you were awarded a vast number of points for it. In one voice you are saying that they do not have enough experience on which to base the application form and then you are asking them theoretical, impossible sort of questions that, if they have a good imagination, they could floor you with very well. Was the short-listing process not pretty awful? Surely the first thing of a short-listing process is a CV.

Sir Liam Donaldson: There are reasons why the form was designed in the way it is, and let us come to those in a second. I agree that aspects of the short-listing system were not good. I am surprised to hear the Work Psychology Partnership say that the process was “random” because I met each of the college presidents individually in the later stages of the application form and she did not say that to me. In fact, she said that they had some of the highest quality applicants and appointments they had ever had in history. That was her comments. No doubt it is another urban myth. We did have problems with the short-listing, particularly for experienced candidates who had trouble reflecting their experience—and highly qualified candidates—in the application form. The application form was more suited to doctors coming off the foundation programme who had not accumulated a lot of experience. Perhaps I could ask my colleague Professor Marshall to talk in a little more detail about the rationale behind the application form and whether the outcome was random, as has been portrayed.

Q82 Dr Taylor: Could I ask him to tell us a little about the Work Psychology Partnership and the forming of that. Did it have on it any people who had been medically trained, people who had gone through training?

Professor Marshall: The Work Psychology Partnership is one of the most respected groups in the UK and maybe even internationally in terms of designing recruitment and selection processes for medicine. It is headed up by a person called Professor Fiona Patterson. She has done a lot of work in this field and a lot of work specifically with a number of Royal Colleges, particularly the Royal College of Surgeons, and for many years the Royal College of General Practitioners.

Q83 Dr Taylor: In what field is she a professor?

Professor Marshall: I think her background is in psychology, but she did work extremely closely with a whole range of different professional stakeholders. You will see the consultative process that she went through described in our submission to you.

Q84 Dr Taylor: There were a lot of doctors who had passed these rather odd questions.

Professor Marshall: Who had been through that process. I think it could talk about what you describe as “rather odd questions” because there have been a lot of criticisms about the nature of the application form. I have to say that at the time most of those criticisms were being expressed and the Douglas Review Group was trying to come up with a solution to a problem, we did not have any answer to whether those criticisms were valid or not. Subsequently, there have been formal evaluations of this process, a number of them, and we include the evaluation particularly from the Peninsula Deanery which demonstrates quite clearly that the process was not fundamentally flawed. There might be some legitimate questions about how it ran—for example, whether the traditional academic merits, like higher degrees or prizes, were involved: I think those are legitimate challenges which need to be addressed and are being addressed—but if you look at the data from the Peninsula Deanery, it shows a number of important points that I think need to be recognized when we describe this process has fundamentally flawed.

Q85 Dr Taylor: I am sorry to ask, but do we have that?
**Professor Marshall:** Yes, you have.

**Q86 Dr Taylor:** I am afraid I have only just received this booklet today.

**Professor Marshall:** That is in your evidence, yes.

**Q87 Dr Taylor:** The Peninsula evidence about this was in there.

**Professor Marshall:** It is in the summary. Could I describe it to you. (1) The process was not random. If you look at the short-listing scores of all the candidates who applied, there is a normal distribution—so it was not random, it was entirely what you would expect of a scoring system. (2) If you compare the different parts of the application form—and I know there have been some criticisms of particular parts of the application form—there is a good correlation between these different parts; that is, some parts were not very weak or some parts were not very strong, there is a good correlation between them. (3) If you look at the independent scoring of different independent scorers, the correlation between those scorers was again very high—for those who are interested, over 0.85, which is a very high correlation, so surprisingly high. Finally, and perhaps most importantly: (4) The correlation between the short-listing score and the final interview scores was, again, very high. We have here an evidence base here for this process being far more rigorous and far more discriminating than many people criticised. The problems, I think, are not that the process was fundamentally flawed in its design but that it did not operate well in certain circumstances. The prime circumstances, I think, were probably the very large deaneries, like London and the West Midlands, where they were just overwhelmed by the numbers and therefore the processes did not work as effectively as they should have done.

**Q88 Dr Taylor:** The complaints we received or I received time and time again were from consultants who were extremely bothered that their very bright, very effective, very efficient juniors had been passed by by the system.

**Professor Marshall:** Yes, that has been a criticism that has been made, and, indeed, there was one survey which suggested that that might be the case. I have to say that the survey itself was rather flawed in its design, but if we accept that there might be some high quality candidates who were not selected by this process, then I think I have two responses: first of all, t was ever thus—no selection process has ever been perfect and there have always been good quality candidates who have not got into post—and, secondly and most importantly, I think what this reflects is the very high competition ratios for certain specialties. If you have 200 applications for two posts, for example, you would expect the first unsuccessful candidate to be of extremely high calibre and, indeed, you would expect the eleventh candidate, if you were only short-listing ten, to be of extremely high calibre as well; so the fact that there are certain very high calibre candidates who did not get posts reflects the high competition ratios rather than anything flawed about the process.

**Mr Greenfield:** I think it is also worth noting that the application form that was designed for use on MTAS was not dreamt up in isolation from best practice that had previously existed within a paper-based system. It actually took the best practice from two deaneries, London (probably the largest deanery) and Yorkshire, where we had used similar questions, similar approaches, with some differences, but we had used the principle of white space within those processes in those deaneries when it was a paper-based system; so we were not designing something from scratch.

**Q89 Dr Taylor:** Coming back to the Work Psychology Partnership, they have told us, “At the outset we were asked to deliver a short listing process for ST1. We were not asked to deliver the selection methodology for doctors in transition via ST2, ST3, ST4 and FTSTAs. We were led to believe transition arrangements would be delivered by local processes.” Were local people given any power to alter the short listing? I do not think they were, were they?

**Professor Marshall:** Perhaps Mr Greenfield could answer this question.

**Mr Greenfield:** I think this leads back to the question you asked at the start: at what stages did we decide to extend their remit from ST1 to include the subsequent more senior rounds? If I may, I will address that in the note we promised you.

**Q90 Sandra Gidley:** In the department’s evidence it says, referring to a lot of unhappiness after round one, “In practice many would have got a post in round two, because only about 50% of posts would have been filled in round one”, and then goes on to say, “It appears applicants and their colleagues did not appreciate this, suggesting it could have been communicated more effectively.” Why was this fairly arbitrary 50% chosen? It seems to have been plucked out of the air almost in retrospect. Actually when was this 50% post-filling common knowledge? It is actually a key fact about the application system. If people had known about it, there may not have been quite such an outcry. What communication was there? Did everybody just miss it or was there not anything at all.

**Professor Marshall:** The 50% figure of projected fill-rate for round one, if it had been allowed to go ahead as was originally designed, was not plucked out of the air, it was based on modelling and it was based on the modelling that would result from people having four preferences. That is where that figure came from. The question about whether that figure was appropriately communicated to applicants so that they would understand the implications of not getting an interview in the first round I think is a legitimate criticism.

**Q91 Sandra Gidley:** When you say “modelling”, can you clarify, because you had 32,000 eligible applicants, four choices each, competing for 44,000
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Interview slots. I find it hard to believe that there would not have been sufficient people to fill those slots almost first time round. Where did this 50% cent come from?

Professor Marshall: I am not an expert modeller either. Perhaps Mr Greenfield can describe the process.

Mr Greenfield: I can confirm that we did modelling for—

Q92 Sandra Gidley: I am sorry, are we talking about a computer model here?

Mr Greenfield: No. Essentially it is a mathematical model, saying that if you give people four choices, the people who will select the shortlist will generally choose the people who are of the highest calibre. They may be the same people in every case. So the top 25%, as an extreme, could be the ones who get four interviews. In practice, because not everyone applies for different posts, competition ratios vary quite a lot. The natural conclusion of giving people four choices is that the people who are the best get more interviews, and I think 17% got four interviews. We went through the modelling with the JDC, but there was a very strong feeling from the JDC that the first round was about maximising individual doctor choice. Bear in mind that where we come from was a system where we could apply for any job at any time whenever it happened to arrive; so that was important to them. The decision was made at the UK strategy group, under pressure from the JDC to protect that in round one, and then the second round would be about filling the remaining vacancies. I am sure we would be happy to share with you the modelling for those.

Q93 Sandra Gidley: So those remaining vacancies would be the less popular jobs?

Sir Liam Donaldson: No. Can I just add, and I know that this may be getting into more numbers and technical detail than you want, but basically, because the decision was taken to move to four offers under pressure from the medical profession, for all the good reasons, this meant that 60% of the interviews in the first round—19,000 out of the 32,000—went to a sixth, the 17% of candidates. So, as a result of such a small number of people getting interviews, many good candidates would have been squeezed out of round one. That is why it was necessary to have a full round two. If the choices had only been two choices, as originally envisaged, there would have been more people getting jobs in the first round.

Q94 Sandra Gidley: What was the percentage number of jobs left in round two then?

Sir Liam Donaldson: As far as interviews are concerned, 40% of jobs would have been available, but then the Douglas Review extended round one and created a round 1B, which again, for all good reasons, confounded some of the other problems we had with numbers.

Q95 Sandra Gidley: Was your modelling actually right when you looked at it in retrospect. Did your modelling get the right answer?

Sir Liam Donaldson: The fill-rate on rounds 1A and 1B became around 72%, but we had not envisaged having a round 1B.

Q96 Sandra Gidley: I am asking about 1A, because that is what the model was designed to do.

Sir Liam Donaldson: We cannot really tell that now easily, because the two rounds blended into each other, but I would guess it would have been pretty accurate.

Professor Marshall: I think that is right. Certainly, subsequently, looking further down the process, for example, the fill-rate at the end of round 1B proved to be highly accurate? I think we predicted 85% and it was about 85%.

Q97 Sandra Gidley: Can you tell me who knew about this and how it was communicated, the 50%?

Professor Marshall: Certainly the MMC team and the workforce team working within the department knew about it.

Q98 Sandra Gidley: Yes. I am thinking about the poor people who actually had to apply for these jobs?

Professor Marshall: It was not adequately communicated to the applicants, and I think if it had been—

Q99 Sandra Gidley: Was it communicated at all?

Professor Marshall: I do not know the answer to that. I do not think it was.

Mr Greenfield: I would be certainly happy to look into that, but, if I might go back to the point, this was not something proposed by the Department—the Department would have wished to have fewer choices—it was a response to the requests of the representative body of the junior doctors, the JDC.

Q100 Sandra Gidley: That is a bit of a wriggle, if you do not mind me saying so.

Mr Greenfield: I am only saying that that was the position as it was.

Q101 Sandra Gidley: Did you take responsibility?

Mr Greenfield: We did, but we were trying to arrange this arrangement. Round one was about maximising choice; round two was now ensuring the fill-rate. We did communicate with all the junior doctors, because clearly the JDC is just one part of that. We ran websites on MTAS, websites on MMC, and it is those I will go back to, but we updated those on more than a weekly basis over the many months throughout this process. I will look at those and find out that detail for you.

Q102 Chairman: Some of the criticism of the short-listing process was that it did not give enough weight to academic achievement. Do people with first-class degrees make better doctors?
Sir Liam Donaldson: My own view is that it is wrong if doctors have got extensive high level academic qualifications, MDs, PhDs, and they are rejected by the process. It is very important that we have those high-flyers in the system and, if any of them were rejected, and we do not have, as Professor Marshall said, a comparison with the old system to know whether that was a good way of including them, but for those who were rejected, I think they were rejected in two ways: one was through the short listing process, but I heard accounts of interviews where the consultants doing the interview said, “Well, this person may have a first-class honour’s degree but we are not sure they are the right person as a practical doctor in this particular post.” I think we need basically both for medical science in the future, which we do very well as a country internationally, We want to continue to have a strong academic cadre, but we also need doctors with the interpersonal skills and the caring skills necessary in the National Health Service, and the two often come together in the same person but sometimes they do not.

Q103 Chairman: Do you agree with that, Professor Marshall?
Professor Marshall: Yes, I do, absolutely, and that is why it is not possible to answer your question in the way that you ask it. There are lots of different types of doctors that require different skills. I know that there is no evidence that correlates having a higher degree with being a good caring doctor providing clinical services on the ground. I suspect there is a lot of evidence that having a higher degree correlates very well with being an excellent clinical academic and, as Sir Liam says, that is a really important part of British medicine.

Mr Greenfield: Whilst we might think all higher degrees have the same currency, an MD means different things in different parts of the world, and there was caution around making sure that was taken properly into account.

Q104 Dr Taylor: Coming to the Douglas Review, which was obviously formed because of the tremendous tide of criticism that was coming, I have not, I am afraid, been able to find out its constitution or its powers. We know it had members from the Department of Health, the BMA and from the Royal Colleges, What was the sort of proportion of members of this?
Sir Liam Donaldson: Mrs Chapman and Professor Marshall were particularly involved with it. The majority were professional members, but I do not know whether we have got a list. It will probably be in one of the annexes to the Tooke Report and I can look it up for you.

Mr Greenfield: It is Appendix 9.

Q105 Dr Taylor: Appendix 9.
Mr Greenfield: Yes, I have actually got the list in front of me here and I can count them.

Q106 Dr Taylor: What page?
Sir Liam Donaldson: Page 175.
Mr Greenfield: I cannot see the membership.

Q107 Dr Taylor: If you will forgive me for putting it like this, people employed by the Department of Health come at this from a rather different angle, I suspect, from people who are pure, unsullied independent doctors, and I am trying to get at the proportion of the unsullied and the potentially sullied.

Professor Marshall: As someone who is sullied, certainly Professor Douglas made it very clear what kind of membership he wanted for the group, particularly in terms of the professional members, and he wanted strong representation, both from the Royal Colleges and from the BMA and from junior doctors, and that was what was achieved. In addition to that, he accepted that this process could only be taken forward in conjunction with the department, since the department was funding it, and ministers were responsible publicly for the process of delivering the medical education system; so there were Department of Health and deanery and NHS representatives in the group as well.

Sir Liam Donaldson: I can say, Dr Taylor, from my observation of the group’s work, that it was largely the professional view at this phase of the crisis that held sway and led the process.

Q108 Dr Taylor: Would it have had the powers to stop the whole process in its tracks at that stage?
Sir Liam Donaldson: Yes, it would. If they had made that recommendation to Patricia Hewitt, that is what would have happened.

Q109 Dr Taylor: Why did they not make that recommendation?
Sir Liam Donaldson: I believe they were right not to. A very substantial number of interviews had already been scheduled or taken place, we were getting feedback from the deaneries that, despite the great difficulties and pressures they were under, they were short listing apparently good quality candidates and at that stage it would have meant that the career of those doctors would have been cast into uncertainty, and, indeed, some interviews had already taken place, I think, at that stage, so it would have caused a different sort of problem, I think.

Q110 Dr Taylor: Although there would still theoretically have been time to have gone back to the old process just for this year?
Sir Liam Donaldson: What, put people back into SHO old posts and make them apply in a ratio of 900 to one? I do not think that would have been a good idea. I think we had to try and improve and manage out of the crisis, which I think, with the leadership of the Douglas Group, is what happened.

Q111 Dr Taylor: Was it a question that you were absolutely committed to going on regardless, whatever criticism?
Sir Liam Donaldson: Absolutely not, no. We were under severe criticism and I think we were really dependent on the Douglas Group for coming up with a balanced view in the middle of a furore about what the right way to proceed was, and that was the view they came up with.

Professor Marshall: Certainly, as a member of the Douglas Review Group, I do not remember many meetings at which whether the process should be stopped was not discussed and considered, and the decision, as Sir Liam said, was that, on balance, the benefits of continuing far outweighed the benefits of stopping the process.

Q112 Dr Taylor: From memory, did you get many letters from consultants, juniors, saying, “Please stop it”?

Professor Marshall: Certainly there were a lot of letters, e-mails, blogs on websites, that suggested the process should be stopped, and I think the voice of those who felt that it should continue was muted, particularly in the spring in the heat of the problems, but those voices were expressed very strongly. They were expressed by a lot of the candidates who had had interviews, who wanted them to stand, they were certainly expressed by the service, who did not want a vacuum created on 1 August, and they were expressed by a lot of educationalists as well.

Q113 Dr Taylor: Is it fair to ask: did you get roughly an equal balance of people who wanted it scrapped and people who wanted it to continue?

Professor Marshall: In terms of volume, certainly not, though in terms of the amount of noise that was created certainly not. The people who wanted it stopped were making a much louder noise but the decision had to be a rational one, not one based on the amount of noise that was going on in the system.

Ms Chapman: Dr Taylor, like Professor Marshall, I was a very active contributor to that group and I think two things. At the beginning the noise around stopping the process was quite high. One of the things that the Douglas Review did was to try and get as much evidence as possible to make sure that any decisions that were taken were proportionate to the issues that were on the table, and I think over time, as the information started to become clearer, both in terms of what doctors themselves wanted and also what the service needed, on balance the decision was a difficult one but taken because it was felt that to carry on and put in the commitment to an interview for everyone was a proportionate response. It honoured those people that were already going through the process and pleased with what they were getting from it, it enabled us to protect the service in the way that Professor Marshall talked about in terms of fill for 1 August and, because we tried to take out of the process those parts which were most contentious, particularly around short listing, we tried to make sure that we took out as much of the anxiety as we could.

Sir Liam Donaldson: The two big questions that arose at the first meeting were that there was the strong impression that the interview, the short-listing process, had not been a good discriminator of good candidates. As Professor Marshall said, it is not as straightforward as that when you look at the eventual outcome, but, on that basis, the argument was made to give as many people interviews as possible. There was even a suggestion that everybody should be interviewed for all of the four choices, but the logistics of that were just impossible, you could not do it, and an argument that I made very strongly at the first meeting that we should create a special strand for the academic trainees, to look at them separately, because it was clear that some very good candidates had been disadvantaged. Things moved forward from there.

Q114 Dr Taylor: So the doctors on the Douglas Review agreed with the Department of Health people. They were not just steamrollered into it?

Sir Liam Donaldson: Absolutely not. It was the opposite. If anything, we were looking to them, I think, for their leadership, and certainly Patricia Hewitt was---. Absolutely not. If they had recommended anything differently, it would almost certainly have been adopted.

Mr Greenfield: It might also be worth pointing out that the issue of whether we could stop the process and start again was considered by judicial review, and the evidence was presented and that upheld the approach and the recommendations of the Douglas Review Group.

Q115 Dr Taylor: Although the judge did make some pretty condemnatory statements about the whole thing.

Sir Liam Donaldson: Yes, he did.

Dr Taylor: Although he did not overrule it.

Q116 Chairman: Can I ask you about the on-line computer system and the security field. There were clearly two major failures of the on-line application system in late April 2007. Who was responsible for that?

Sir Liam Donaldson: Maybe I could ask Mr Greenfield to answer.

Mr Greenfield: There were two significant security failings. The first one was actually not a systems design failure but was a breach of the agreed protocol which we had contracted with the supplier where an individual working for the contractor sent information to denaries about foundation applicants which was not adequately password and otherwise protected. It was not about anything to do with the fundamental design of the system, it was about an individual human error but one which breached the contractual agreement we had and the principles and protocols that were in place. That one meant that a large number of foundation applicants were exposed for a brief time, and clearly we took action to remove that as soon as we became aware of it. The second security breach was of an individual who was eligible to apply, register and get into the system who then chose to manipulate his or her password (their unique identifier) and, by manipulating the numbers, they were able to again access to certain messages that were going to people with that other number. So it was not about people
outside the system being able to access it, it was about someone who was either a candidate or someone who was in the system eligible not doing what they should have done. It is right that that should have been picked up perhaps under user-testing; it was not. As soon as the fault was identified, it was corrected. Of course those two events together rocked confidence among our junior doctors, the members of the review group and the trust in the system and, therefore, we felt obliged to take action and suspend its use in the full range of purposes.

Q117 Chairman: Have you taken any further action other than suspending the use of this in 2008?
Mr Greenfield: With the one incident, a police investigation followed of the person who had abused the normal processes. The police investigation, I understand, has been now ceased. That is a matter for the police. They are from a university. We have passed them the information and they are looking to see what further action might be taken. That is considered a proportionate and appropriate response.

Q118 Chairman: What about the breach of contract, or breach of protocol as you first called it? Has any action been taken against the company on that basis?
Mr Greenfield: I would have to check that, but I would be happy to do that and to come back to you.

Q119 Chairman: Whilst I recognise that it will be commercially confidential, could you tell the Committee, or share with us, if that has caused a loss of income to the company concerned?
Mr Greenfield: I will include that in my response to the extent I am able.

Q120 Dr Naysmith: We have talked a bit about Sir John Tooke’s Review of MMC and he has recommended some further changes that seem to be quite widely accepted by the medical profession. Are you embarrassed by the popularity of Tooke’s proposals?
Sir Liam Donaldson: No, I think we welcome the report. I think it is an excellent report. I think there are some differences of view on the proposals. We are very much looking forward to working with Sir John, seeking his on-going advice and trying to build his ideas into a new system for the future.

Q121 Dr Naysmith: I have seen it argued that his review has achieved more in a few months than the department has managed in five years. Would that be a fair criticism?
Sir Liam Donaldson: I do not think so. I think it is a very, very good report and, as I say, we will be using it. You will have noted, in his report he does say a lot of positive things about the original principles behind the training programme, which I set out in my report.

Q122 Dr Naysmith: You may have answered this question already earlier when we were talking about the project management, but is it quite clear that one of the four of you will accept personal responsibility for responding to the Tooke Report?
Sir Liam Donaldson: I think the response to the Tooke Report is a response primarily to be made by health ministers in the Department of Health.

Q123 Dr Naysmith: It will not be your responsibility then as Chief Medical Officer?
Sir Liam Donaldson: It will be our responsibility to give advice. The precise way in which we construct that advice will be—

Q124 Dr Naysmith: Clearly, one of the problems, and we have talked about it earlier, is there have been too many people involved in taking control of different parts of this project. If it is going to go through with Sir John Tooke, is there going to be one person responsible in the department for this?
Sir Liam Donaldson: I think there are two aspects to that. One is determining the way forward with the design of the training programme for 2009 onwards (we have got four UK health departments), and then it would need to be consulted on quite widely. I think the second question is: in the future what organisation implements any training programmes and whether that should be retained centrally within the Department of Health? I think that is a big question that needs to be very carefully thought through.

Q125 Dr Taylor: Continuing with the Tooke Report, one of the criticisms is that by going straight from foundation year to specialty training very early on you do not have the time and the chance to make the right choice. Tooke recommend uncoupling the run-through training, reducing the lengths of foundation training so, in fact, you have a longer period of broad-based training in which you can come to a decision about what you want to do eventually. Is not this just going back to the previous system?
Sir Liam Donaldson: No, it is not. It is going back to the Unfinished Business proposals which I made in my report and it is restoring that. Portraying it as having a period of time for people to make up their minds may be a bit of a luxury. I think there is an element of that in it, but I think it is also about gaining experiences and competences. Certainly if you contrast our system with the US system, which a lot of people do, they do not have this period, they do not even really have much in the way of Foundation, they move straight from medical school, many of them, into run-through specialist training. Indeed, when I met recently to talk to them about their system, they were very surprised that we needed to have such a period of general training as we may now have. I think there are different views on the best way of doing it, but certainly I think restoring an element of general professional training, as in Unfinished Business, would be a good thing, but I do think you have to think about the situation of people who have made their minds up, more mature graduates who want to move straight
into specialist training and how you would take account of that. In other words, whether you would ban them from doing that under a new system which would introduce its own form of inflexibility.

**Q126 Dr Taylor:** I did not really mean just giving them time to make a choice, I meant time to get a broad base?

**Sir Liam Donaldson:** Yes.

**Q127 Dr Taylor:** Because, as an ex-physician, you do not want a surgeon who has done nothing but surgery.

**Sir Liam Donaldson:** No, that was what was envisaged in the Unfinished Business.

**Q128 Dr Taylor:** Tooke also proposes extending GP training. Will we ever be able to afford that?

**Sir Liam Donaldson:** The GP training scheme is already a very good one, but Professor Marshall is actually a qualified GP himself and might want to comment on that.

**Professor Marshall:** I think, although the quality of general practice training is generally regarded as very high and general practice has in many ways led the educational work for the last 20 or 30 years, I think there is a question to be asked about whether training is sufficiently long enough for the extended role of the GP in the future. Whether that requires an increased length of training in the future I think is one that we need to consider carefully when we look at the final Tooke recommendations, and we need to consider the cost of doing that against the opportunity cost of it.

**Q129 Dr Taylor:** Going on, the Tooke Report, very helpfully, in the first few pages gives us the abstract with eight crucial points. The fifth one is: “The medical profession’s effective involvement in training policy-making has been weak”, and the recommendation is that, “The profession should develop a mechanism for providing coherent advice on matters affecting the entire profession.” Is there really one medical leader of the whole professional at the moment, and who is that, and should there not be one leader?

**Sir Liam Donaldson:** There is not one leader, and it goes beyond medical education into other areas of health policy. I think some have been arguing that there should be a single medical body to cover medicine.

**Q130 Dr Taylor:** Who, in your opinion, should it be? I do not mean the individual, I mean the type of individual, the background?

**Sir Liam Donaldson:** Perhaps when I have retired, Dr Taylor, I would love to pontificate on these provocative subjects, but it is not for me to tell the medical profession what to do. Otherwise I would be in the soup.

**Q131 Dr Taylor:** So it is not you as the leader?

**Sir Liam Donaldson:** No, it is not.

**Q132 Dr Taylor:** So really there is not one?

**Sir Liam Donaldson:** I think the Chief Medical Officer has a role in leadership, but I think I would be seen as not a true, pure professional given some of my roles within government, and so on.

**Q133 Dr Taylor:** Is not this one of the problems: we have got a BMA, we have got umpteen Royal Colleges and we have got nobody at the top?

**Sir Liam Donaldson:** We do have representative bodies. You have mentioned some of them. We have corporate representative bodies, we have an Academy of Medical Royal Colleges, we have an Academy of Medical Sciences. We do not have a unified professional body. There are not many countries that do. They have all got diversity, and I am not quite sure whether having a single person would necessarily solve things because nobody would agree with him or her all the time.

**Q134 Chairman:** The last question on the Tooke Report. It criticised the MMC for focusing on competence rather than excellence. Do you accept that argument?

**Sir Liam Donaldson:** I take a slightly different view, in that I think both can be—. I do not think necessarily by saying that you are looking at competence that somehow you are going down to the lowest bare minimum. I think you can combine the concept of excellence with competence, but I do think that the idea of competence is that it is associated in people’s mind with a more basic standard of care, but I do not think so. I think there have been many examples where in the past patients have been harmed by doctors not being aware of the limits of their competence or stepping outside and, especially as we are moving into an arena of team work, I think it is much better for us to be clearer about the competences of not just doctors but each member of the team and people stick to their competences rather than stepping outside. My colleague Professor Marshall might want to add, but I do not think that necessarily excludes the concept of excellence.

**Professor Marshall:** I agree; I do not think they are mutually exclusive. What I do think is that the concept of competences, of identifying what somebody needs to learn in order to be a good doctor in whatever specialty, is a very important idea and one that we need to keep on pushing because it does come under some threat occasionally. As a junior doctor, in a way that I did not when I was a junior doctor, first of all, you have got to know what you have got to learn in order to be a good doctor and, secondly, that you will be assessed in terms of your ability to learn those things has to be a good thing for the patients and the public.

**Q135 Chairman:** Is competence easy to measure and easier to plan for in terms of knowing what you need to teach and the cost of doing that?
Sir Liam Donaldson: Absolutely. Certainly when I was a trainee in surgery I was completely thrown in at the deep end—I was practising on patients—and I do not think that is the right thing to do.

Q136 Chairman: It is a wonderful expression, but we have had that before in the Committee about practising on patients.

Sir Liam Donaldson: Yes. It is not right. It does not happen today, except, I am sure, in rare cases, but I think being much, much clearer that when you go to do an operation, if you are a surgeon, that you have seen one, you have perhaps have even gone into a simulator and practised the skills required, you have been overseen by somebody experienced and only then do you operate on your own. I think that is the model of training that we need.

Q137 Dr Stoate: Briefly some questions about workforce planning. You will know that earlier this year we produced a report on workforce planning which was somewhat critical of the way the NHS goes about it. In the light of the MMC, do you think that the department will take a more robust view of workforce planning to try and sort these issues out?

Sir Liam Donaldson: Clare, would you like to start?

Ms Chapman: Certainly. In the light of the Select Committee Report, action has been taken, particularly around some of those things which were very practical and needed to be operationalised quickly. I think it is worth pointing out that all the evidence from across the world would suggest that, if you want to try and get workforce planning better, you have to try and bring supply and demand as close together as possible, and that is also a very good way of giving out much better demand signals to higher education so that we are able to be truly demand-led rather than supplier-driven. I do think that this idea of bringing supply and demand together is important, which is why the deaneries and the SHAs working together in the regional health economy is important, and at the time of the Select Committee’s Report I think that accountability had been in place for less than a year. So work has gone on to try and improve accountability and definition and, back to our last conversation, if you cannot describe what good looks like you cannot teach it, and I think work is going on to be able to describe it. Having said that, I do think that what Sir John points out in the review is also true, and that is that if we are going to improve workforce planning in a much more devolved health system, we actually have to change, not just the structure of it, but the methodologies that are used. So, as part of NHS next stage review that Lord Darzi is leading, one of the enablers that is a critical piece that is being commissioned is what do we need to do to change the methodology so that, as Professor Marshall pointed out, there are a number of things that influence workforce planning, like the shape of the service you want to have delivered, like the demographics and some of the formalisation issues that Mr Greenfield pointed out? There needs to be a much better methodology for doing that.

Q138 Dr Stoate: There is a problem though. Sir Liam has just talked about the importance of the team. You do not talk about doctors in isolation, it is now a team approach, and you should integrate a team and plan for a team. Yet Tooke is suggesting creating new bodies dedicated to medical workforce planning. Surely that is going to exacerbate the existing problems rather than make them better.

Ms Chapman: I think that is why it is important. Dr Stoate, to recognise that part of the principles behind MMC was around how to make sure that doctor training is not done in isolation of the rest of the healthcare professionals they are working in the team with. A piece of work that is going on at the moment is to look at integrated care pathways and actually understand what the workforce implications are of those, which, of course, will cover all of the professionals involved in delivering that care. I think that it is both. I think that it is professional workforce planning and integrated patient pathway planning that will get you to a better answer, but I come back to my first point, which is that there is no point in setting up big centralised solutions for this. Part of it is to try and make sure that you have got a methodology for the supply and demand to come together as effectively as possible and as locally as possible.

Q139 Dr Stoate: We have all this wonderful jargon like “integrated patient pathways” and all this stuff. Where is the actual evidence that doctors, pharmacists, nurses, and so on, are training together and sharing medical either undergraduate or postgraduate training? It does not actually happen.

Ms Chapman: In terms of some actual evidence, I was out in the service last week with some social care colleagues and it is very clear to me that, when patients think about the service, they do not think about whether it gets delivered by the NHS, or by social care, or by one professional or another, they actually think about the service they are receiving. This is actually starting by looking at what are the skills to ensure that is delivered across the entire system.

Sir Liam Donaldson: There is more of the multi-professional education now in some of the new medical schools but, I agree with you, at post-graduate level there is not very much of it and it is something that we need to address.

Q140 Dr Stoate: Do you think you will be able to do something about that? I constantly meet GPs, pharmacists, and so on, who often want to work together in a post-graduate setting, but there was no opportunity?

Sir Liam Donaldson: I think it is something that will be addressed.

Q141 Dr Naysmith: The Post-graduate Medical Education and Training Board is another player in this drama and it has been widely criticised for its inflexibility and unwillingness to take responsibility for any of the problems with MMC and MTAS, but it has told us in its evidence that it is not responsible for recruitment and selection. Is that right and, if it
is, why was a body created which is responsible for the quality of training schemes but not the quality of the process for selecting doctors to undertake these training schemes?

Sir Liam Donaldson: It is a regulatory body and we have limited powers to intervene in its style of working. I have seen the comment made that the PMETB was not responsible, and I am not quite clear how they were making that distinction. As I understand it, they did have responsibility for approving, not just the curriculum of the new specialty training programmes, but also the applications procedure. I am sure that they are not maintaining that they did not have any significant role in all of this, because I think they did.

Q142 Dr Naysmith: Could I quote to you what they say in their evidence: “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.” That is what they are saying is their responsibility.

Sir Liam Donaldson: I think that is quite an extensive role, given the context that we are talking in.

Q143 Dr Naysmith: In your report on medical regulation you recommended that the GMC’s role in education be taken over by the PMETB.

Sir Liam Donaldson: I changed my mind on that, and fairly publicly.

Q144 Dr Naysmith: I was about to say, two reviewers suggested the exact opposite.

Sir Liam Donaldson: When we had the response to consultation on medical regulation, it was clear that some very strong arguments were mounted for merging the PMETB into the GMC, and that became my position and I would agree with Sir John Tooke that that would be a good thing to do.

Professor Marshall: Can I come back solely on your question about PMETB? I think there are some obvious clear advantages to separating out the regulatory standard setting role from the implementation role, and that is where PMETB’s role is different, it is at the regulatory standard setting role, and I think that the differentiation is an important one.

Q145 Dr Naysmith: Just the standards for admission to training?

Professor Marshall: Yes, for admission to training and for outcomes at the end of the process as well.

Q146 Sandra Gidley: The previous Secretary of State has apologised on several occasions for this whole fiasco. You tell us you apologised in April. I have to say, most of us had not noticed. Can you tell us what form that apology took?

Sir Liam Donaldson: Yes, I will be absolutely sure I have got the date correct, but it was at a major surgical conference, with the media present. I also apologised in other more informal fora and also, I think, in a television interview.

Q147 Sandra Gidley: That is fine. Is an apology enough? Seeing as you were the architect of the MMC reforms and also the person ultimately responsible for overseeing their implementation, should you not have actually resigned?

Sir Liam Donaldson: The principles and the policy were commended in the Tooke Report and by others, so I do not think the question of criticism of the policy arises. As I indicated to you, accountability did not rest only with me, it was spread quite widely, and I have already given a pretty full analysis of that in response to an earlier question. Policy in relation to the two factors that made the biggest difference, I think, in the crisis were on international medical graduates and on the design of the application form, and those were not matters where I had overall or sole responsibility.

Q148 Sandra Gidley: If the responsibility was spread, how can doctors who are going to have to apply in the future have any confidence that the department can rectify the problems with medical training, seeing that most of the people who were responsible for the initial problems remain in post?

Sir Liam Donaldson: Because I think a lot of the problems that did occur with the implementation were put right, or at least mitigated, by the follow up action that took place from March onwards. The Tooke Review was commissioned, and we have pledged ourselves to redesigning the system, taking account of the Tooke recommendations, so we are looking to learn as much as we can from the things that did not go well in the process and, as you will have heard in response to some of your earlier questions, the negative has been overwhelmingly emphasised. Nobody has said anything positive about the outcome, and there are some positive points to be made, and those are things that we will build on.

Q149 Sandra Gidley: Was not one of the problems that nobody seemed to take overall responsibility and there may be a lack of leadership on this? I fully accept that you have to take account of concerns that came up along route, but the fundamental problem here seems to be that things were changed at the last minute, something else was put into it, there was lack of time for consultation over any changes. Nobody really seemed to have a steady hand on the tiller with this. Would you accept that?

Sir Liam Donaldson: I think it is very difficult. If one single person had been in overall charge, taking all the decisions, that would have brought its own problems of maybe insufficient participation, different points of view, not having the opportunity to be expressed; and in a government department we have to accept also the need to involve ministers—that is very, very important in some of these big policy decisions—so I think it is inherently in such a programme quite a complex governance structure, and I do not think there is any simple way out of it. I am sure that it will be, and can be, improved but I do not know that somebody could just sit down and say: this is the thing that you need to do and the problem is all solved. It is not as simple as that.
15 November 2007  Sir Liam Donaldson KB, Professor Martin Marshall, Ms Clare Chapman and Mr Nic Greenfield

Sandra Gidley: That was not quite what I was saying, but we will move on.
Chairman: Could I say to all of you, we actually published the written evidence for this inquiry earlier this week. It is now in the public domain and on our website as well if anybody needs to access it. Could I thank all of you very much for coming along and giving evidence to us this morning. I have no doubt that you will be watching with eager eyes the events of the next few months when we are looking into Modernising Medical Careers, but thank you very much for this first session.
Thursday 6 December 2007

Members present

Rt Hon Kevin Barron, in the Chair

Stephen Hesford
Dr Doug Naysmith
Mr Lee Scott

Mr Robert Symns
Dr Richard Taylor

Witnesses: Professor Sir John Tooke, Dean of Peninsula Medical School, Head of the Tooke Inquiry, and Sir Jonathan Michael, Deputy Managing Director, BT Healthcare, Member of the Tooke Inquiry Panel, gave evidence.

Q150 Chairman: I welcome you to the second evidence session of our inquiry into modernising medical careers. For the sake of the record, perhaps you would introduce yourselves and the positions you hold.

Professor Sir John Tooke: I am John Tooke, chair of the independent inquiry and I am a physician.

Sir Jonathan Michael: I am Jonathan Michael, a member of the panel which supported my colleague in the inquiry. I am also a physician by training.

Q151 Chairman: Sir John, what were the circumstances under which you were asked to undertake an independent review of the implementation of Modernising Medical Careers? Who asked you to do it, and how was your remit described when you were first approached?

Professor Sir John Tooke: The Committee will be aware that the distress caused by the selection system known as MTAS in the spring generated a good deal of anxiety within the profession. That ultimately precipitated the then Secretary of State for Health having a telephone conversation with me and inviting me to consider chairing an independent panel to look into the circumstances surrounding that perceived failure. The terms of reference of the report show that although MTAS was the catalyst of the concerns the issues were much broader than that. It had unearthed real concerns within the profession about MMC as a whole. Therefore, the terms of reference were cast fairly broadly to consider all of MMC with a particular remit to look forward as much as backwards to learn from the past to ensure that postgraduate training in future could be optimised. We were particularly concerned that the report should embrace issues around the professional, service and workforce environments that impacted on postgraduate training and that was also swept up in the terms of reference.

Q152 Chairman: Your report is entitled Aspiring to Excellence, but MMC aims to have “competent” doctors. How do competence and excellence relate to each other in the context of medical training? Are they mutually exclusive?

Professor Sir John Tooke: I do not believe they are mutually exclusive. Nobody can argue with the fact that we want healthcare professionals, whatever their role, to be competent at what they do, but in the view of the panel “good enough” is not good enough and we should aspire to excellence in all the professions, but obviously this focuses on medicine. The problem is that “competence” is a reductionist concept; it says that you can interpret a professional’s role as a sum of particular competencies or the things he or she is good enough to do. To be proficient and capable in one’s role requires considerable experience, depth of knowledge about one’s discipline, experience in exhibiting fine judgment—a lot of medicine requires that—and not just a capacity to undertake certain tasks under defined conditions. I think the idea of proficiency is a more embracing one that wraps up competence but accepts the need to embrace these other qualities that we and society would wish to see in a doctor.

Q153 Chairman: The Chief Medical Officer told us he did not resign over MMC because “the principles and the policy were commended in the Tooke Report”. Do you believe that to be correct?

Professor Sir John Tooke: When I started the inquiry it was very difficult to get clarity about what the principles of MMC were. As our interim report makes clear, there was scope drift; it began to embrace wider workforce redesign as well as the principles underpinning an education and training programme. I agree that some of the starting education and training principles in the Chief Medical Officer’s document Unfinished Business endure in the minds of most doctors, that is, broad-based beginnings, flexibility and a structured programme.

Q154 Chairman: Obviously, you have conducted widespread consultation with doctors as part of the review. How has this helped you to reach the conclusions at which you have arrived? Do you believe there was a lack of consultation during the development of MMC?

Professor Sir John Tooke: If I take the second part first, during MMC it is clear from the evidence we present that the medical profession was involved in the numerous bodies included in the process and, furthermore, that it turned up for those meetings. Nonetheless, we did unearth evidence that its views were sometimes not taken fully into account. For example, we were concerned that the minutes of some meetings were not going forward to meetings that set policy and strategic direction. There is an issue about the extent to which the structures and framework of accountability allowed the
profession’s voice to have influence. On the other side, one issue we bring up is that the medical profession has a responsibility to speak with a coherent voice—one voice is probably an over-expectation—about those issues which are of fundamental importance not only to that profession but, more importantly, to the health of the population. In terms of the consultation process we undertook, we were obliged to produce a report in fairly short order so it would have a bearing as soon as possible on thinking about subsequent rounds of recruitment. We had a broad-based e-consultation in which over 4,500 people participated. We generated some 39,000 answers to the questions we posed. One of the most valuable things I did was to co-ordinate a series of eight workshops for trainees throughout the UK, visiting eight cities in the country. That revealed first hand the distress that had been caused and gave us a very real sense of the aspiration of trainees for their future. For me, one of the encouraging things to come out of it was that despite their distress their professionalism shone through. They realised that if we wanted to have excellence it was a competitive process and they echoed the fact that they did not join medicine to be good enough but to be the best possible doctors they could be.

Q155 Chairman: It does appear that your proposals have been welcomed by the profession and organisations like the BMA and Remedy UK are happy with them. Do you think you have achieved a consensus on the way forward or do you believe these groups have united with you because you are not the Department of Health?

Professor Sir John Tooke: What I can say is that based on the e-consultation we have conducted on the interim report there is 87% agreement or strong agreement across the 45 recommendations and only 4% disagreement or strong disagreement, with 9% neutral in terms of the questions posed. For each of the recommendations there is a majority opinion in favour. In my experience of consultation exercises I do not believe I have ever seen that degree of overall support for a set of recommendations. Clearly, there are issues for individual constituencies which we will address in the final report.

Q156 Chairman: Sir Jonathan, do you think that employing organisations are one of the groups that have had too little involvement in MMC up to now?

Sir Jonathan Michael: Yes, I do, and in part that is because the structure of the NHS and the role of employers have changed in the intervening years with an increase in decentralisation, the devolution of accountability and the development of foundation trusts with separate legal status. The view now is that the NHS is no longer a single majority employer in the way it used to be and the role of employers and their engagement has been sub-optimal. Clearly, employers have accountabilities as employers and therefore they need to be engaged not only in employment issues but they have a responsibility to their employees to make sure they are properly trained and their professional training continues while they are in their employ. They also have a responsibility in terms of engagement in workforce planning because the needs of individual employers must be part of the overall picture.

Q157 Chairman: Do you think employers’ views are now represented in your report?

Professor Sir John Tooke: We made great effort to try to capture that view. We had a sub-committee that reflected service. We obviously talked with NHS employers as well and tried to capture that. Clearly, postgraduate education and training sit very much at the interface with service issues, education and training requirements and academic aspiration and we must capture that response.

Sir Jonathan Michael: From my point of view as a former NHS chief executive, I am very comfortable that the employers’ needs and reviews have been reflected in the report.

Q158 Dr Taylor: I want to go on to MTAS and its implementation, looking first at leadership and then project management. Your abstract which sets out the whole thing on two pages is brilliant. I tackled the Chief Medical Officer about these matters a fortnight or so ago. In No.5 we see: “The medical profession’s effective involvement in training policymaking has been weak.” The corrective action is: “The profession should develop a mechanism for providing coherent advice on matters affecting the entirety of that professional constituency.” I tried to get the CMO to say who should be the leader of the medical profession and he had great deal of difficulty with it but was quite certain it should not be him. I would like to sound you out on this because at the moment among the royal colleges, the BMA, the academy and all the different specialties it is totally confused. I should like to hear ideas from both of you as to who should be the medical leader particularly for this sort of issue.

Professor Sir John Tooke: I agree that it is difficult and goes back to my point about avoiding factional interests that sway things one way or the other. In a sense we are throwing down the gauntlet to the medical profession and saying it has to stand up and exhibit leadership particularly on issues of such national importance and forget its particular constituency and allegiance in the interest of those ideals. Whether one can have one individual or body that represents it is questionable. I believe the Academy of Medical Royal Colleges could create some device which enables perhaps a small representative group of college personnel to reflect the entirety of that professional constituency. That appears to be a sensible way forward, but it is for them to come to the required agreements. Rather than think in terms of a standing group that reflects on everything it may be better to have short-term representative professional groups that deal with particular issues. Inevitably, the input you need will vary according to the issue being discussed. For example, in something like this clearly people with education and training expertise will need to be well
represented. I am afraid that is a rather vague answer, but I do not think you can pin on an individual the responsibility for a coherent voice.

Q159 Dr Taylor: There would have to be a spokesperson for the group who in effect would be the leader?
Professor Sir John Tooke: Indeed, if you want to use those terms.

Q160 Dr Taylor: Sir Jonathan, you were very much a medical leader in your job both in Birmingham and then London. How did you manage to steer across all the many different interest groups?
Sir Jonathan Michael: As my colleague says, it is difficult and there is not a one-size-fits-all solution. I would be keen to make sure that the doctors who are involved in the running and delivery of services are also represented in those discussions because there are a number of different constituencies—professional societies, colleges and the BMA—but often the voices that are not heard so well are those that represent organisations that deliver the care. Whether or not one sees that as an employer or organisational voice that needs to be heard. With decentralisation and an increasing number of foundation trusts the views of the delivery organisations for the NHS need to be represented.

Q161 Dr Taylor: Very condemnatory statements have been made in some of the letters we have received personally and some of the written evidence. I quote just one: “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 NHS must learn to identify poor performance at these high levels and be seen to take action.” A neurologist writes: “I would very much appreciate a hard-hitting inquiry into the evidence that was used to support the changes in medical training introduced by the Department of Health. This would also require calling all the advisers, medical and non-medical, reviewing their qualifications and their remuneration arrangements.” Should we be looking to attach blame somewhere, or will that not be productive?
Professor Sir John Tooke: You will know that it was not the primary aim of our inquiry to attach blame. What struck us and I hope comes out strongly in the interim report is the ambiguity over accountability. To set up something of this complexity and introduce it at the speed required with ambiguous accountability arrangements, deficient project management and woefully inadequate risk escalation processes was essentially the structural fault where much of the blame lies, but the very fact that accountability was ambiguous makes it difficult to pin down singular responsibility.

Q162 Dr Taylor: How do you suggest improving project management at the Department of Health?
Professor Sir John Tooke: I think there is a big question whether the Department of Health should be trying to implement something of this complexity. Clearly, the department in conjunction with professional stakeholders has the key role in determining policy and ensuring that policies which impact on education and training—workforce policies and health policies more generally—are aligned, but at least for the panel there is an open question as to whether the Department of Health has the resources and professional skills to implement something of this nature. My personal view is that for something like this it is probably better conducted by an accountable arm’s length body which can have a continuing function in terms of scrutiny of the necessary linkages between national and regional activity, ensuring that the contractual base for training reflects the desire to see optimum training in the workplace and so forth. It is that policy and implementation separation that I think needs to be considered. Whatever happens, there must be more professional project management and better risk escalation processes; and there needs to be better UK-wide co-ordination. There was a perception by the devolved administrations that on occasion the approach was too English-centric or resulted in policy on the hoof to deal with implementation issues in England and that disrupted the cohesion of what was essentially a UK-wide application.

Q163 Dr Taylor: You were critical of split governance between MMC and MTAS?
Professor Sir John Tooke: One of the more alarming features is that the two issues that caused the major difficulties—MTAS itself and the international medical graduate problems—were handled by the workforce capacity unit which did not have direct line accountability to either of the senior responsible officers, so the two pivotal issues, one in catalysing the problems and the other provoking a considerable increase in applications over available places, were handled essentially outwith the main accountability structure, ambiguous though that was.

Q164 Dr Taylor: Therefore, it was chaotic?
Professor Sir John Tooke: That is one word to describe it.

Q165 Dr Taylor: Obviously, communication should be a key part of leadership and the implementation of anything. What did you think of the communication within the department and between the department and the profession and between the department and junior doctors?
Professor Sir John Tooke: Clearly, there were attempts to engage the profession in terms of representation on all the key bodies. I suggest that because the fundamental principles were unclear and evolved over time it made clear communication difficult so that people on the ground who did not pour over the details of the documentation would have been less than clear about what was coming. There was a major communication failure in relation to MTAS itself over the implications, for example, of having four choices. A conscious decision was made not to reveal that to trainees, and inevitably it
meant that people were disappointed because very good candidates were not being called to interview. Had they understood in advance the implications of the four-choice structure I think that some of that distress could have been avoided.

**Q166 Dr Taylor:** Do you agree with one person who wrote to me: “I’ve just returned from a trip to Malaysia where I spoke to doctors, university educators and other professionals, and the common views expressed were amazement at how the UK got itself into this mess and, secondly, that they would no longer consider it wise to send their bright young people to the UK to train in medicine”?

**Professor Sir John Tooke:** How we ended up where we were was remarkable. I believe part of that reflects the big bang application of the new system and the fact that once the pipeline was rolling and people were going through foundation there was a sense that something had to happen to accommodate them. One of the graver mistakes was not to recognise there was a group of highly talented SHOs who were the bulge and try to accommodate them at the same time as people coming out of the pipeline. I am sure that in retrospect most people would regard that as an error and some forethought should have been given to how they would feel and how that bulge should be managed effectively and fairly.

**Q167 Mr Scott:** Last week the CMO acknowledged that the 2007 selection system had caused distress but denied that the system was unfair. Do you agree?

**Professor Sir John Tooke:** You have to unpick the value statement “fair”. If by that word you mean something that allows equal opportunity and selects the best person for the job I argue that there were aspects of unfairness in the process. It was not fair to those SHOs who through dint of their year of graduation were disadvantaged by the system; it was not fair in the sense that it was family-unfriendly to several candidates. In terms of whether it selected the best, we know from the data and in-depth studies done in a number of deaneries that some very good candidates went forward for interview. Whether or not they were the best is a moot point. The fact that there are many examples of people with excellent qualifications and experience who did not get the positions suggests that that is not the case either.

**Q168 Mr Scott:** Referring to the matters you have just raised, officials cited evidence to suggest a high correlation between candidates’ short-listing scores and their interview scores. Does this prove that short-listing works or not?

**Professor Sir John Tooke:** It is a normal device if you are looking at the so-called predictive validity of a selection process, and if you look at the correlation between that and the next stage it gives you some assurance that you are picking people who are appropriate. I believe that the data from my own deanery in Peninsula show a correlation between the short-listing scores and the interview performance of about .37% which is not bad for that type of assessment, but that does not necessarily prove that the best people are coming forward. Clearly, very good candidates will probably be better at completing any form of assessment and will apply their guile to whatever process through which you put them. They are very bright people and will find a way to score well. It does not necessarily mean that you are picking those with the best skills, knowledge, behaviours and attributes to make trainees of the future. The other aspect of fairness is that what matters to any of us going through a particular test is the face validity of the test. If it seems a reasonable test to you of what you expect of the role you are to undertake you are likely to be more satisfied with the outcome of that test. If to you it bears little relationship to what you think the role is about and it is perceived, as stated on many occasions, as an exercise in creative writing it does not give you much confidence when you are rejected by such a process, whatever the correlation coefficients are.

**Q169 Dr Naysmith:** Could we focus on the role of the medical profession? I think you agreed with Dr Taylor that we were talking about a chaotic situation. Can we be a little more brutal in a way? Your report shows that the medical profession was closely involved in developing MMC—I do not think you disagree with that given what you have said—yet most doctors appeared to be outraged by what happened in 2007. You have already explained that in advance in answer to Dr Taylor. Nonetheless, should not the medical profession accept just as much responsibility as the Department of Health for what happened?

**Professor Sir John Tooke:** I would not say that the culpability was equal. I believe the medical profession failed to exhibit sufficient leadership and should have ensured it had more influence. I have already mentioned that I believe some of the influence we might have had was eroded by the structures and processes employed, but the very fact that the accountability arrangements were not organised by the profession puts the weight of accountability on the department.

**Q170 Dr Naysmith:** From your report it appears as if there was a lot of consultation. You could even argue that the medical profession was over-engaged in the process with so many different voices being heard.

**Professor Sir John Tooke:** Yes.

**Q171 Dr Naysmith:** Do you believe that too many people were speaking and perhaps there was not enough clarity about who was speaking with authority and what should happen?

**Professor Sir John Tooke:** That is a very reasonable perception and it takes us back to my point about the need to have a coherent voice on critical issues which can be resolved and policy and principles can be clarified and collectively we move forward.

**Q172 Dr Naysmith:** That takes us back to my original question. Is it not up to the medical profession to get itself sorted out? I refer to the leaders of the royal colleges—too many of them—
and other voices. It is up to the medical profession to get itself sorted out and decide what its attitude is to this?

Professor Sir John Tooke: I absolutely agree. Just as there is a call here for the department to ensure there are proper accountability structures and project management in place so it is necessary for the profession, if it wishes to have influence in co-developing policy and implementation matters, to find a way of speaking coherently. I have laid down the challenge at every meeting I have attended that this is something that only the profession can address.

Sir Jonathan Michael: There is a difference between the department, which is a single entity with a coherent structure and lines of accountability, and a much more diffuse grouping called “the medical profession” that works across a whole range of different industries, businesses and sub-specialties. It does not mean that having a more coherent voice for the medical profession is not important but, as was said in answer to Dr Taylor, where that voice needs to come from depends sometimes on the issues. I think there is a difference, but it does not however diminish the importance of having as coherent a voice as one can get from a very diffuse population called “the medical profession”.

Q173 Dr Naysmith: This is really the nub of the question. How do we get this voice? As someone who is not a medical doctor—I worked in a medical department for 30 years before I came here and sat on this Committee for six years—I observe that there are a number of colleges all of which jealously guard their bits of territory, and yet in order to develop the medical profession properly and modernise medical careers something must emerge which will speak on behalf of the whole profession. You hinted at it. Do you suggest that a new body should be set up to do this on behalf of all the different interests involved?

Professor Sir John Tooke: What I can say is that I know the heads of various institutions are meeting in the very near future to discuss precisely that issue. Whether it is a standing structure or one formed to deal with a diversity of issues as the need arises—a constituency from which one can pull representatives, as it were—is an open question, but we have to do our part to make this process work.

Q174 Dr Naysmith: Are you hopeful?  
Professor Sir John Tooke: By nature I am an optimist, so yes.

Q175 Dr Naysmith: Your report called for urgent resolution of the status of international medical graduates, but a recent decision of the Court of Appeal means that IMGs will be free to apply for training posts in 2008. Will that not make it especially difficult to re-establish the credibility of the selection system in the year ahead?

Professor Sir John Tooke: Indeed; it will cause very real strain on the system because the likelihood is that there will be three times as many applicants as there are trainee posts available. It will probably be a worse ratio than we experienced in 2007. What we called for in the report was a very rapid reconciliation of central policy with conflicting demands for open doors and self-sufficiency and nobody can plan unless that is resolved.

Q176 Dr Naysmith: Can you offer any suggestion to help the situation? I know that another report will be in preparation eventually, but this will happen before you have an opportunity to do that, will it not?

Professor Sir John Tooke: Indeed it will. I think it is a policy question. We are on track for self-sufficiency. We have had an expansion in medical undergraduate education in this country in line with such a policy. We need consistent policies through the rest of training which support that if society is to see the value of the very considerable investment in medical undergraduate education. Another issue is that if we believe, as I do, in the continuum of medical education and the fact that a trainee doctor continues to enhance his skills throughout his training and professional life there is something to be said for ensuring that UK medical graduates, from whatever country they derive, have the opportunity to move forward in their training.

Q177 Dr Naysmith: Sir Jonathan, when you gave evidence on workforce planning you argued for a light-touch approach to NHS workforce planning. Are you therefore pleased that IMGs will be eligible to apply for UK training posts? Would that fit in with your light touch? That will give employers more choice.

Sir Jonathan Michael: Yes. In the previous evidence that I gave the Committee on workforce planning I argued for a light touch partly because I believe in principle that is the right approach but also because of some of the difficulties associated with forward workforce planning when there are such rapidly-changing medical and technological advances and a long training period. Therefore, you need to have flexibility in training to allow people to change their direction of training if their perceived or aimed for opportunities either diminish or are not achievable. To give an example, the change in cardiac surgery with the advent of non-surgical intervention for coronary artery disease made a significant difference in the careers opportunities for potential cardiac surgeons. That happened very quickly and a number of people were caught in a programme which was to train them for something which would no longer be so necessary. One needs more flexibility. In terms of the national view, there needs to be national oversight which will then drive the commissioning of training programmes—it is largely a commissioning view—but that needs to be well informed. The difficulty is to make sure that decisions at a national level are informed by people who know about the individual specialties and what is likely to be happening round the corner so they can take a five, 10 or 15-year view. The other element is local workforce training which has to be much more to do with the needs of employing organisations.
Q178 Dr Naysmith: I am still not sure whether or not you think the Court of Appeal decision was the right one in this situation.

Sir Jonathan Michael: Fundamentally, yes, it is the right one; it just makes it more complicated. The incompatibilities at policy level must be resolved because if you have a combination of open access for international—European—graduates and produce sufficient UK graduates to staff our requirements undoubtedly there will be tension there. 

Professor Sir John Tooke: In determining policy it is probably worth reflecting on the fact that many people have asked for the medical profession to be more representative of the society from which it comes; in other words, there should be greater access within the UK to people who aspire to be doctors. You cannot do that if you have a completely open-door policy that results in a group of doctors who may be largely unrepresentative of the society from which they derive.

Q179 Mr Symes: Sir Jonathan, you have already acknowledged that there will be three applicants for each post in 2008 which could mean up to 1,500 UK-trained doctors being displaced. Clearly, medical workforce planning has gone awry. Should we not be turning the tap and reducing the number of doctors coming out of UK medical schools; otherwise, will we not have this continual problem?

Professor Sir John Tooke: We acknowledge the deficiencies in workforce planning which was borne out fully by this Committee's report. My view is that we do not need a knee-jerk reaction in terms of the number of people entering training at the level we are discussing here. I do not believe that you can resolve the question of how many doctors you need until you have asked that fundamental question or until you have absolute clarity about the role of doctors coming out of UK medical schools; otherwise, will we not have this continual problem?

Professor Sir John Tooke: Indeed, and it is incredibly important. It is also another dimension of flexibility.

Q180 Dr Taylor: Turning to the future structure of medical training and the big bang approach and the single date, is there any way that can be changed? Sir Jonathan, from the hospital trust point of view what are the disadvantages of everybody changing on August 1?

Sir Jonathan Michael: They are significant because of the implication for service delivery and training. Employers are required to provide mandatory training and induction programmes. If everybody changes on the same day employers will struggle to maintain effective services during the initial few days or couple of weeks.

Q181 Dr Taylor: Would your suggestions about the future structure be compatible with a staged change of at least twice a year rather than once a year?

Professor Sir John Tooke: Perhaps I may give a fairly detailed answer to that because it is one of the structural recommendations that has raised concerns predominantly from the quarters involved in foundation training itself. One understands that. Foundation in comparison with MTAS for the purpose of entire training went pretty well. There is no doubt that the evaluation of trainee experience to which we have had access since the interim report suggests that that is valued. The critical issue here is that unless we disaggregate F1 and F2 in our requirements, will we not be turning off the tap and reducing the number of doctors coming out of UK medical schools; otherwise, will we not have this continual problem?

Professor Sir John Tooke: Indeed, and it is incredibly important. It is also another dimension of flexibility.

Q182 Dr Taylor: To go on to your structure, you want to cut down the two-year foundation programme to one year and then go into core training. The BMA have argued that that is perhaps too soon because the first group of foundation people is just finishing.

Professor Sir John Tooke: In determining policy it is important. It is also another dimension of flexibility. 

The BMA have argued that that is perhaps too soon because the first group of foundation people is just finishing.
the successful bits and improve on it. I would rather it was perceived that is what we are trying to do than that we are just axing something.

Q183 Dr Taylor: Therefore, the second foundation year would become the first year of your core training?

Professor Sir John Tooke: F2 essentially would become themed and feed into the core training. No curriculum is set in stone and it would be reviewed. My guess is that over time we would revise the core curricula and almost certainly foundation year one curricula to be more fit for purpose. A general concern that we expose in the report is the sense of drift to the right of acquisition of skills and responsibilities by trainees. That is really worrying given the European working time directive and other contractual responsibilities one has to those people get. One of the devices that we believe is needed is a pulling back of the acquisition of responsibility under supervision and the acquisition of practical experience. That is a call to the medical schools to ensure that the current high standards are even better and we put people into F1 jobs who really are skilled up.

Q184 Dr Taylor: Core training of three years would put back the time when people had to make a final decision about which specialty to pursue?

Professor Sir John Tooke: Indeed. It puts back the final decision about the 57-odd sub-specialty areas. Currently, they have to make a decision about halfway through the second foundation year. That is important because most trainees felt that they had to make a choice prematurely. If you get it wrong you are taking a very high stakes decision. Therefore, there are core themes in very broad areas with some flexibility particularly during the first year. If you have got it wrong you can switch, but there is a time-limited core programme so we do not go back to the less desirable aspects of SHO training where people can mill around for seven or eight years. Therefore, it is a time-limited, broad-based and themed process towards the end of which one makes the ultimate career decision.

Q185 Dr Taylor: Can you give us any idea about the split between service and training in those core training jobs? Would you expect a big service commitment from them?

Professor Sir John Tooke: Inevitably. Training and service are intimately combined in my view. They have to be considered separately in some ways, but we must not lose sight of the importance of experiential learning that comes with actually doing the job and a better acknowledgement of that integration is important, just as is the recognition that trainees are doctors who are doing a job of work. We point out in the report that in some areas the perception is that some young doctors saw themselves as trainees rather than doctors first. Our generation probably regarded itself as doctors in training. I think we need to enhance that perception for their morale as much as anything else. Their very real and important contribution is valued by the health service.

Q186 Dr Taylor: What is the effect on run-through training which is said to be one of the advantages? If you are splitting it what effect does it have on such training?

Professor Sir John Tooke: I take issue with that. I believe that “run-through” was one of the fundamental mistakes in this process. We have talked about the principles in Unfinished Business and that morphed into something that involved run-through training. The process by which that decision was made is unclear to the panel. The document The Next Steps simply states that “thinking has moved on”. We are not quite sure whose thinking that is and with what policy objectives in mind that new construction came. If there are sufficient training posts available for everybody the idea that one is in one place and comes out as a finished product obviously has superficial attraction. In reality, if it becomes a premature choice onto rigid train tracks in a specialty area clearly that becomes less attractive to trainees. It does not allow future sub-differentiation of the workforce as health needs evolve because they have not had a broad-beginning to their training on which they can build as requirements for change emerge. I believe it is something that as a principle should be resisted. That said, as we harmonise the new with the old there may be a case in the short term for retaining run-through in one or two disciplines for very specific reasons, but as a generality and principle we wish to see broad-based beginnings and very good career advice and intelligence on what the opportunities are within the various specialties starting from before medical school and going all the way through so people can make informed choices and know where they stack up in relation to their peer group.

Q187 Dr Taylor: Where would you retain it are you talking about the very small specialties?

Professor Sir John Tooke: It is an extreme minority of cases. One example I suggest—please do not interpret this as any definitive diktat from us—is histopathology. One could argue that one does not need three years of basic clinical training before one goes into a histopathology school, but that is a special case with a special rationale behind a different approach. The point is the diversity of the profession to which my colleague referred.

Q188 Dr Taylor: If these changes are made what happens to the doctors who are already in the run-through programme?

Professor Sir John Tooke: One must honour the contractual responsibilities one has to those people who have entered into that. Clearly, it would mean that very soon we would have to uncouple the core training from the subsequent step. That competitive step is welcomed by the majority of trainees and viewed as being entirely consistent with an
aspiration to excellence. If everybody gets on at the beginning and comes off at the end that is not aspiring to excellence.

Q189 Dr Taylor: If we turn to higher specialist training, you allow what you call the trust registrars or staff grades to get back into specialist training which seems to be an excellent move? Professor Sir John Tooke: Indeed. Our workshops with junior doctors involved people in those grades. There may be a debate about the nomenclature but that is second order. What was required was rapid resolution of the contract so there was certainty about what the roles meant and to get away from the sense that it was a dead-end career or cul-de-sac. Part of that is to ensure first that there is an opportunity to compete for entry into higher specialist training. It may be you limit the number of times you can do that just to introduce some reality into the equation, but we feel that is very important, as is the maintenance of a route to completion of training through the existing so-called Certificate of Eligibility for Specialist Registration route. All of those things are important. The other matter that comes through very strongly is the separation between training and non-training grades. In our view no doctor should be in a position where he receives no training, even if it is just updating him on advances in his particular disciplinary area. Therefore, some ongoing staff development and training opportunities, though clearly not of the intensity that specialty training demands, should be provided for people in those roles.

Q190 Stephen Hesford: To pick up your thinking on run-through, arguably does it not militate against what you say about flexibility and where the profession should go in future given that there may be more community service? As I understand it, run-through will give maximum flexibility in terms of that kind of thinking. Are you not answering the question already by moving away from run-through about what the profession is for going forward? Professor Sir John Tooke: To take the “community” question first, there are those who regard community or primary care/medical activity as the easy bit. I can say as a hospital doctor that that is the difficult bit and it will become even more difficult with an ageing population with multiple chronic diseases or comorbidities requiring 15 medications. To deal with those sorts of problems in a community setting, particularly if it is a vulnerable individual, requires great skill and a general-based depth of experience so one has a hope of interpreting the range of problems with which one will be presented with the sophistication that the public will expect in future. This is not simple medicine; it is difficult stuff, and we have to prepare a medical workforce that is able to cope with it. I believe that the broad-based beginnings are absolutely key to that, as is our suggestion that GP training should be extended. In our view, it is simply inadequate to have people who have had only three years’ training taking on the type of role I have sketched.

Q191 Stephen Hesford: As I understand it, there remains tension between what you have been outlining and where the CMO is on this. How do we resolve that tension? Professor Sir John Tooke: I think you resolve it by aligning the health policies, workforce and education and training policies which reflect future health needs. I know that some of that is going on as part of the NHS review but ultimately workforce and therefore education and training need to be driven by health need. We are there to respond to health need and we require clear policies to enable us to meet it.

Q192 Mr Scott: Sir John, some proposals such as extending GP training from three to five years will have significant cost implications. What has been done as a priority to assess the cost of implementing your recommendations? Professor Sir John Tooke: Clearly, there are financial implications for that particular proposal but, as we point out in the interim report, having trainees delivering a service element as part of their GP training clearly will be cheaper than having more principals in general practice, so the costs are not like a direct expansion of general practitioners. There are also potential cost savings if you enhance that element of the workforce along the lines I have just described. You may achieve a lower rate of referral to secondary care for more expensive interventions or treatments. There is also the possibility of using extended training to align trainees with areas of great need or where it is difficult to retain general practitioner services. Therefore, one can begin to influence the distribution of primary care activities through careful placement of such posts. At the end of the day, it comes down to resources being aligned with the health policy that you want to effect. You cannot have pluses for more care in the community, which is where the public want to see it, and more sophisticated care in the community, which the public will demand, unless you provide resources to match those expectations.

Q193 Mr Scott: Do you think there is a risk that the Government will agree to changes that it cannot afford to avoid further embarrassment, or for any other reason, and they will be gradually watered down as time goes by? Professor Sir John Tooke: Some of the recommendations are pretty fundamental and nobody would want to see a continuing process of restructuring. We will need certainty as soon as possible about what the future framework will look like. As a panel we would be extremely disturbed if our recommendations were watered down to any significant degree, not least because of the 87% support we have for the recommendations across the board. Therefore, in terms of engaging the profession with the solutions and aligning them with an aspiration to excellence it is absolutely critical that the report is carried through in almost its full extent.
Q194 Dr Naysmith: Sir John, one of the matters we have already mentioned is that your report highlights the lack of resources and expertise for workforce planning. You pay quite a lot of attention to workforce planning in your report. We raised the issue in our recent report on the same subject. Do you think the Government will now address these problems and, if so, what do you think it should do? How should it go about improving workforce planning?

Professor Sir John Tooke: As you say, we believe that it is an absolutely critical and interrelated issue. I am conscious that through The NHS Next Stage Review there is a process of looking at the future structure of workforce planning and how that is aligned with education. For me, an absolutely critical issue, which has not come up yet, is role clarity. We must have clarity about what the medical professional contributes to the multidisciplinary healthcare team. For that matter, we need similar clarity for the other professional clusters involved. You cannot do effective workforce planning until you know what those contributions are. That is the starting point. Any future structure needs to deal with the tension between demand-led local planning, in which SHAs are now heavily involved, and national oversight to ensure that shortage specialties are covered, quality of commissioning and training structures is up to a national standard and that the service perspective is also embraced within that. An integrated approach rather than the idea that all of it must be decentralised is crucial. We need better databases of existing skills. We think that having the GMC as the overarching regulator will cost-effectively help us achieve that. We need better modelling capacity than exists within the department. That may mean calling on academic expertise or expertise from other sectors to enhance that. We then must have the sharp end professional viewpoint; in other words, we must have doctors who are at the front end of their profession in terms of driving forward developments to provide foresight to get over the great difficulty of trying to anticipate future needs and technological and other solutions. There is a strong case for deconstituting something like the Medical Workforce Standing Advisory Committee which was stood down fairly coincident with the development of many of these changes. Despite the difficulties inherent in workforce planning—we all appreciate that it is an inexact science—that committee did a pretty good job of rationalising medical student numbers, for example. We need to ensure that some structure such as that is imbedded in future arrangements.

Q195 Dr Naysmith: Is there not a danger that this would enhance the isolation of the medical workforce planning bit as opposed to the team approach that is being followed?

Professor Sir John Tooke: If you have clarity of role any danger inherent in that can be avoided. Your previous report identified the shortage of doctors which led to a number of other solutions being employed, particularly role substitution. That report points out the need for evidence that substitution works. From our perspective what is important is that each professional cluster, if I may so describe it, needs an appropriate educational foundation on which to build. A healthcare professional, whether a therapist, nurse or doctor, is not simply a sum of competencies or good enough skills. We will get a second-rate health service if that is the model we pursue.

Q196 Dr Naysmith: It is interesting that you raise the question of clarity of the role of the medical professional. Elsewhere in the report you recommend a wide-ranging debate on the role of the doctor in healthcare. Leaving aside for the moment your views on the subject—you can add them in if you like—should not the Government already have a very clear idea of the role it wants doctors to play? Should not the medical profession really know what it is providing when it turns out a doctor?

Professor Sir John Tooke: One cannot disagree with that. Inevitably, the roles of all professional groups evolve over time. If one is to aspire to something better one must look at each group and how to enhance the roles and get the most out of each professional contribution. This is not about medical elitism but asking: what does this major foundation in medical education equip somebody in a medical practitioner role to do? How do we get the most out of that? How do we ensure there is a good contribution of doctors to management and leadership, which is something we recognise as a potential problem with the existing structures? How do we ensure that healthcare which is so important to UK Plc science flourishes in this country and that doctors have a key role to play in that, and so on? It is about enhancing the role of each professional group and looking clearly at the educational foundations and training necessary to do that.

Q197 Dr Naysmith: Part of this is due to the feeling that there will be more trained people than there are jobs for them in future. I am talking particularly about consultant grades. When he gave evidence the Chief Medical Officer said that the United Kingdom was only 21st in the table of doctors per head of population; in other words, we are under-doctored compared with some other advanced countries. Would your specialist grade provide a mechanism for breaking the linkage between consultant and training numbers and help in this situation?

Professor Sir John Tooke: It is likely that there will need to be some differentiation at the top end of the profession. It seems unlikely to me that you can have the majority workforce made up of autonomous practitioners operating in precisely the same role. I use the analogy of my experience. When I became a consultant in a district general hospital nearly 20 years ago I was the only specialist in the two specialties that I served. There were only six physicians of whom I was one. Therefore, I had to lead the specialties and run the
training. I also ran a research programme. I was embracing many of the enhanced roles to which I have referred with which people have historically associated the consultant position. In my service there are now five of me. We do not all do those things; some operate as sub-specialists, some major on research and so forth. I believe that there will be greater differentiation. A useful analogy that has been put forward is that in clinical academia you recognise at consultant level that you can have a senior lecturer, reader and a professor. Therefore, there is a differentiation within that hierarchy. We need an open debate. What we have done is to expose the need for resolution of that issue. It will not go away.

Q198 Dr Naysmith: You open up a very interesting debate, if I may say so.

Professor Sir John Tooke: Even if one had not, one suspects that foundation trusts will be making decisions because they have a responsibility to provide the skill mix and layers they need to do the job.

Witnesses: Dr Richard Marks, Head of Legal Team, and Mr Matthew Jameson Evans, Press Co-ordinator, RemedyUK; and Professor Steve O’Rahilly, University of Cambridge, member of Fidelio, gave evidence.

Q200 Chairman: Gentlemen, for the sake of the record perhaps you would introduce yourselves and the positions you hold.

Mr Jameson Evans: My name is Matthew Jameson Evans, a co-founder of RemedyUK, the group that opposed a lot of the processes that went on this year.

Dr Marks: My name is Richard Marks, a consultant anaesthetist. I have been involved in postgraduate training for 15 years. I am a programme director for the London deanery and I am deputy regional adviser for the Royal College of Anaesthetists.

Professor O’Rahilly: I am Steve O’Rahilly, a consultant physician at Adenbrook Hospital in Cambridge. I am also a professor at the University of Cambridge where I research and teach. I was part of the spontaneous group that got the name Fidelio attached to it. We were horrified at the evolution of the spontaneous group that got the name Fidelio Cambridge. I am also a professor at the University consultant physician at Adenbrook Hospital in

Q199 Mr Syms: When and how do you expect the Government to respond to your final report? Do you expect the majority of your recommendations to be accepted?

Professor Sir John Tooke: I wish I knew the answer to the second bit. As to the first part, we plan to get out our final report before Christmas. We hope that we shall receive a response in very short order. I am conscious that some of the work streams we have identified are already being drawn into some of the work streams associated with Lord Darzi’s review of the NHS, that is, some of the issues around workforce planning, the architecture in terms of regulation, the management of commissioning and so on. We welcome that. We shall watch it very closely because we are concerned that things are not diluted in translation. I did not wish to join the national board taking forward that work because I want to be able to stand back and monitor how things are going, but I have agreed to advise on that process as it goes forward.

Chairman: Thank you both very much for coming along to assist us with our inquiry. We shall not be reporting quite on your timescale and we hope that is quite useful to us.
was that it had nothing to lose and could, if I am not being disingenuous, express what the vast majority felt at the grass roots.

Professor O’Rahilly: Similarly, we consulted people at the royal colleges and the BMA. We felt that it was a professional issue. The BMA is largely a trade union and we did not feel that it would have the public legitimacy to engage at that stage. The response of the royal colleges initially was very disappointing. Many of us are fellows of the royal colleges and are associated with them in some way. There was an issue about the colleges having been involved and consulted at least in part throughout the process. They were in effect partly steeped in it and found it very difficult to extricate themselves even when changes of leadership led to the appointment of people who perhaps might like to extricate themselves from it.

Q203 Chairman: On the basis of the answer to that question, do you think that the profession is as much to blame for this situation as the department?

Professor O’Rahilly: I think the profession has participated in this. To some extent it has been rather hoodwinked and blind-sided, because a lot of the worst aspects of MMC and MTAS were thrown in at the last minute through this process. Initially, the whole purpose of MMC was to solve a particular problem of training of SHOs. Rather rapidly, towards the end of the whole process other issues started to come in, such as medical manpower and the use of the MTAS questionnaire which really was not discussed at all. I believe that the profession was brought along and at the last minute was somewhat hoodwinked. I believe that is a reasonable way to put it.

Mr Jameson Evans: I agree with that. I think that Unfinished Business looks pretty good on paper to anyone and it contains a lot of truisms. Sir Liam Donaldson makes three important points about flexibility and the fact we must have an excellent transition period. All of those crucial points were slightly brushed under the carpet and it was very much railroaded through. I believe the BMA objected to it, or certainly wanted a postponement of the process.

Q204 Chairman: Obviously, the Junior Doctors’ Committee of the BMA seems to have been especially involved in the implementation decisions. Do you believe that they failed to represent the interests of the majority of young doctors, or is that too harsh?

Mr Jameson Evans: I think it is a difficult job to be involved at a high level. In some ways we had an easier job to identify it as a bad way forward at the point we entered. The BMA has been involved from the beginning. I agree with Professor O’Rahilly that the whole profession was hoodwinked and it changed very much along the way.

Q205 Chairman: Hoodwinked in what way?

Mr Jameson Evans: The core goals of Unfinished Business bear no relation to what happened this year.

Dr Marks: The time at which a lot of these things were in development was very different from now in terms of manpower requirements. At the time there was an expansion of SPR numbers and the idea that you could go from what was the SHO to the SPR grade seamlessly seemed like it could happen. Since then the numbers have all become tight and the system which would have worked if there had been a shortage, or the right number of doctors, does not work in the present climate.

Professor O’Rahilly: Neither of the two elements that the profession has emphasised, flexibility and careful piloting, has happened. Those were set by the professional members of the MMC as key elements.

Q206 Dr Naysmith: I should like to come in on the suggestion that the leaders of your profession were hoodwinked. You are talking about a number of the most powerful people in the land; some are members of the House of Lords; some have knighthoods and they are professors of this, that and the other. Some have multiple degrees. They could not have been hoodwinked. You are talking about a number of the most powerful people in the land.

Mr Jameson Evans: There are two ways of looking at that. All the reports we got were that the Department of Health was not listening to the objections made by key members of the profession. Whether you call that a failure by the profession to engage or blindness in the Department of Health, you could describe it both ways. There have been a lot of changes, but there was a failure at that stage.

Professor O’Rahilly: Professor Ian Gilmore, President of the Royal College of Physicians, produced a four or five-page paper documenting the college’s objections to the evolution of MMC, all of which were completely ignored.

Q207 Chairman: Your organisations have responded to the events of this year. Do you go as far as to say that the leaders of the medical profession have lost touch with doctors to some extent, or again is that too harsh?

Mr Jameson Evans: I do not think that is too harsh at all. It was obvious, given our success as an organisation this year, that there was a failure of communication between the leaders of the profession. Certainly, there was a feeling that the whole of MMC had been conceived behind closed doors, and that is why we have succeeded. We have seen changes in the way the BMA and the colleges communicate with their members. There have been changes, but there was a failure at that stage.

Professor O’Rahilly: You are right that there was a fragmentation of doctors’ responses. In Britain there is a fragmentation, given the number of royal colleges, almost to a Ruritanian level of complexity and too many individuals speak for the profession. If you take Canada which has a single college of physicians and surgeons with a powerful voice for all specialists the communication with government is far more effective. We suffer in this country from a multiplicity of bodies. There are some very good
examples. The Academy of Medical Sciences has developed into one of the four learned academies and is a wonderful body that focuses on biomedical science, but in a way it took a lot of the more senior academics eyes off the ball in this important issue which is basic to doctors’ training. Therefore, at a period of even further fragmentation with the biggest challenge to the quality of medicine in the country in 50 years as a profession we took our eye off the ball.

Q208 Chairman: Mr Jameson Evans, earlier you said that you had 15,000 doctors on your list. Would you call them members?

Mr Jameson Evans: We describe ourselves as a community. Essentially, we came into being through the Internet; it certainly could not have happened without that. We have a lot of communication with those 15,000 people. We certainly do not call them paid-up members. We raise money through various means including subscriptions but we are inclusive to all those 15,000 people.

Q209 Chairman: Do you think either of your organisations or both have a future role to play in all of this?

Mr Jameson Evans: One thing that has been levelled at us is that we are a single issue group, but if you look at our original manifesto workforce planning was at the top of it. There are a huge number of issues in which Remedy can be involved. We certainly agree with Sir John that this is the big issue for the future and it needs an urgent review and certainly the resources to be allocated. A massive amount of this country’s money is being used to pay for doctors and their training and it needs to be done efficiently.

Professor O’Rahilly: The benefit of our group is that we are an unaffiliated loose gang, if you like, that can continue to act as a ginger group, but if you are talking about distinction a look through the list of individuals who signed the letters will show that they are among the most distinguished clinicians and clinical scientists in the country. From an international perspective they would be seen as Britain’s leading doctors, far more so than many of the people who have formally taken on those leadership roles.

Q210 Chairman: Do you believe this ginger group has a long-term role to play?

Professor O’Rahilly: I sincerely hope not. A lot of the recommendations in Tooke seem very sensible. A lot of the things happening in the academic world with the National Institute for Health Research seem very sensible. Some sensible solutions are on the table, and we are just as keen to get back to our patients, labs and students as everybody else. This has been a terrible waste of time. We could have been discovering new treatments for diseases.

Q211 Dr Taylor: I go back to the reforms of the SHO grade which you mentioned. The original principles were built on that. Mr Jameson Evans, in your written evidence you say that reform of the SHO grade was necessary but implemented badly. How do you react to Sir John Tooke’s suggestions about reform?

Mr Jameson Evans: We broadly support Sir John. Obviously, quite a lot of work needs to go into various aspects of what he suggests and a good deal of that will be to do with people who do not get into training. I refer to core training and then a break between the old SHO and registrar grades to allow individual doctors flexibility so they can perhaps do some research, work in the developing world or do something like that. The rigidity of the current plan is an absolute disaster. For that reason, that would be a much more preferable solution.

Q212 Dr Taylor: You support the core training and say that it is roughly equivalent to the old SHO grade?

Mr Jameson Evans: I think it is roughly equivalent to a well structured, basic surgical training that you would have got. It was not across the board and would have been a goal to aspire to. What we had was a lot of disparate SHO jobs with a few structured rotations which in many ways were excellent. Sir John advises that that should be a standard, not just an exception.

Q213 Dr Taylor: The GPs were ahead of the hospital doctors in the rotations?

Mr Jameson Evans: Yes.

Professor O’Rahilly: I think the SHO situation was a problem but a limited one. The MMC is a bit like giving someone cholera to cure his dysentery. It was a very manageable problem. The problem was that there were unstructured elements in some parts of the profession and medicine was doing much better. Most of the SHO rotations in medicine were structured and educationally-based. There was a perception that thousands of people were applying for SHO jobs. Yes, there were. It was a bit difficult, but 400 or 500 of those would always have struggled to get appointments. It was the same 500 coming around time and again. There was some difficulty with the appointment systems but it could have been solved by an American-style matching programme which works perfectly well at residency stage in the US. It does not mean that we have to take on US-style healthcare, but their training and organisation of training is a model of efficiency when it comes to that stage in a person’s career. That could have been solved easily by a matching style programme. Finally, the problem was really restricted to surgery where there were permanent surgical SHOs rotating around for ever and ever. If you have a fixed residency with a fixed exit point that cannot happen. The solutions to the SHO grade were therefore straightforward. The problem was used as a means to have a radical restructuring of the profession with all sorts of long-term views of what should happen in terms of sub-consultant grades, number of doctors and so on. This whole process which should have been used to fix a simple problem was used as a way to restructure the entire medical profession and it overreached itself.
Q214 Dr Taylor: I do not know whether you were here for the first session. We probed Sir John on the training and service parts of the jobs of junior hospital doctors. He said very clearly that primarily even a doctor in training was a doctor and therefore a hospital doctor. He said very clearly that primarily here for the first session. We probed Sir John on the European working time directive is that you do not get that continuity of a mixture of service delivery and training because essentially you are punching in and out of shifts and do not see it. But training is intimately linked to service. One of our big concerns for the future is that we will not have that experiential learning. All the surveys we have done with 3,000 or 4,000 people suggest that we are not the only ones who feel that way because there is grave concern about the skill base of specialist doctors in future. 

Dr Marks: Medicine is an apprenticeship and people learn by working with their boss, seeing how things happen and gradually taking on more and more responsibility. I think that has been damaged by MMC because it has increased the number of training posts. The problem that was always there in the past and one of the reasons that the SHO grade needed to be reformed was that in some jobs people did not get any training or supervision; they were left. A lot of them spent their time filling out forms and doing stuff where they were not supervised or looked after. That has not been addressed and has not changed very much. One of the fundamental things that this was supposed to do has not been addressed.

Q215 Dr Taylor: Going up to the more senior levels, Sir John makes it quite clear that staff grades should not really be dead-end jobs; people should be in training as well. Presumably, you would agree with that? 

Mr Jameson Evans: That is one of the areas that needs to be clarified. Obviously, he cannot make any detailed analysis of exactly what that structure will involve. How easy will it be to implement that, and who is to provide the service if they are to be trained? The people not in training are also a crucial part of the delivery of service. The crucial element of what went wrong with run-through is that essentially the people who will be staff grade in the current system will come out with only two or three years' experience in training and that is just not a level at which training can be cut off. They have no specialist skills whatsoever and it is naïve to think they will remain low-grade SHOs in their fifties, for instance.

Q216 Dr Taylor: I do not know whether it is fair to ask you about the BMA, but it supported the introduction of run-through training. Do you think that it was putting job security above flexibility? 

Dr Marks: It perceived at the time that it would be getting security for its members. At the time this was introduced people would apply for an SHO job, do it for a year and then apply for another SHO job and then a registrar's job. There was a constant applying and reaplying. What it thought would happen is that there would then be job security and people would know where they would be for seven years and everything would be hunky-dory. What I do not believe it took into account was that for every one that got in some did not and they were locked out. It is almost like bringing back the 11-plus. They were locked out from an early stage. It has become very hard for those people to get in. Worse, they are selected to be in or not in before they have even had any chance in that particular specialty. Therefore, they would get in or not get in at a very junior level.

Q217 Chairman: Professor O'Rahilly, do you agree with that? 

Professor O'Rahilly: I agree with most of what has been said. I am more sympathetic when I hear what my colleagues from Remedy say about the issue to which Sir John referred late in the session, that is, the idea of the sub-consultant or specialist grade going in at different levels—lecturer, senior lecturer, reader and professor—and the possibility that current staff grade doctors could apply and the more ambitious or able ones could even progress fully up that ladder. Therefore, the notion that all consultants are the same at the age of 30 and stay that way until 65 does seem a little strange. Personally, I have more sympathy. I am aware that certain members of the original Fidelio group are uncomfortable about the notion of a sub-consultant grade. I speak here in a personal capacity. I think it makes quite a lot of sense.

Q218 Dr Naysmith: Both of your organisations have said that introducing run-through and FTSTA posts would create a two-tier system, but last week the Chief Medical Officer told us that there would be plenty of opportunities for FTSTAs to apply for long-term posts in the future. Does that reassure you? 

Dr Marks: That was not what he said. I believe he said that they would be trained so they would be eligible. The posts would not be there because the posts that would have been there have been filled by the people coming up from below.

Q219 Dr Naysmith: So, it does not reassure you? 

Dr Marks: Not at all. I think it was inherent in the design of the system that the people who took FTSTA jobs would not progress unless they could get into dead men's shoes.

Q220 Dr Naysmith: Does that mean you think they will become a new lost tribe if this happened? 

Mr Jameson Evans: Currently, FTSTA equals lost tribe.

Q221 Dr Naysmith: My next question will interest you, Professor O'Rahilly. One of MMC's principles was to improve career paths for academic medicine, which is something that both you and I want to see happen. To what extent do you think this has been achieved?
**Professor O’Rahilly:** I think that if MMC is allowed to go ahead it will be a fatal blow to the quality of academic medicine in this country. This country has led the world. It is second only to the United States in clinical academia and the quality of research that comes out of its medical schools. I sincerely believe that MMC means rigidity and an inability to take our brightest young doctors and put them into research posts, because there will be nobody to fill the gaps. The unbelievable rigidity that run-through has brought about will be a terminal event for the quality of academic medicine in the UK and will not be fixed at all by the wonderful NIHR and the quality of academic medicine in this country. This country has always been the bulwark of the National Health Service. This would have sorted out all of that. What happened was that the NHS said they did not get value for money from them and the academic side said that their people did not get enough time to do their academic medicine. Do you think that was a better system?

**Professor O’Rahilly:** I have worked in academic medicine in the UK since I came here over 25 years ago and I do not recognise what you are talking about. I have worked in pretty splendid institutions; I have been very fortunate to be able to work in Oxford, Cambridge and London. What I see in the UK is a very well functioning relationship and if there is a tension it is a productive and productive one and is essential. What we have here and does not happen so much in other countries are dedicated and world-leading academics who are actively involved in clinical care and bring that research into new treatments and patient benefit. Therefore, I do not recognise the scenario you describe.

**Q222 Dr Naysmith:** I worked in a medical school for 30 years, not as a medical doctor. There is constant tension between medics employed as academic lecturers and lecturers also working for the National Health Service. This would have sorted out all of that. What happened was that the NHS said they did not get value for money from them and the academic side said that their people did not get enough time to do their academic medicine. Do you think that was a better system?

**Professor O’Rahilly:** Perhaps I am very fortunate in my experience.

**Q223 Dr Naysmith:** I did not have the opportunity to work in Oxford and Cambridge but I did work at Bristol, Edinburgh and Yale. Yale does not count for the purpose of this discussion, but there was always that tension there.

**Professor O’Rahilly:** Perhaps I am very fortunate in my experience.

**Q224 Dr Naysmith:** Do you have any observations on academic medicine?

**Mr Jameson Evans:** I go back to what I said before. There are formal degrees for which one can take some time out, but one of the things that run-through obliterates is the opportunity. Research opportunities are not always predictable and you react to something that you encounter in your clinical practice. There is an opportunity to take out six months or a year perhaps to do just a few good papers on something, as I did last year. It is a great part of the old system. That enhances the clinicians of the future. They do not have to become academics, but there is also value in research done by non-academics, and that is not really allowed for.

**Q225 Dr Naysmith:** The department has repeatedly tried and failed to exclude international medical graduates from applying for training posts. Do you think that is so, or do you believe that the recent judgment of the Court of Appeal was right?

**Professor O’Rahilly:** It is a very difficult issue. As an international medical graduate myself who came here 25 years ago I would have been in very much the same position as the other IMGs. Now I would be an EU graduate. I did put in about 50 job applications before I got one, so I have a great deal of sympathy for these talented people who come from abroad and who over many years have been the bulwark of the National Health Service and produced wonderful work. It is an extraordinarily painful scenario. We have now produced vast numbers of new medical graduates at £200,000 a pop. It is a judgment of Solomon.

**Q226 Dr Naysmith:** What do you believe should happen?

**Professor O’Rahilly:** My view in this case, which is based more on emotion than rationality, is that the court judgment should stand and they should be allowed to compete on an equal footing.

**Mr Jameson Evans:** The writing was on the wall as to what was going on with the joint goals of self-supply and an open-door policy. In your report of last December you said that the ratio of GMC registrations in 2004 was 70% IMGs and 30% UK graduates. It does not take a genius to work out what will happen at this point. To hold the IMGs responsible for that failure of government policy is completely unacceptable. We all work together and do not differentiate at a clinical level. I think it is insulting to everyone, not just IMGs, that government is prepared to say they can go home and it will not honour what was said to them when they arrived. If it had been made clear along the way—it was not—that it was a fixed-term contract and they would have to return at that point that would be completely appropriate. It is also very interesting to note that Fidelio, ourselves and pretty much everyone would agree there has to be an incredibly tight closed-door policy from now on. That is the consensus. We hope that the Government has got its act together on that.

**Q227 Dr Naysmith:** The alternative would be to reduce the number of UK medical training places, would it not?

**Mr Jameson Evans:** We would support that. The problem is that there is a 10-year lag on a ballooning medical workforce. That is why we need funds urgently to create a body that acts in a slightly more intelligent way than it has done in the past five or six years.
Q228 Dr Naysmith: People argue that the UK is under-doctored, per head of population there are fewer doctors here than in many other countries of the world.

Mr Jameson Evans: The BMA’s 1999 figure was 1.7% versus 3.4% as the European average. We have now moved up to almost 2% which is still 60% of the average. The Government promised a consultant-delivered service and that is one of the goals that has now disappeared from the agenda. The expansion of medical students was part of that policy. The people who are now paying the price for that change in policy are my generation of doctors.

Q229 Dr Naysmith: The Chief Medical Officer told us that every effort would be made to help UK-trained doctors who could not find training posts in 2008. Is that a reassuring guarantee?

Mr Jameson Evans: No, not really.

Q230 Dr Naysmith: Are you happy with what was done to help the 1,200 misplaced doctors who did not get jobs in 2007?

Mr Jameson Evans: I am sorry; I do not know where that figure comes from.

Q231 Dr Naysmith: I apologise. It is a misprint in my briefing and should be 12,000.

Dr Marks: Over the next few months something will happen that will change that. For the first half of next year we will see a shortage of doctors.

Q232 Dr Naysmith: To make it clear, that is not a misprint; it is the Department of Health’s figure. Therein lies something that needs to be explored!

Dr Marks: During the second half of the year we shall begin to move to a period when there is a shortage of doctors and hospitals will find that they cannot fill places. Because of the change to yearly recruitment at the beginning of the year, August, all the jobs were filled and the people who did not get jobs either left the country or went off and did something else. As the year runs from August 2007 to August 2008 people drop off the top because they have finished their training and have started out of step with one another so it is a gradual trickle rather than a deluge at the end and we have no way to recruit people back into those places. Therefore, as the year progresses we will move from a period of doctors without jobs to a period of jobs without doctors. I anticipate that in July we shall be down by about 20%.

Q233 Dr Naysmith: We heard in the previous session that there was difficulty in getting locums.

Dr Marks: We have a terrible difficulty which will impact on patient care. In the programme for which I am responsible in February we shall be down by about 16%. You cannot get people from anywhere. Anyone who got a job last year will now be locked into an FTSTA which does not finish until August so, whereas under the old system there was a constant turnover of people at SHO grade, now there is no one available to apply for these jobs as they become vacant during the year.

Q234 Chairman: Clearly, potentially that has serious implications because locums are used for temporary vacancies on occasions because of illness or because doctors are on maternity leave or whatever. Is the national picture that the availability of locums is not like it has been in years gone by?

Dr Marks: I have three pieces of evidence for that, although I do not have any national figures. There was an article in the Eastbourne press in which one of the hospitals said publicly that it had a problem. I have heard that some locum agencies have closed down. At a meeting of our colleague I raised the issue and said we were about 10% down. There appeared to be agreement around the room that 10% was about the national figure.

Q235 Chairman: You said that potentially this could affect patient care. Is there any evidence of that?

Dr Marks: It has not happened yet but it will start between January and August.

Q236 Mr Syms: Do you agree with the overall findings of the Tooke inquiry? Do you believe that its initial report gave the Government an easy ride?

Mr Jameson Evans: We absolutely sanction Sir John’s report. We suggest that although different areas of the profession have different points to make there is a consensus. I did not realise that Sir John had received 87% broad-based support. That reflects what we think and it should go through. The main issue we are concerned with is what happens to the FTSTA cohort and whether there is a decent and realistic provision for their future.

Dr Marks: I do not think that Sir John’s report was soft on the Government; it was quite critical. It started off by saying that no one really knows what these reforms were for and there was a big loss of direction and now no one quite knows what it was all about.

Professor O’Rahilly: It is a remarkable piece of work carried out over a short period of time and it has achieved more than the mandarins over the years. I believe that it should be supported almost in its entirety. We desperately need something to take us forward and get us out of this mire. This presents most of the solutions. There will be some dissenting voices but very few, for example perhaps postgraduate deans. It will be widely supported by the profession.

Q237 Mr Syms: Many of the problems in 2007 were caused by poor project management, communication and leadership. Should not addressing these problems be a greater priority than making further structural changes?

Mr Jameson Evans: Accountability is one issue that I hope the Committee will look into. I do not believe that it is the job of Sir John Tooke and I do not believe that was the agenda of Professor Neil Douglas. To have at grass roots level what has been described by Professor Douglas as the biggest disaster in a generation of doctors with no significant impact on the architects and implementers sends out
a poor signal to the people who went through this and look forward to years of trouble. I hope that some accountability is achieved by this Committee.

Dr Marks: Accountability is an issue but the underlying structure of modernising medical careers was seriously flawed. We need to go back to the drawing board and say that this was wrong from the start.

Professor O’Rahilly: I agree. I think the outcome is bad and it will not be changed by fiddling with project management. It is fundamentally flawed.

Q238 Mr Syms: If the Department of Health accepts all or most of the recommendations it will be responsible for implementing the Tooke proposals. How much confidence do you have that the department can do it successfully?

Mr Jameson Evans: It is difficult to quantify it. Our experience is that intermittently the Department of Health has been helpful in communication, but by and large the manner in which MMC was conducted was very much top down and it did not listen to anyone. If it adopts the same approach we are lost. I see no evidence that it has changed its approach, so I am very concerned about it.

Dr Marks: Success or failure depends a little on whether or not what it tries to bring in works at local level. The problem with MMC and its structure was that the programme directors, deaneries and people who had to implement it could not devise a way to make it work. I do not believe the situation will be addressed in the way in which MMC was conducted. As it happened, it was half-term. There were 650 CVs to go through. Many of the answers were virtually indistinguishable. It was impossible. When I got about half-way through I realised that I had not been consistent and started to do them again. The answers were so difficult to assess that I had absolutely no confidence that I was giving people the right answer and I did not have time to do the job properly. There was a meeting of those of us responsible London who had been short-listing and a whole bunch of forms had not been scored. We divided the pile between six or eight of us and went through them. We could not agree on the scoring we should give to some of the questions, so I had no faith at all that we were doing our job properly.

Professor O’Rahilly: Fidelio is a gentle academic group and tends not to become involved in blood lust, but I am afraid that the points made by Remedy are cogent and hard to ignore.

Q240 Chairman: You are both very critical of the short-listing process. We have received data from the department which shows that the initial short-listing was a good predictor of how successful candidates would do. Do you accept that the short-listing was not as consistently flawed as you first thought?

Dr Marks: Let me tell you my personal experiences as a short-lister. A box of CVs arrived on my desk on Friday and I had to have them looked at and done by the following Monday. I had a weekend to do it. As it happened, it was half-term. There were 650 CVs to go through. Many of the answers were virtually indistinguishable. It was impossible. When I got about half-way through I realised that I had not been consistent and started to do them again. The answers were so difficult to assess that I had absolutely no confidence that I was giving people the right answer and I did not have time to do the job properly. There was a meeting of those of us responsible London who had been short-listing and a whole bunch of forms had not been scored. We divided the pile between six or eight of us and went through them. We could not agree on the scoring we should give to some of the questions, so I had no faith at all that we were doing our job properly.

Q241 Chairman: Unfortunately, I do not have the data in front of me; otherwise, I would quote it. You say that the data are incorrect?

Dr Marks: What the data did was pick out the very good and the very poor, but there is a big grey area in the middle which is not identified. At the judicial review we presented evidence, which we do not have here, from a statistician. He pooh-poohed the data. The correlation was very weak.

Q239 Mr Syms: Given the events of 2007, are you surprised that nobody from the Department of Health either resigned or was disciplined as a result of this process?

Professor O’Rahilly: It is absolute nonsense. If you take 100 CVs and throw them down the stairs on Monday and then throw them down the stairs on Tuesday there will not be randomness; there will be some association. You might then say that to throw them down the stairs provides a positive correlation, albeit a very weak one. We are told that the data are no better than that. I am not reassured at all that there was any validity in the short-listing procedures.
Q242 Chairman: Do you accept that the use of the “white box” questions was suitable for less experienced candidates for ST1 posts? Was it not the decision to apply the same selection methods to more experienced doctors that was the real mistake?

Dr Marks: I was involved in ST3 selection. We have had white space boxes for many years and they have worked quite well. The difference this time was that you had the white space boxes in isolation and so you did not have the rest of the candidate’s CV to look at. To give an example, one of the questions was, “How have you coped with a stressful situation?” The first thing you need to know is whether that is a stressful situation for someone with that level of experience. Something that a junior would find stressful could be coped with by someone who was a little more senior. One did not have that so one was marking them completely in isolation from the rest of the CV.

Mr Jameson Evans: From a trainee’s perspective I was horrified about the white space questions. The fact that there is a rash of courses where you pay £300 to bone up on the relevant buzz words which get you points is a complete travesty of what selection should be for professionals. Whether it is ST1 or ST3, the white space questions are very questionable. The other issue is that with ST1 selection essentially you are trying to select people for run-through training at a very early stage in their careers. You do not have any experience of the value of white box questions. Therefore, it is probably the wrong time to select them for the rest of their career.

Professor O’Rahilly: Sometimes it is important to put a human face on these things. At 8.30 this morning I spoke to a doctor from Scotland. He graduated from the University of Edinburgh, one of the finest in the country. He came second place with honours in all subjects throughout medical school and then applied for a senior house officer job rotation in the south of Scotland, and out of 600 applicants he came second. He passed all his exams and was given extremely good reports by all his clinical supervisors for his quality of patient care, communication skills and so on. He had a lifelong desire to become a cardiologist and decided to take some scientific training in cardiovascular medicine. He took a PhD and got a competitive fellowship from the British Heart Foundation. This chap is not a nerd; he is an international athlete. He represents his country in a major sport, so he is a remarkably rounded person. This person went through the white box procedure and got short-listed for one set of interviews. At that interview there was no CV and no reference made to his academic achievements. He was unsuccessful in obtaining a cardiology training post. All good people occasionally are unlucky, but this is his last chance. He will never be able to do cardiology again. He was bitter and his voice was shaking. I do not say that he is a destroyed man, but he is in serious distress having given all his life to this. He has superb intellectual and academic credentials.

Q243 Chairman: There are courses for filling in CVs—quite a lot of them are paid for by the Government—for would-be job applicants, as it were. You tempt me on that basis. Do you believe that people with first-class degrees make better doctors?

Professor O’Rahilly: Yes, I do. I think it is a nonsense to say there is no correlation between academic activity and quality. To get a first-class degree you have to work hard, be committed and know what you want to do. The idea that on the one hand you can have Dr Finlay and on the other Dr Mengele is a complete nonsense. In my experience, by far the best people I have trained—the ones who communicate best with patients and the most compassionate—are those who are also fired up by a desire to understand the disease. They work hard to understand it so that treatments can be better in future. It is a very common misconception throughout much of this debate—and it is a pernicious suggestion—that what we need are nice warm, woolly caring doctors who do not need to be clever or able. Medicine is difficult; it is about handling complexity and making difficult, life-changing decisions at three in the morning on the basis of complex information. That needs a high IQ and smart people to do medicine. If we get dumb people doing medicine we are all in trouble, and I do not look forward to my own future healthcare.

Q244 Chairman: I am a lay member of the General Medical Council. Based on my experience, I would probably take you up on one or two issues. Dr Marks, do you have anything to add on the relationship between first-class degrees and good doctors?

Dr Marks: When you assess someone’s suitability for a job and try to pick out how people will do in their future careers the only thing you have to go on is their track record. By and large, one can pretty well predict the people who have done well at medical school and in the jobs they have done up until the one for which they are applying.

Dr Naysmith: Getting into medical school in this country is the second most difficult academic course to follow, so there are very few dumb people getting degrees in medicine. Even though they may have had some trouble in their finals they can still turn into excellent doctors. What is it that makes doctors so special that there is such a fuss about not being able to get the job of their dreams when they qualify? In every other sphere in this country there are clever people who graduate, go for interviews for jobs and do not get them.
**Professor O’Rahilly:** That is the second myth that is constantly discussed, namely that all doctors are smug, fat and happy and believe they can get exactly the jobs they want for the rest of their lives.

**Q246 Dr Naysmith:** That is not my question. I am asking: what is all this fuss is about.

**Professor O’Rahilly:** You asked two questions. First, what is special about medicine compared with the other healthcare professions?

**Q247 Dr Naysmith:** Not just other healthcare professions but the other sciences and so on?

**Professor O’Rahilly:** They are all very important professions. The handling of complexity and making important decisions on the basis of complex inputs is the characteristic of most high-level professions such as law, medicine and science. We value medicine because it is close to our survival. The doctors we have to deal with make decisions or help us make decisions which are concerned with our very existence, so of course we consider medicine to be important; it is very close to who we are.

**Q248 Dr Naysmith:** Does the fact that one doctor is married to another doctor mean that they need to get jobs close together? That was argued by somebody who gave evidence to us just two or three weeks ago from the chair in which you are now sitting. It was suggested that one of the faults of the system was that it did not allow the matching of spouses for jobs.

**Professor O’Rahilly:** No one ever expects to get the first or even the second job that he applies for. What one expects is to be able to enter into a competitive system that looks at one’s abilities and provides multiple opportunities over a period of time.

**Q249 Dr Naysmith:** It should be fair.

**Professor O’Rahilly:** If after a couple of years one does not get a job in cardiology or neurology somewhat reluctantly and perhaps in a slightly disgruntled way one chooses a less competitive discipline about which one makes a positive choice. We face a future with MMC where there are multiple individuals forced prematurely into disciplines not of their choosing. I would not wish to be a patient of theirs in 10 to 15 years’ time when they are bitter, twisted and disgruntled.

**Q250 Dr Naysmith:** That is an absolutely ridiculous statement.

**Professor O’Rahilly:** It is not. Why?

**Q251 Dr Naysmith:** Because thousands of pounds have been spent on these people and they have been trained in every specialty under the sun at a basic level. You say that because they cannot be cardiologists they will not be good at something else.

**Professor O’Rahilly:** I spoke to a doctor this morning who was one of the best graduates. He said that so far what he had been offered was psychiatry or obstetrics and gynaecology. Neither of those was on his radar.

**Q252 Dr Naysmith:** But general medicine and all sorts of things are open to him.

**Professor O’Rahilly:** There are no general medical posts open to him. These are the two options he has at the moment. Under the old system there were lots of ways. There is a myth that there was a golden era when we all got exactly the jobs we wanted.

**Q253 Dr Naysmith:** You are putting out that myth, not me.

**Professor O’Rahilly:** But the golden era was not golden; it was a perfectly rational competitive era in which people did not get all the jobs they wanted but it evolved over time in a way that allowed them to look at a broader range of choices from which to select. It is a bit like saying that every lawyer who comes out of law school is made to do either conveyancing in Coventry or matrimony in Manchester and is geographically and specialty-placed by central government diktat.

**Q254 Dr Naysmith:** It is not central government diktat; it is choice, is it not? Nothing forces you to become a doctor.

**Dr Marks:** One of the good things about the old system and very bad about the new one is that people had a Darwinian chance to find their level. If you decided that you wanted to be a cardiologist in London and you had applied for it three or four times and did not get anywhere you could reassess the situation and change what you wanted to go for. One aspect that people find hard about the process is that it has all happened in one go. People have not had a second chance or been able to match what they want with what they will get realistically; and they also perceive that the selection itself is unfair.

**Mr Jameson Evans:** There are data to show that only 25% of doctors really know what they want to do definitively at the stage when they have to make irrevocable decisions. I do not know how they will end up in 10 or 15 years, but I do not think it is the best way of selecting the right doctors for the job. That will probably impact on the patient population in some way.

**Q255 Dr Taylor:** Because of the problems of selection lots of people called for the whole thing to be abandoned early on, particularly Fidelio. Looking back, do you still think that would have been the preferable thing to do?

**Professor O’Rahilly:** If we had all had the courage of looking at the facts rather than the emotions of the trusts managed within three months. The notion that it could not have been reversed and things fixed was given the lie by the fact that between June and August medical staffing officers of the trusts managed within three weeks to find 45% of those jobs. It required incredible work but they managed to do it. It was all fixable and at the time we felt strongly that it should have been stopped. Looking back, I see absolutely no reason to change that judgment.
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Q256 Dr Taylor: Earlier today you said that the whole of MMC should be abandoned. Have you said that in the light of the fact that the Tooke report is addressing all your concerns?

Professor O’Rahilly: The Tooke report substantially addresses the concerns in that it breaks the inflexibility and run-through element. It provides a period of time of core training with multiple experiences after which there is an opportunity for individuals to reassess it and decide on what course to apply for at specialist level. I think Tooke is a very sensible document and addresses the vast majority of questions.

Q257 Dr Taylor: It means the same thing as abandoning the original scheme?

Professor O’Rahilly: Effectively, it means the abandonment of MMC.

Q258 Dr Taylor: The department has told us that those who wanted the process to be abandoned were noisier but less numerous than those who wanted it to continue. How do you think it made that assessment?

Dr Marks: There were four people who wanted it to continue.

Professor O’Rahilly: And they double-counted them!

Dr Taylor: I had literally hundreds of letters not one of which asked for it to be continued. There was one brilliant condemnation which I must read: “MTAS means that whether a doctor is competent or dangerous, hard-working or lazy, experienced or green, a team-playing communicator or arrogant sociopath, has no relevance to whether they get the next job or not.” I think that sums it up very well.

Q259 Mr Syms: Remedy brought legal action to challenge the changes to the recruitment system introduced by the Douglas review. Were you surprised that your legal challenge was not upheld, or was your main aim to raise awareness of the problems with MTAS?

Dr Marks: The answer to the first question is that we were advised by our barristers beforehand that judicial review was a very blunt and unpredictable instrument. I do not think we were disappointed, although we were upset. Did we do it because we wanted it to happen or because we just thought it would create publicity? We wanted it to happen because we felt that the process was so unfair that the stakes should not be as high as they were going to be. We believed that this year particularly the stakes of getting a job or not getting a job were much higher than they had ever been. Therefore, this year more than ever it should be fair, not unfair, and that it could be delayed for a year.

Q260 Mr Syms: Your legal challenge was opposed in court by the BMA. Did you regard the BMA’s stance as a betrayal of junior doctors?

Dr Marks: The BMA has for many years opposed pressure groups. Did we regard it as a betrayal of junior doctors?

Mr Jameson Evans: We were very surprised. We did not expect it. The BMA had its own reasons, which we have since discussed. Essentially, we listed it as an interested party in the case. I believe that it regarded it as some kind of attack by us, which is certainly never was. The BMA was involved in the process and we felt that it should be involved also in the judicial review, but certainly not on the other side of the fence.

Q261 Mr Syms: Officials told us last week that the judicial review upheld the approach and recommendations of the Douglas review group. Is that correct? Did not the judge uphold the review’s right to take its decisions but not the decisions themselves?

Dr Marks: Yes. The judge said that its decision may or may not have been the right one but it was one which it was entitled to reach.

Chairman: I thank all three of you for taking part in our second evidence session. I believe you were in the room earlier. We certainly shall not be making our report this side of Christmas.
Members present

Mr Kevin Barron, in the Chair
Charlotte Atkins Mr Lee Scott
Sandra Gidley Dr Howard Stoate
Stephen Hesford Dr Richard Taylor
Dr Doug Naysmith

Witnesses: Professor Alan Crockard, Former National Director, MMC (England), and Professor Shelley Heard, Former National Clinical Advisor to MMC, gave evidence.

Q262 Chairman: Good morning. Could I welcome you to what is our third evidence session of our inquiry into Modernising Medical Careers? I wonder if I could ask you, for the sake of the record, if you could just introduce yourselves and the position that you currently hold; Professor Heard?

Professor Heard: Good morning, thank you for giving me the opportunity to meet with the Committee. I am Professor Shelley Heard, I am a medical microbiologist by training, and despite my accent, I trained in the UK, at St Bartholomew's Hospital, and have been living and working here for the last 40 years. Just to say, I have a wide NHS experience as a consultant, but also as a chief executive in an Acute Trust in east London, as a non-executive director on an SHA, and as a Postgraduate Dean, from which I was seconded to the MMC team. I was the National Clinical Advisor to Modernising Medical Careers.

Q263 Chairman: Fine, thank you.

Professor Crockard: Hello, I am Alan Crockard. By training, I am a neurosurgeon. I was a neurosurgeon at the National Hospital for Neurology and Neurosurgery. I trained originally in Belfast, in the middle of the hot times. I have had a lifelong interest in training, and about the middle 1990s, I was recruited to the Royal College of Surgeons as the Director of Surgical Education, and I co-ordinated the development of the surgical curriculum for all surgeons. It was from there in mid 2003 that I became the Curriculum Advisor and then the National Director of MMC.

Q264 Chairman: Right. I am going to start the session by asking you just some general questions about the current situation and recent past. The Tooke Report shows that there was a very complex governance structure for MMC and MTAS as well. What were your roles, and to whom were you accountable within your roles? Shelley, would you like to start?

Professor Heard: I was obviously directly accountable to Alan as the National Director. My understanding about the accountability of the MMC team was through the Programme Board and the SRO for Modernising Medical Careers in the Department.

Q265 Chairman: Alan?

Professor Crockard: I was recruited at the early stages of MMC to help shape the thinking into what Modernising Medical Careers might be. I then also saw myself as a facilitator to get round all the Colleges, the groups who were involved, and made it my business to make sure that they knew what was going on. Finally, as big headings, I and my team were the implementers of Foundation, and we looked after every bit of that, and we think it was reasonably successful.

Q266 Chairman: You both chose to resign at the end of March/beginning of April, if my memory serves me well. Why did you resign and why at that particular moment?

Professor Crockard: I think the final stage was total frustration, feeling that our views as medical people, and as people with an interest and background in education, was being neglected. I felt that the whole principles of MMC, which I thought were very important, were being subsumed into an attempt to get the workforce running. We saw the situation unfold from fairly well back; I had tried very hard to make this known to the SRO to whom I was accountable in terms of MMC, and to the DCMO. At the latter stages in December, from October to December, I had actually spoken to the regulator, to people from the Treasury, to the advisors to Ministers and to the NAO about my concerns.

Professor Heard: I resigned, I think, for a very specific reason, and that was in relation to the direction of travel of the review group. I really was very distressed at what was happening to young doctors and applicants. I thought that given the high stakes of this, the decisions of the review group, and in particular the proposal to consider appointing only into one-year training appointments for this year, to give everyone the very necessary breathing space in this high stakes arrangement, should have been considered and indeed adopted. I would not like to say it was not considered; I raised the issue, it was considered, and it was rejected, and I felt that in the face of that, it was unsustainable to say. I thought it was the wrong decision to take.

Q267 Chairman: Shelley?

Professor Heard: I resigned, I think, for a very specific reason, and that was in relation to the direction of travel of the review group. I really was very distressed at what was happening to young doctors and applicants. I thought that given the high stakes of this, the decisions of the review group, and in particular the proposal to consider appointing only into one-year training appointments for this year, to give everyone the very necessary breathing space in this high stakes arrangement, should have been considered and indeed adopted. I would not like to say it was not considered; I raised the issue, it was considered, and it was rejected, and I felt that in the face of that, it was unsustainable to say. I thought it was the wrong decision to take.

Q268 Chairman: Are you surprised that you are the only people who did resign and that other senior officials did not, over this issue?
Professor Heard: I thought it was unjust that Modernising Medical Careers and the implementing team, which did not have direct accountability or responsibility for a recruitment system which, for a variety of reasons, had not worked, was extremely unfortunate. I am not saying anybody else should have resigned, I think it is unfortunate that we did not find a way of managing it once we were in that situation more effectively.

Q269 Chairman: Do you agree with that, Alan?
Professor Crockard: Yes, I do. I point out that we were, at that stage, the only two surviving medical people on Modernising Medical Careers. There were some medical people in the Foundation programme, but those involved in speciality. I think that was because we could see, shall we say, both sides, and we had great difficulty in getting our escalation route to see that there was another side to what was a very difficult and increasingly desperate situation.

Q270 Chairman: Could I go on to the Tooke Review? That concluded that "... the precise policy objectives of MMC do not appear to have been definitively stated at any point nor agreed by key stakeholders”, that is a quote from the Tooke Review. Do you think this is a fair criticism? What did you understand the policy objectives of MMC to be?
Professor Heard: I thought I was quite clear in all the time I was working on the programme what they were. The first was to ensure and develop a system whereby we could develop more trained doctors delivering more frontline care for patients, because at the root of this was an improvement in care for patients. We should not be in the position, which I am sure this Committee is aware of, where young doctors have poor supervision and make very inappropriate decisions leading to significant difficulties for patients. This programme was aimed to address that issue. It was also aimed to be very, very clear for the public, as well as for doctors, and for those training them, about what the standards of training should be; and just as important, what the assessment criteria should be, in order to make sure those standards had been met. I have to say, I think that is clear from the 2003 MMC policy statement.

Q271 Chairman: Do you agree with that, Alan?
Professor Crockard: Yes, indeed. I think what MMC was about, and what the Tooke Report said was that MMC was an honest attempt to accelerate training, and I think what we were trying to do with that was not accelerate the training by making it faster, but by making the training more appropriate to the task that was there. This was the first time, I think, in British medicine that we were putting the standards first, and they were explicit standards. Up to now, it was implicit, “Good chap; my best SHO”, et cetera. This was explicit, and we felt that that was the way that it should go. It was the way that it had gone in Canada, it has now been adopted in Australia and New Zealand, so that was the thinking at the time, and that is why we went that way.

Q272 Chairman: Most people in the initial stages thought that MMC was the right way to travel. I think, most organisations involved in this debate, Professor Crockard: Yes.

Q273 Chairman: The real issue, of course, is when it comes to implementing, there is a level of confusion about what the MMC’s objectives were, and as a consequence of that, the policy goals -- were they not agreed coming out of MMC, what it was about, or were they just badly communicated? Because the events before this year do not look very good, in terms of actually driving the policy through, from something that seemed to be acceptable a number of years ago. What happened?
Professor Heard: I think the reason why it was accepted, and this was certainly the very early advice that we gave to the Department, was that this process depended on managing international medical graduates into training. Not managing them out, but managing them in. If you look at the figures produced, I am sure you have, by the Douglas Review and available quite widely in other fora, there were sufficient training programmes available for UK and indeed EU graduates, with capacity for international medical graduates to be managed in as and when on a work permit basis. So this was not around excluding international medical graduates, it was understanding the arrangements under which they could come into training, and I think the long-term intention was that steady state would be achieved, so that we actually matched our medical school graduates into the workforce that we required.

Q274 Chairman: Do you agree with that?
Professor Crockard: Absolutely. If you like, that which had been designed was designed for one size of workforce. We raised concerns right back from February 2006 about what to do with regard to international medical graduates. We were assured that that was all being taken care of; well, unfortunately, it was not taken care of, so the shape and the size of the training programme was not appropriate to in fact the number that applied.

Q275 Chairman: Do you think the failure to set and communicate clear policy goals for MMC was the responsibility of Ministers overall?
Professor Crockard: It is easy, is it not, when you do not have to do it. But it is a very complex situation. However, if we take something like the international medical graduates, it was clear that there were discussions between the Treasury, the Home Office and the Department of Health, but the results of those discussions were never communicated to us, we had no idea. I was so concerned myself that we organised a meeting with senior people in the Treasury to put to them, I think this was in the summer of 2006, the importance of coming to a decision to actually guide us, so that something could be done. So we were aware of the problem. We were aware that there were discussions, but we were given no clear guidance.
Q276 Chairman: That has not quite answered the question. There was not direction there; who was responsible for the lack of direction? You did not have clear policy objectives, else we would not have ended up in this situation.

Professor Heard: I think the policy objectives were clear but were not synchronous, so the policy direction around international medical graduates and around supporting graduates from UK medical schools was clear and set in the late 1990s, when the increase in medical students was organised. It was organised against a background of trying to reduce, I think the phrase was, our reliance on overseas doctors for delivering healthcare services. So that policy was quite clear, and it was clearly implemented, because we had an increase of something like 3,000, a 74% rise in the number of medical graduates coming through, so we knew that policy. The second policy, which turns out not to be synchronous with that, is the MMC policy statement of 2003. Although I do believe it was predicated on managing the international medical graduates, it was never explicit, although the stopping of permit-free training in March 2006 clearly signalled that the intention and the direction of travel was there. If those two policies had actually been convergent, I do not think we would have been in the situation that we are now.

Q277 Mr Naysmith: Professor Crockard, just a supplementary in this section, before we move on to something else. I think about ten minutes ago, you talked about having discussed this with a long list of people ending up with the National Audit Office, and you seemed to give the impression that you could not get through; is that right, no one would engage properly with you about this matter, is that true? Is that what you meant to imply?

Professor Crockard: I was stating that I was very concerned, that my own escalation route was not taking our concern seriously. I realised in terms of the IMGs, and the fact that it was across three departments, that it was difficult, and on that, I wondered, as I had done on other things, that if I could put in something, it might tip the balance so they could consider it.

Chairman: Thank you. We will only look at particular aspects of it now, starting with Richard.

Q280 Dr Taylor: Thank you, good morning. Just before going on to the specific aspects, can I pick up on something you also said, Professor Crockard? You said that when you two resigned, you were the only two surviving medical people involved. One of the huge criticisms we have had is the lack of medical leadership, so when you two went, were there no other medical leaders left in it?

Professor Crockard: There were civil servants who were medically qualified --

Q281 Dr Taylor: No really independent medical personnel?

Professor Crockard: There were no medical people in the speciality team when we left.

Q282 Dr Taylor: Thank you. Moving on to run-through training, it seems to us to have been a sort of policy drift rather than a formal decision. What we want to know is: how was the decision made, and when was it made, to go on to run-through training?

Professor Crockard: It depends what you mean. In fact, if you go and look, and I am sure you have gone to consultation, and I believe what had happened then was the follow-up to Unfinished Business, which was the report of the four Chief Medical Officers, and in that, they were more specific about run-through. But exactly how run-through was going to work is not something that was mentioned in either of those.

Q283 Dr Taylor: Can I just pick you up? My understanding was Unfinished Business did have a division between the basic specialist training and the higher specialist training.

Professor Crockard: Yes.

Q284 Dr Taylor: That did allow a change at that point, so it was more flexible.

Professor Crockard: More flexible, yes, but in fact, I think the very careful wording of Unfinished Business was very important, where they said “speciality by speciality”. There are some things, for instance, as Professor Tooke said when he was before you, divisions -- sort of basic and then going to more particular was not appropriate to histopathology. It is my view too, and when I was part of the Royal College of Surgeons, urological surgery was that sort of thing, where there did not seem to be that much that was general and then specific.

Q285 Dr Taylor: You mean you could specialise much earlier in those sort of limited specialities?

Professor Crockard: Absolutely. In the same way, I think as Sir John Tooke has said, it is very difficult for one size to fit all; it is still very difficult, there are
57 different specialities, it may be very difficult to have one training programme to cover all 57 forms of training.

Q286 Dr Taylor: So really, what you are saying was it was not a good idea to have run-through training fixed in every speciality?

Professor Crockard: I think in retrospect, we should have looked at it very much more carefully, but we took considerable advice from those who were in the American training programmes and the Canadian training programmes, and it seemed there that one could design a run-through training programme for the specialities.

Q287 Dr Taylor: Did you say the actual decision was taken by just four Chief Medical Officers?

Professor Crockard: It was following the period of consultation, which is the --

Q288 Dr Taylor: Was there much consultation on finalising it as run-through training?

Professor Heard: May I? I have just pulled off the consultation document this morning actually. There were 254 responses in England from a range of -- many of them organisational and key organisations.

Q289 Dr Taylor: So this is The Next Steps? Professor Heard: No, this was the response to Unfinished Business. I think there is a story between how we move from Unfinished Business core programmes, time capped core programmes, to run-through training or seamless training. A suggestion in recommendations 17 and 18 in Unfinished Business, and then a year later, in February 2003, following on from this consultation, which raised concerns around a range of issues, but certainly around time capping and how that could possibly work, the policy statement that emerged from Unfinished Business, and that is where the scene was set for run-through training. Indeed, if you look at Modernising Medical Careers: The Next Steps, this is the only evidence I have been able to find by way of a sequence, which says: “In response to the consultation on Unfinished Business ... we will support and encourage the [PMETB] working with the Royal Colleges to develop competency-based training and assessment and to review the length of training programmes. This will be done on a speciality by speciality basis ... It will aim to provide seamless ... training programmes leading to a CCT”, that is a quote. The Next Steps goes on to say: “This 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”.

Q290 Dr Taylor: So that is where it came. So The Next Steps took the consultation on Unfinished Business as adequate?

Professor Heard: I think The Next Steps looked to the policy statement, which was Modernising Medical Careers 2003, the response of the four CMOs, which was the policy statement. The Next Steps developed that very high level statement, only six pages, nothing operational, very strategic, which set the direction for run-through training, and added this paragraph, if you like, as an explanation of how you move from Unfinished Business to run-through training programmes.

Q291 Dr Taylor: But in retrospect, you are really implying that it should have been more flexible, and there should have been differences between the different specialities?

Professor Heard: I would suggest that there were, and if you looked at the proposals that met the criteria for run-through training, if you look just at medicine alone, there were 28 options out of medicine. Two years very general, and then there were 28 options, some where an allocation would be made, and almost certainly that would have had to be competitive within the cohort chosen to get into run-through training.

Q292 Dr Taylor: I am sorry, at what stage? So you had done general medicine for what, two years?

Professor Heard: Yes, two years of general medical training.

Q293 Dr Taylor: Then after that you would have gone into gastro or cardiology or whatever?

Professor Heard: Exactly, so you were going to do a very general medical programme, and in some but not all arrangements for surgery, that too was true, you would do a couple of years of core surgical training before settling on one of the -- I think it was seven and not nine, because there were special arrangements made. Whereas in anaesthetics, paediatrics, O&G, where already there was a long-standing tradition, as I am sure you know, of SHO basic rotations specifically in those specialities into which you then competed to get into specialty training, it that speciality. I mean, there were variations, because you might move into general practice through those, but most people probably moved from their SHO paediatric rotation into paediatrics or psychiatry or whatever have you. So I think there probably is much more flexibility in what was being proposed for run-through training for most specialities than has been assumed, particularly for medicine.

Q294 Dr Taylor: Anything to add?

Professor Crockard: No, I was just going to say -- well, having said no, the answer is: for the surgeons, it was clear that some branches of surgery felt less of a need for doing basic surgical skills, like urology, like neurosurgery. The view of ENT was the same. In anaesthetics, there was no particular arrangement. So a long debate had already occurred, and in the models that we were proposing, as Shelley has pointed out, although it sounded draconian and rigid, we had already negotiated with many of these people to do those sort of things.

Q295 Dr Taylor: So it really was more flexible than we have been led to believe?
Q296 Dr Taylor: Initially? Thank you.

Professor Crockard: The problem then became once the recruitment into those things came along.

Q297 Dr Taylor: So you are coming back to the disasters right at the beginning with MTAS?

Professor Crockard: Yes.

Q298 Mr Naysmith: Professor Crockard, Professor Tooke's review recommended an end to run-through training, but the Secretary of State and the Chief Medical Officer just recently have defended the concept, and said they are going to stick to it. Do you expect run-through training to be abolished?

Professor Crockard: I am not sure what I expect any more. If you ask me, is it appropriate in certain specialties, I still say it is. We have a situation in this country where it takes 12 years to train a cardiac surgeon, and the disease process was changed by catheters and tablets in five years. Now are you going to tell me that we are going to treat them the same way as I was treated as a boy? Inappropriate. What we have to have is some way of looking at training programmes that are appropriate to training in this century now.

Q299 Mr Naysmith: What you are saying is there must be different training programmes for different specialties.

Professor Crockard: Absolutely.

Q300 Mr Naysmith: Even though there is a basis that they all branch out from.

Professor Crockard: Absolutely. My only thing about the Tooke Report or his comments are I am concerned that he is taking away one run-through system by suggesting it goes back to something that has to have three years of this and two years of that. It may or may not be needed.

Q301 Mr Naysmith: Professor Heard, what do you think?

Professor Heard: I think what Alan says has been borne out. There was a document released last night by the Department around arrangements for 2008 recruitment, and in that document, they have produced a small table which says, "Those specialties which are uncoupled", in other words there is going to be a period of a few years and then people will compete for the next stage, and a group of specialties in which run-through training will be maintained. I cannot off the top of my head tell you how the list reads, but, for example, I think the paediatricians are still going for run-through training. I think the obstetricians are still going for run-through training. As far as I know, the general practitioners are. Those are huge -- particularly when you add in general practice, where we would anticipate half our graduates going into general practice. We are looking at the majority, if you like, of medical graduates being accommodated into run-through training programmes.

Q302 Mr Naysmith: So you are in favour of that?

Professor Heard: I absolutely am. Not only am I, but I do think people who have made their career decisions early -- and indeed those specialities which are clear about offering run-through training will have, I think, a competitive edge in getting good applicants, because if you can sort yourself out basically for the rest of your career with an outcome, why would you not?

Q303 Mr Naysmith: Can we look at another aspect of Professor Tooke's recommendations? He has recommended that the two-year Foundation programme be scrapped. Some people think this is the only element of MMC that has really shown some promise, and has been successful. If I could just read you something from my own Deanery, the Severn Deanery, and as you know, that covers Swindon, Gloucester, Cheltenham, Bristol, Weston-super-Mare, Bath, Taunton and Yeovil, and they really think the Foundation programme is superb. They say, "Foundation training is a success story for the NHS throughout the UK and the dedication of the NHS staff involved locally has contributed to that success."

They really think it is a good thing. Do you agree?

Professor Crockard: I certainly do.

Q304 Mr Naysmith: So what do we need to do to convince people that it has got to stay?

Professor Crockard: I think first of all, in terms of the Tooke Report, I think he will, I hope, look at the evidence that has been submitted to him. I think he did say when he was here --

Q305 Mr Naysmith: It is only an interim report.

Professor Crockard: That is right. I hope they will take it on board, because this, for the first time, has given young graduates the opportunity to look at six different specialities before making up their minds, and a significant exposure to general practice. We fought hard in the MMC team to convince the Minister of State for this, and we got the funding to allow that. We believe, as many people believe, that primary care, or a revitalisation or a vitalisation of primary care, is what our treatment of patients should be about. So I believe very much that Foundation should stay. I think the argument that it is somewhere blocking people coming from outside, I think if there is a will, there will be a way, in terms of ensuring that the graduates from our programmes get Foundation training. I think what Professor Tooke was saying, if I got it correctly, that the first year was protected, as enshrined in the law; I am sure it would not take a legal team too much trouble to make sure, but in summary, I believe that Foundation is a very good basis for the beginning of treatment. After all, it was possible, when I was a boy, maybe not when you were a boy, but when I was a boy --

Q306 Mr Naysmith: We are probably talking about the same period.
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**Professor Crockard:** -- it was possible to go into laboratory medicine and become GMC-approved and maybe never have seen a cardiac arrest. The whole thing about the Foundation training was not a dumbing-down but ensuring that everybody could recognise the difference from acutely ill and chronic, and over a wide variety. So as you can gather, I am passionately a believer.

**Q307 Mr Naysmith:** Yes, I can see that. I assume you agree, Professor Heard?

**Professor Heard:** I certainly do. I wrote the operational framework for Foundation training. I know that competency training does not come in for a very good review from Sir John, but I would like all our doctors to be competent in recognising sick patients. That is the least patients should be able to expect, and that was the overt and clear purpose of Foundation training. It does not prevent us from having absolutely excellent doctors, but I would prefer them to be safe and competent to start with.

**Q308 Ms Atkins:** The implementation of MMC was divided between two separate directorates at the Department of Health. Whose decision was that?

**Professor Heard:** The Department’s.

**Q309 Ms Atkins:** You do not have any view about why it happened, why that rather odd decision was made?

**Professor Heard:** I think there was not a coherent and sustained view from the Department about Modernising Medical Careers. I think there were some very strongly held views from CMO and DCMO about the programme. I think these were not necessarily, through the period of implementation, always held by the Director of Workforce, and there were competing issues here: the Working Time Directive which really has shaped Workforce, and there were competing issues here: the Working Time Directive which really has shaped workforce, which is really what run-through was trying to do, in order to be able to plan better than we had ever been able to plan before in workforce terms, was not necessarily compatible. I do not think anybody had any difficulty about the notions of having explicit standards and clear standards and clear assessment processes, but the structures to support that, I think, were variably believed to be different, because they wanted different outcomes.

**Q310 Ms Atkins:** So what sort of problems did it cause operationally?

**Professor Heard:** For quite a while, the direction of travel was not entirely clear. We had, for example, three very comprehensive days, including the Service, various stakeholders, the Royal Colleges, looking at the proposed workforce outcomes and arrangements for Modernising Medical Careers, at a time at which of course we were supposed to be thinking about implementing this. So we heard a lot from the service saying that they wanted the option to be able to employ accredited doctors, was the term they used, doctors with CCT, in a whole range of variable jobs. I think we felt that our responsibility was to ensure that training people to accreditation was appropriate and adequate. It was not our responsibility to say then what jobs they would be offered, that would be really open to a whole range of different forces. It did mean that we were forced to focus more on thinking about issues that were outside the scope, if I can put it that way, of MMC, and which involved people from not thinking about the training arrangements but thinking about the outcome arrangements. Now that is not inappropriate, but it does mean that in project management terms, it is very much more difficult to see how you are going to do this.

**Q311 Ms Atkins:** Did you want to add anything?

**Professor Crockard:** No, not at this stage.

**Q312 Ms Atkins:** Can I ask you about the two areas then which were very much outside your implementation remit, which was the MTAS computer system itself, and the question of international medical graduates. These were run, as I understand it, by the workforce directorate rather than by your team. How did you allow these crucial elements to fall outside your remit?

**Professor Crockard:** Shall I take that? We were given no option. It began about October 2005, when we discovered that an MTAS board had been set up, and I certainly had not been invited to join it. Then there was the compromise where there was a medical recruitment board where our team were on it, but MTAS was already set up. So it went on. As it went on, it was clear, at least to me, and in my opinion, that the DH had decided that e-recruitment was something they were going for in a big way, and they were not going to allow anything to get in its way.

**Q313 Ms Atkins:** So judging by the way you have been choosing your words, I assume that there was quite a lot of argument about this at the time?

**Professor Crockard:** There has been a fair bit of open debate, or closed debate, let us put it that way.

**Q314 Ms Atkins:** You were not very happy about it?

**Professor Crockard:** No. And it went on; in the early days, there was a gateway review. I think 2005 was the first one, and then we had another gateway review in 2006, and those who had done the gateway review in 2006 noted the progress that the MMC team had done, in fact were quite complimentary. The only red issue was recruitment, and they pointed out that there was no contingency plan for that. You can imagine that I was, to say the least, a little disturbed, and that is when I tried to make other people aware that we had a significant problem. I attempted to escalate it through my own SRO, I was told that that was being taken care of. How far it went, I have no way of finding out.
Q315 Ms Atkins: So you did try to influence the running of these projects even though you were basically excluded from them?

Professor Crockard: Yes. Well, I personally -- Shelley --

Professor Heard: I was at most of the meetings, I would say, both of the recruitment and selection group and of the higher level recruitment board which looked after a range of things, not just speciality recruitment. I did have and I was fairly clear that I had reservations about the direction of travel. Very early on, I was contacted by the Chairman of the Conference of Postgraduate Deans to say that there were concerns that I was being difficult about things; and subsequently, about a year or so later, a second call from people who were organising this. I would like to think that I am not difficult in committee, but I would like to think I am very challenging. I have had a lot of experience in recruitment; within the London Deanery, we had set up, if you like, a competency-based recruitment system ten years previously, which was based on issues of transparency, fairness, independently reviewed, it was a very good system. It was based on white spaces, I have to say, which in the late 1990s, when we set it up, was the way in which -- and I think still is the commercial world recruits, but we are now, of course, in 2006–07, where the impact of electronic communications is much bigger. It is open to plagiarism, it is open to misunderstanding, and I think we would say that this approach to recruitment needs to be looked at again, and you need to be using much harder and firmer criteria, things that you really can count. This is a very big debate for this country, because we have no metrics, as the Americans would call it, we have no undergraduate transcripts, we have no standard examinations. I think we will see a rapid change with regard to this, so it was difficult to design a recruitment process that was going to actually suit this very, very challenging time. I personally thought that the use of the electronic modality should have been used only to receive and disperse applications, and although the underlying processes, of course, drove the specification for the electronic set-up, I think that there was probably equally a drive from the recruitment system to drive the process itself, and I think that was regrettable.

Q316 Ms Atkins: Do you think you were labelled as difficult and therefore your comments were sidelined?

Professor Heard: You know, when you work in this -- there were other people obviously who raised concerns as well. At the end of the day, if you are going to move things on, you either have to leave and then it happens without you and you cannot influence it at all, or you stay and try and influence as best you can. With hindsight, maybe I should have left, maybe that might have said, “Well, we ought to really think about these things again”. I cannot say. I do know that there were concerns raised that were difficult to get through, and then in the end, those people who form these committees are complicit ultimately in the decisions that are taken.

Q317 Ms Atkins: So in view of what you have said, are you surprised that no one from the Workforce Directorate resigned following the problems with these particular projects?

Professor Heard: I have to say, I think we probably could have gotten away, and I will put it that way, with the recruitment system, had the international medical graduate issue been dealt with, because it was not so much the electronics, but the overwhelming of the whole system, how we managed shortlisting, how we actually did interviewing, which actually made the huge difference. The fact that there were probably 10-11,000 additional applicants within the system I think was the thing that finally drove this to its failure.

Q318 Ms Atkins: But given that they did not get away with it, are you surprised that no one resigned from the Workforce Directorate?

Professor Heard: I cannot say that. I think resignation like this is personal, it was a personal decision for me. I do not know within Government whether these things are personal or whether or not pressures are applied. I am not in a position to say whether they should have or not.

Q319 Ms Atkins: Professor Crockard, do you have anything to say on that?

Professor Crockard: No, I would just say that my own view was that I had to live with myself and I felt that I had to resign. I cannot predict, in Government or related to Government, what makes people resign.

Chairman: Could I just remind everybody, we are running quite late in terms of time on this first evidence session, we have another two to follow, so could I ask for probably a bit more precise questions and possibly answers as well?

Q320 Dr Stoate: I am going to ask a fairly precise question. One of the reasons we are in this mess is because of the huge number of IMGs that were effectively unaccounted for in the initial planning. When did you become aware that the Department of Health intended to issue unilateral guidance, rather than working with the Home Office, to change immigration rules? That seems to me to be a fairly crucial point.

Professor Heard: I am not entirely sure that would be fair. I think the Department was working with the Immigration Office, particularly in the context of managed migration, for a considerable period of time. I do not think the timescales for this recruitment episode and what might come out of managed migration were coincidental, and that therefore was an issue. I would say that in my experience people in the DH who were working on this issue, they were very, very vexed by it. They were absolutely clear this should be done, hence we lost...
permit-free training in March 2006, and I think they did believe that the arrangements and the guidance they put into place would be safe.

Q321 Dr Stoate: But they appeared to have gone it alone without the Home Office working with them. The conclusion of Lord Justice Maurice Kay at the Court of Appeal, and I quote, “. . . it is impossible to avoid the conclusion that the Department of Health decided to ‘go it alone’”. That was his view. Is that the case, did they go it alone and if so, how could that situation possibly have arisen?

Professor Heard: I cannot say. In the feedback I had, they indicated that there were discussions with the Home Office about this.

Q322 Dr Stoate: Obviously the judge did not believe that.

Professor Heard: I can only report it as I saw it.

Q323 Dr Stoate: As a supplementary really, is it true that the desire to limit applications from IMGs was actually opposed by other Government departments? Alan, do you have a view on that?

Professor Crockard: I have no idea what other Government departments -- we were not privy to those sort of discussions at any stage. However, it is fair to say that even if the Department of Health had decided to go it alone, as you put it, or as the judge put it, it was clear that the Postgraduate Deans had made up their minds that they were not going to necessarily follow the DH line on this, because some of the Deans had decided that they were going to let everybody apply, other Deans did not, so in fact, it was not as clear.

Q324 Dr Stoate: That is the point I am making. The point is we seem to have got into a terrible mess because the Department of Health thought we ought to limit the numbers; it appears the Home Office thought we ought not. Because they felt, I have to say, that that advice was unsafe, and indeed, that is what the final view was, it appears, of the courts. We would have been potentially in a much worse situation had the Deans not been very vigilant about this.

Q325 Dr Stoate: Should we not have sorted all this out beforehand?

Professor Heard: Of course, it was intended to be. I will recount a very brief discussion in which we were talking about international medical graduates, it was noted that permit-free training had been stopped, and Alan said, “What about HSMPs?” The response was, “Very few people go into training through use of the HSMP route”, and I responded and said, “Well, they do not have to, because there is permit-free training”. “It is a very small loophole which we will watch”. And three or four months later, there were many thousands of people who had applied, and having applied, we are where we are with that cohort, who are in, and therefore this year will be very difficult.

Q326 Ms Gidley: Professor Crockard, you say in your written evidence, “I am also uncertain how politicians and senior DH were on warning such as the red status awarded to the MTAS project by the gateway review team in August, I doubt they were also informed of the missed drop dead dates in December 2006.” Why were they not aware, and why were not senior officials and Ministers keeping a closer eye on them?

Professor Crockard: Or more correctly, why did I have my doubts, which is what I have said. Because firstly, I was surprised that there was nothing that politicians said once there was an obvious red status. We had a meeting very shortly afterwards with the SRO and other people, and I was assured, and we have a document, that that would be taken up to DH board level. However, when I went to see the Private Secretary or the Political Secretary of the Secretary of State, I was not sure that he was aware of the gravity of some of the things. MTAS was another one, MTAS and MPET. At that stage, before the huge release of money which came at the review process, there was a major problem with money as well, and there was the so-called unbundling of MPET where money was going to be given, and for the first time, it was not going to be protected for training. The potential hazards of that, which were very real, August through to December, I believe in the same way as we discovered the HSMP issue, we discovered the MPET issue. So it was those sort of things that made me wonder if it was going up the chain as far as it might or should.

Q327 Ms Gidley: You said you spoke to the SRO and other people. Did you at any time make the Chief Medical Officer aware of the extent of the problems?

Professor Crockard: I spoke on a very regular basis to the DCMO, but I had difficulty in getting it directly to the CMO.

Q328 Ms Gidley: Do you know whether the DCMO forwarded your concerns to the Chief Medical Officer?

Professor Crockard: I hope he did.

Q329 Ms Gidley: But you do not know. Professor Heard, did you raise any concerns with the Chief Medical Officer?

Professor Heard: No, I did not speak with the Chief Medical Officer for I do not think any of the time that I was the Clinical Advisor. Those sorts of communications would have gone through Alan.

Q330 Ms Gidley: Final question to both of you really: what faith do you have that some of the problems with MMC can actually be put right, given that most of the same people are in position?
**Professor Heard:** I think for 2008, we are likely to have an extremely difficult year again, and I think that is quite clear from everything that is coming from the Department. I think that local recruitment may help to manage some of that and smooth some of the difficult issues out for applicants, but I think it will be very difficult. I think there is now an understanding, however, that policies around international medical graduates in relation to UK EU graduates have to be sorted, one way or other, actually, and I think that needs to be brought into some sort of coherent approach. If we continue to have open availability to the entire world -- anyone, after all, can apply, under the current system -- then I think we will have some serious issues to deal with in the future. If we manage the process carefully, recognise our obligations to current HSMPs, but then using a migration policy which reflects our obligations to our own graduates, then we will have a chance in 2009 and beyond, I think, in managing this.

**Professor Crockard:** Just briefly to say that the other aspect of all of this, there will still have to be a very radical look at how we train the next generation. Just getting them into jobs is not the same as training. Giving everybody an extra lecture on a Friday afternoon is not training. We were talking about training programmes. My concern is that some of the stuff that we are getting is little top-up training that you might get applying for a local health authority evening class.

**Q331 Mr Scott:** Do you agree with the Tooke report that MTAS acted as a lightning conductor for problems with the MMC itself, or was the MMC a perfectly good system which was undermined by the failure of the selection process?

**Professor Heard:** I think that what has happened since January 2007 has been a conductor for raising the profile, importance and critical nature of postgraduate medical education in the UK. These sorts of very difficult events often have some positive outcomes, and one of them is that thankfully, postgraduate medical training is right up there on everybody’s agenda. It now has become core business, training the future generations, it has now become core business for the NHS, and I do not think I could have said that before. It is on every health authority’s agenda, it is on your agenda, and that is one of the positive benefits of this. That is what I think this has done for us.

**Q332 Mr Scott:** Professor Crockard?

**Professor Crockard:** Thank you. I do believe it is a lightning conductor, but it was bringing a whole lot of things, there were a lot of things that people were dissatisfied with, shall we say, but would have gone along with. However, the sum of them was such that there had to be a huge reaction. The things I believe that have survived, just to extend what Shelley has said, is for the very first time, we now have curricula for every speciality, and they are explicit curricula. That is a huge advance. I realise that some of the, shall we say, older freer spirits believe that nothing was as good as it was when they were young, and the apprenticeship training: at the end of the day, it is important that there are standards, and I believe the one thing that I hope will survive is standards.

**Q333 Mr Scott:** Are not MMC and MTAS both characterised by a top-down big bang approach to reform? Is not this overcentralised approach at the heart of the failure of both projects?

**Professor Crockard:** If I may take that -- and I will speak as an MMC person: the whole point about Foundation training was it may have been a central idea, but I and my colleagues went round absolutely everybody and made sure that everybody was aware of Foundation. The Foundation curriculum was developed by all the Colleges together, with us as the lightning conductor to bring it together. The Chief Medical Officer even proofread and gave advice on it. Everybody was involved at that stage. The worry with speciality training is that was not allowed to happen.

**Q334 Mr Naysmith:** Could I just ask Professor Heard a very quick question on this area? You said earlier on that the difference between this country and the States and Canada was there were standardised examinations, and there are not here. Is that not something that is really critical and important to sort out? It probably should have been thought about from the start.

**Professor Heard:** Yes, I think it has been really difficult. There was an educational meeting yesterday with people from the States, talking just about their USMLE and the fact that at the very least, even if it does not say you are going to be the greatest doctor in the world in the future, when you are looking at selection, there is a validity in using it, particularly for shortlisting, and therefore making the system manageable. I would be very surprised now if we do not see some sort of national examination being seriously considered and developed.

**Q335 Dr Taylor:** Forgive me if this is a question I should know the answer to, but you have said very clearly in your written evidence, Professor Crockard, “Never should a project have two SROs overseeing two parts of the same project.” What were the names of these two SROs? Should I know this?

**Professor Crockard:** I think it is fairly easily obtained.

**Dr Taylor:** Are you allowed to give it to us?

**Chairman:** We know.

**Dr Taylor:** We do know. Could somebody tell me?

**Chairman:** We will in a few minutes, but remember what I said a few minutes ago about timing. Could we progress, please?

**Q336 Dr Taylor:** The question is really very simple, that MTAS was an absolute disaster. Why did you not try and pull the plug on it, or did you not have the power to do that?

**Professor Crockard:** I did not have the power to do that. I suppose the other way of saying it is: why did I not go earlier? I suppose that might be the question.
I think that is a very powerful argument. Perhaps I should have gone in September. But we were part of something, we were reassured that the international medical graduates were going to be taken care of, we thought it was going to work, we were trying, we were genuinely trying.

**Professor Heard:** To be fair, the judicial review, which much of this was hanging on, did not report until after the application process had begun. The fact that the judicial review left things rather open, because appeal was allowed, meant that the action which was presumed was going to happen, which was that HSMPS would have to come in through a work permit arrangement, or after the resident labour market test, did not happen. So there is a bit of, had that happened: we live in hope, we think this is going to happen, let us keep doing what we can to make this work because there was so much at stake here.

**Q337 Dr Taylor:** Did you imply with an earlier answer that the system of not using CVs would never happen again?

**Professor Heard:** Personally, I do not think CVs are appropriate. I think application forms, which explore in a structured way the content of what we would have recognised as individualised CVs, is perfectly appropriate. That is just fairer. So my interpretation of using a CV is that you have a CV in which everyone answers the same questions, because otherwise, as sometimes happens on CVs, you just forget to say you have the MRCP, amazingly, but in a structured question, if you are asked what postgraduate examinations you have, you will not leave it out.

**Q338 Dr Taylor:** So you are not objecting to CVs, you are really objecting to the fact that they are not structured, so people do not say the same thing.

**Professor Heard:** Yes, exactly.

**Q339 Dr Taylor:** Obviously we have heard terrible distress stories of really good people who have not got jobs, not got selected. How do you respond to those stories?

**Professor Crockard:** Of course we are terribly upset that people have been so upset and so disturbed. What the whole process has done, like the lightning, is that it has brought into sharp relief – we feel that the whole review process prolonged this awful dilemma for the applicants. However, at the back of it all, there are still problems, not everybody will become a cardiologist or a plastic surgeon. In the old days, you got seven years to work it out. It is still going to be the same. There are still a lot of very, very good candidates who may not get their first choice, and somehow or other, in the ethos of medicine, of very, very bright people who apply, not everybody will end up with the job they think they should have.

**Dr Taylor:** I accept that.

**Chairman:** Could I thank both of you very much indeed for coming along and assisting us with this inquiry? I know it has probably been a very emotional journey over the last six months for both of you in relation to this issue, and I would like to thank you for your openness and frankness in front of us this morning. Thanks again.

**Witnesses:** Dr Jo Hilborne, Former chair, Junior Doctors Committee, British Medical Association, Dr Ian Wilson, BMA Consultants Committee and MMC Programme Board member, and Dr Ramesh Mehta, President, British Association of Physicians of Indian Origin, gave evidence.

**Q340 Chairman:** Good morning. Could I welcome you to what is our third session in relation to our inquiry into MMC. Could I, just for the record, ask you to introduce yourselves and the positions that you hold? Could I start with you?

**Dr Hilborne:** I am Dr Jo Hilborne, I am the immediate past chairman of the Junior Doctors Committee of the BMA. I was chairman from September 2005 to September 2007.

**Dr Wilson:** I am Dr Ian Wilson, I am a consultant in Yorkshire, and I am deputy chairman of the BMA Consultants Committee and a member of the current 2008 Programme Board for MMC.

**Dr Mehta:** I am Ramesh Mehta, a consultant paediatrician. I am also president of a voluntary organisation called British Association of Physicians of Indian Origin, and this organisation is basically concerned with promoting excellence amongst members. BAPIO is the short form.

**Q341 Chairman:** I think it should be BAPIO this morning. Welcome, thank you very much. I really have a question about this whole issue about the role of the medical profession, and this question is to all of you obviously: the Tooke Review has shown that the medical profession was closely involved with the development and implementation of MMC. Do you all agree with that? Who would like to start?

**Dr Hilborne:** I will start. I cannot speak for the Royal Colleges, I can speak for the role of the BMA and the JDC. We were involved in the original thinking about run-through training, in fact I believe our committee produced a report in 1999 which first proposed the unified training grade, and we were involved working with Professors Crockard and Heard through the development of MMC as it was going forward. I believe the Colleges also were involved, but we were not involved together, so we were not at meetings with them about run-through training and about Modernising Medical Careers. It has been JDC policy for a long while that run-through training is a good thing, but the run-through training that we envisaged was not the same as what turned out in the end to come out of Modernising Medical Careers. There were some key elements that got lost along the way from what we had proposed, and what Unfinished Business had proposed much earlier on in the process, elements like really good robust careers guidance, so that...
Dr Hilborne: We were involved. Myself and my implementation that the profession was engaged in. We look at some of these questions in a bit more detail. I just wanted to know about run-through training, we were never thinking that from our point of view, as JDC thinking in involvement, is it not? I think I want to point out as the issue of development?

Dr Wilson: Thank you, yes. I think I would take it down into a more specialised area, as both you got to know what you liked and were good at, and as it became apparent how many opportunities were available in different specialities. So run-through training, yes, is something that the JDC has supported, it has been our policy for a long time, but run-through training as it has finally arrived in MMC 2007 is not what we had originally envisaged.

Dr Mehta: I think it is a very important question that you raised. I have a role in the Royal College of Paediatrics and I have to say that the college was involved. However, volunteer organisations like ours were not involved, and I think it was a very important omission, and perhaps eventually it would be realised that the wider consultations were not carried out, which is one of the reasons for the failure of the system. We were not consulted as an organisation.

Chairman: Would it be unfair to say that the profession were involved in implementation beside the issue of development?

Dr Hilborne: Again, it is about how you define involvement, is it not? I think I want to point out as well that from our point of view, as JDC thinking about run-through training, we were never thinking of it as a way of aligning workforce particularly.

Chairman: We will look at some of these questions in a bit more detail. I just wanted to know in general terms about the development and implementation that the profession was engaged in.

Dr Hilborne: We were involved. Myself and my deputy chairman came to meetings regularly with Professors Heard and Crockard about MMC, so to that extent we were involved. We did not feel always that we were being heeded, and that the points we made were being taken on board. So involved, yes, we were at the table; involved as in being heard and responded to and our concerns acted on, less so, I would say.

Chairman: Ramesh, do you have a view on that? I know you come in front of us from a different position than this. Do you have a view from your perspective on that?

Dr Mehta: I think it is a very important question that you raised. I have a role in the Royal College of Paediatrics and I have to say that the college was involved. However, volunteer organisations like ours were not involved, and I think it was a very important omission, and perhaps eventually it would be realised that the wider consultations were not carried out, which is one of the reasons for the failure of the system. We were not consulted as an organisation.

Chairman: Right. Do you think that the involvement that the profession had, and they had some responsibility in what has been pretty much a disaster in terms of the outcome of this year, do you think that the profession should accept blame or responsibility for this disaster?

Dr Wilson: I do not think anybody has covered themselves in glory in all of this. The fact that the profession allowed what has happened to happen is something that needs to be looked at again.

Chairman: Certain John Tooke's recommendations are very clear on that, he throws down a challenge to the profession that is one we will certainly pick up and work with him on, and work with our colleagues in the Colleges and elsewhere. To say whether, if I can put it from the BMA perspective, the BMA were responsible in some way, that is a much more complex question, when we had been demanding reforms in training for a considerable period of time, so to that end, it is kind of: be careful what you wish for, you might actually get it. But at the time when implementation started, and this is kind of rehearsed a lot in Sir John's report, we moved so far from the original principles that everybody had signed up to something that became almost entirely based on workforce planning, and very little to do with quality of training and education. Professor Heard's comment about having education well up there and an important part of people's agendas, I think it is now part of people's agendas, but I think it is so seriously subjugated by the catastrophe of the total absence of workforce planning that I am not sure that we can settle and say no, we have had a positive outcome that it is on people's agendas. So yes, the profession must acknowledge that things need to be done differently, things need to be thought about differently, our approach needs to be different, but no, I do not think it is entirely responsible in that the process so carefully and possibly in a calculated way removed the ability of the profession to do much about the problems that it persistently raised and persistently brought up. If I might finish by saying I am very clearly recalling a call at the Joint Medical Consultative Council to call for a delay to explain why a delay was necessary, and being told this was typical BMA shroud waving.

Dr Naysmith: When this was deviating and it was going away from what you say were the basic principles you were signed up to, should not the
medical profession—and I do not just mean the BMA—have said, “No, we have to stop it here” and walk away from it?

**Dr Wilson:** The calls were fairly constant on that one. I have just highlighted my own personal rather unpleasant experience in that one, but Jo is probably better placed because she knows much more of the detail of what actually happened and what was said to whom.

**Q347 Dr Naysmith:** I was just picking up what you said; you were saying that it went wrong and that you more or less stayed in there.

**Dr Wilson:** At that stage we were saying, “Enough, we have to stop; we have to stop.” There were a great many letters, including letters to the Secretary of State, which was why I was suggesting to call Jo in, but there is only so long you can keep calling repeatedly for something that seems, forgive me, blindingly obvious, and eventually if people are not listening to you, and in fact actively exclude you from conversations because you are raising concerns—

**Q348 Dr Naysmith:** There were senior representatives of colleges and paediatricians, as you have just mentioned—they should have walked away and they should have said, “We want no more to do with it.”

**Dr Wilson:** That is an interesting viewpoint and I think it is probably one we might have shared at various times throughout what has happened over the last couple of years.

**Q349 Chairman:** Jo, did you want to respond to that?

**Dr Hilborne:** It is very difficult when you are involved in a process that you have been involved with for a long period of time and it is often harder when you are in the middle of it to realise when you have got to the point of no return, where it has changed because when it is a gradual process, to pick the point of that gradual process where you have got to the point where it is too different is very hard. I think as individual bodies, the separate colleges and the BMA, certainly the position the BMA took was that in order to do the best for our members it was better for us to be engaged and trying to improve things than to just throw up our hands and walk away and say, “It is all crap and we do not want anything more to do with it”.

**Q350 Chairman:** We hear all the time in terms of the future of the Managed Health Care System and the future of the National Health Care System, that it should be clinically led and Ara Darzi and many others are going around the country engaging with you all the time on that. Does this not suggest that probably if there had not been this type of engagement and if they had concentrated more on project management we would not have had the disaster that we had earlier this year.

**Dr Mehta:** I think that is the MTAS/MMC divide, is it not because I think in terms of MTAS, the actual technical system, there was a massive failure of project management in that things that were meant to be ready were not ready on time; elements that were meant to be built in were not built in, it was not properly tested, there was not a back-up system. That is the project management side of it. But in terms of what it was looking for, which was recruitment into specialities, which instead of having a few broad-based entry points had something like 13, some of which were very focused. Urology, you cannot get more specialised than urology and having to choose to do urology when you have done one and a half years out of medical school, which may never have included any urology, it is not what run-through training was supposed to have been about. So that is the policy side of things that was also not going right, if you see what I mean?

**Q351 Sandra Gidley:** A question to all of you really. The MTAS crisis led to the formation of new groups to represent the medical profession, such as Remedy UK and Fidelio. Would it be fair to say that these highly critical groups are now more representative of the profession than the BMA?

**Dr Wilson:** No! Clearly you would expect me to say that, would you not? We welcome pressure groups; we welcome single issue pressure groups because it allows you, as I think Jo was explaining, to do things that you cannot necessarily do as the representative organisation when you are within the body of the Kirk trying to sort things out. We have examples of when the BMA did up its criticism rate we were actively excluded from key parts of the process, including being actively excluded from the writing of the Gold Guide to Training, as a direct consequence of raising concerns about the process, which is pretty poor. We have worked extremely closely with other organisations to build up the campaigning side of the world, which has always been useful. I do not see a conflict. In terms of representativeness, there is a debate one could always have there about who has what members, who does what for whom, but the association is a very, very broad organisation covering a great many aspects of medicine and trade union work and has a very robust democratic structure.

**Q352 Sandra Gidley:** So has your membership gone up or down since?

**Dr Wilson:** Our membership is actually pretty static. I stand corrected but I believe it is actually higher than it was when the MMC/MMAS process started.

**Q353 Sandra Gidley:** Would either of the other two of you like to comment on the initial question?

**Dr Mehta:** Could I say that, yes, BMA remains a very important organisation, it is a trade union, but the success of Remedy UK is something to be taken note of and it shows that a large number of junior doctors actually revolted to join this organisation, and I think that Remedy UK has done a very good job of it. But, at the same time, yes, BMA continues to have a role and should have a role.
Q354 Sandra Gidley: Dr Hilborne, you said that when you are in the middle of something it is sometimes hard to see when you should withdraw. With the benefit of hindsight do you regret that the BMA were not more critical throughout the process, particularly MTAS?

Dr Hilborne: I do not regret the JDC’s actions in this; I think we did everything that we could do to draw attention to the fact that there were major, major problems. In our meetings with the MMC team we tried very hard to engage constructively and when we found things that we were not happy with to suggest a way forward, and very often the answer was, “That would be great, but we do not have time.” As a result of a number of those meetings our conference called for delay in June and in the August or September, I cannot remember which, we published our very detailed case for delay, which was basically all the things we wanted to do to make it work properly, that we were told there was not time for. We published that very broadly; we sought support from the Medical Royal Colleges, from the Joint Consultants’ Committee and the only body that supported us in that call was the Trainees’ Committee of the Academy, which then very publicly withdrew their support in October last year. We launched a campaign called “Train not Drain” when the numbers of posts that were going to be available were announced; we had organised mess meetings throughout the UK. We had a power point presentation that was drafted centrally and was presented to junior doctors in mess meetings throughout the UK, explaining our concerns. We had a letter writing campaign to MPs and I am sure that many of you will have received letters from constituents at that time expressing their concerns. I think as a Committee we did everything we possibly could. I think sometimes we did not get the support, from which perhaps we would have benefited, from the higher echelons of the BMA and, as you know, James Johnson resigned earlier this year over issues around MMC and MTAS, and I suspect if he had been more proactive in supporting us we may have seen more movement. But I do not see that we could have done anything differently; and I really do not see that us as the JDC disengaging from the process would have made any difference, except that when it did all go horribly wrong there would have been no doctor representatives there to lobby for and work for improvements in that rescue group, in the Douglas Review Group, which again we had to fight very hard to get involved with. The Colleges really were not keen to have the BMA involved in that group at all, the Douglas Review Group. We fought very hard to get in there against the opinion of many people who thought we ought not to because they thought that by engaging we were selling them out; but we did achieve significant improvements in what was an awful situation. It was a terrible time; it was a terrible situation for those doctors caught up in the middle of it.

Q355 Sandra Gidley: Why did the Colleges think that you should not be there?

Dr Hilborne: You can ask them obviously, but I think it was because they believed that this was an education and training matter and that is their remit. But we fought really hard; we did get concessions; we were criticised for being in that group, but I do believe if we had not been there we would not have got some of the things that we did get in terms of the ability to re-preference an interview, an extra interview for everybody in their first choice post. We got an extended round two; we got an employment promise while that extended round two was going on, and we got over 1000 extra posts for people who were still unemployed after round two, to keep them in employment until next year’s process. If we had not been there, if we had just said, “This is terrible, we cannot possibly engage because it is awful,” I do not think as much of that would have been achieved, and we would have let our members down worse by not getting involved.

Dr Wilson: Expertise resides in a huge number of places; it does not necessarily reside in only one body or one organisation, which is why it is so important that organisations communicate and work with each other, and I spend a great deal of time at the BMA with another hat on working on processes to improve the way that the profession talks to each other and works with each other. One has to remember, though, when asking questions like why did the Colleges think this or why did they think that, that the Colleges are actually educational charities that are set up to improve education, they are not representative organisations—they never have been and under their current charters they never will be, they are charities for educational purposes. Remedy UK was set up with a specific purpose in mind—it may have morphed into something rather different but it was set up with a specific purpose in mind and worked extremely closely with the BMA to achieve those goals. It was a symbiotic relationship where there were benefits and losses from both parties in that relationship. You have hinted at the question about membership earlier on and, yes, the BMA did and does have people who have resigned membership over that—there is no point in pretending otherwise. But if you think about it in a slightly different way, that was a symptom of the desperate frustration that members of the profession felt by what was happening, the absence of communication, the absence of engagement, the absence of any genuine involvement, and the bottom line too is where else can you resign from?

Q356 Sandra Gidley: So who is actually to blame for that absence of communication?

Dr Wilson: That is a very important question. If you are feeling that frustrated where else can you vent your frustrations other than the march that Remedy organised on that one occasion with the BMA, or indeed resigning your membership from somewhere. You cannot resign from the GMC then because you are no longer a doctor; you cannot resign from your Colleges because that has no standing and it is not possible then to career progress. There is only one place left to vent your spleen and unfortunately the
spleen was often vented at the organisation that was actually doing the most to help junior doctors. In terms of the communication—you may well move on to what is happening in 2008—but the difficulties with getting clear messages out from the process are well documented and well expressed. It was impossible to persuade the Department of Health to tell trainees and to tell trainers exactly what was going on, what the numbers were, when they were happening; what the process was going to be.

Q357 Sandra Gidley: You say the Department of Health. Are you able to say more specifically? The Department of Health is a big organisation, are you able to say more specifically who was not listening?
Dr Wilson: Would it be fair to ask to bring in Jo on that because Jo was actually in the room—I came subsequently?
Dr Hilborne: Nobody was listening as far as I could tell! In terms of communications in particular I think the trap that the BMA fell into last year, certainly once things had started going wrong, was that we felt that the Department of Health, the MMC team, the workforce team, whoever, trainees were not being told what was happening and so we tried to step into it and tell people what was happening, and because these communications were coming to them in mass emails from the BMA we became associated with them as if it was our idea. Do you see what I mean?

Q358 Sandra Gidley: Yes.
Dr Hilborne: I know that this year on the programming board, Ian and his colleagues from the BMA are working quite hard to make sure that these messages come out with the DH badge on them because doctors need to know them, but when we tell them it is our fault. In terms of communications and whose fault it was at the DH, the trouble is that there was no clear responsible person. You have heard already from Sir Liam Donaldson that there was no person in overall charge. I take that to be a significant failure of his because I believe that as the Chief Medical Officer it is his job to make sure that there is somebody in charge of a process as important as this, and if he has not done that then it is his responsibility. Even the MMC team—you have heard already from Professors Heard and Crockard—were they negotiating with the other people on the MMC team, were they responsible? The lines of communication were so vague and it was so difficult to know where responsibility rested that I cannot tell you who should have been communicating, except to say that this is a Department of Health initiative, absolutely led and implemented by them, and therefore they as a department should take responsibility for telling doctors what is happening.

Q359 Sandra Gidley: Very quickly to finish, you have hinted at the way you communicated that might change; how are you going to re-establish the trust of the medical profession, some of which has been lost?

Dr Wilson: Being on the board now we are trying to get communications regular and thorough, open and honest. That last word is probably the most important word at the moment—honesty in what expectations should be. We have established a communication from the Department of Health, very recently signed off by the Chairman of the programme board, as a first stop to telling people what the numbers are. We regularly as an association after every meeting post our reports of the board widely; we have established communication with other groups like Doctors.Net.UK, the online web forum, and have a regular and lively debate through that, and we regularly liaise with Remedy, who have their own lines of communication. The important thing is regular, accurate and honest.

Chairman: Did you want to add anything to that Ramesh?
Dr Mehta: Yes. I just wanted to say that we feel that the BMA was in a position to exert an influence which they did not do as well as they could have. To be fair to JDC, I have to say that JDC tried their best; we know that they were trying to work very hard. But the BMA leadership had unfortunately to change course and they did not use their influence as well as they should have. As Jo said, eventually the resignation of the Chairman amplifies the fact that things were not done as they should have been.

Dr Stoate: I want to put on the record at this stage that I am a member of the BMA and a Fellow of the Royal College of GPs, just in case there is any confusion. The BMA seem to be painting themselves a nice picture of, “Nothing to do with me guv!” but one of the reasons that we are in this mess is because of the very large, unexpected number of non-EU medical graduates who have applied for posts, and that has certainly caused a huge pressure on the system. Yet, despite the fact that the Department of Health has made several attempts, unsuccessfully, to limit the number of non-EU graduates applying for jobs the BMA has opposed that position; why is that?
Dr Hilborne: I do not think it is fair to say that high numbers of non-EU overseas applicants is anything more than a very small part of the whole problem that is MMC and MTAS.

Dr Stoate: Really? 12,000 more graduates than were expected have not caused any problems?
Dr Hilborne: It did cause problems. That is the problem about the numbers—the numbers of posts compared to the numbers of applicants. That is not in any way to do with all the problems that have precipitated this crisis: the problems with the short-listing, the criteria and the questions, the inability of short-listing to pick out good quality candidates.

Dr Stoate: We know all about that.
Dr Hilborne: All of that stuff. So I just want to make it clear that although this is an issue it is not by any means the only issue or even the most important issue about the whole thing that went wrong with
MTAS. Now to come to the numbers; the Home Office changed the visa rules in March 2006 absolutely completely out of the blue as far as we were concerned, and we have already heard that that was an attempt to ensure that UK graduates got first go, going through the application process through MMC—

Q364 Dr Stoate: But that was the intention of the system at the beginning. That all went wrong.
Dr Hilborne: That went wrong.

Q365 Dr Stoate: The Department of Health tried to put that right and you opposed them. I still do not understand why you are opposing the Department’s attempt to put that right.
Dr Hilborne: We opposed them because what they were trying to do, they were trying to change the rules not only to prevent new doctors from coming into the UK who had not previously worked here, but also for those doctors who had already come to the UK in good faith, who had been enticed here by campaigns abroad saying, “Come and work in the UK, it is fabulous; we really want you,” either expecting to be able to continue their training on a permit-free basis and then go back home when they had completed their training, or who had come here on the HSMP, expecting to be able to stay and settle because HSMP is very definitely explicitly a route to settlement. By allowing people on to HSMP you are saying, “We want you to come and live in our country for the rest of your life with your family and work here and be part of our community.”

Q366 Dr Stoate: But HSMP is only a relatively small part of the numbers. The point I am making is that the Department of Health, in good faith, increased the number of medical undergraduate posts in this country with a view to Britain becoming self-sufficient in medical graduates in the fullness of time. That went wrong and we all know the reasons why it went wrong, but what I do not understand is why you have opposed the government’s attempt, the Department’s attempt to put that right?
Dr Hilborne: Because it was wholly wrong, immoral, unethical and unfair to entice doctors here on a promise, make them spend a fortune getting here, sitting the required exams, uproot their families and then when they have been here for six months, a year, two years, say, “Actually we have changed our minds, we do not want you; go away again.” It is a wholly unethical and immoral position to take, which we could not in any way support.

Q367 Dr Stoate: I am disagreeing with your position. I am just asking for your position. What I want to know then is do you feel any responsibility for the disadvantages that UK graduates may undertake this year and next year because of that decision?
Dr Hilborne: No, I do not because the whole issue about workforce planning, about numbers is something we have been raising—even with yourselves, and I believe I wrote to you as a Committee last summer, and in the past we have raised it as well—issues to do with workforce planning, the failure of this government over a long while now to actually grasp the issue of medical workforce planning, to look at very objectively the numbers in, the numbers out, who you need and what you need them for. You have already alluded to the increase in medical school places. Surely at that time when you are deciding, when the government is deciding to increase the number of medical students in order to be self-sufficient in doctors, would that not have been, “By the way, we need to think about what to do about all the overseas doctors?” Surely if you are going to think about it you do it then. The fact that this all happened in a big rush at the end, all of a sudden, “Oh, dear! We are so far down this process, we have all these overseas doctors, how are we going to manage it?” I know, we will just shut the door now and we will kick out the ones who are already here.” It is not our fault. We have consistently said that workforce planning is a disaster and you need to sort it out and it is not our fault that the government failed to close the door soon enough and then tried retrospectively to kick out people they had already invited in.

Q368 Dr Stoate: I am not blaming the BMA for that—
Dr Hilborne: You said did we feel responsible.
Dr Stoate: I am simply saying that you have done your best to block the attempts of the government trying to block that right, and that is the point I am trying to get to. I just did not quite understand why you were trying to block what the government was trying to put right. I have the picture clearly now, so that is fair enough.

Q369 Dr Naysmith: Can I just ask has the BMA ever opposed the expansion of medical school places in the past six or seven years?
Dr Hilborne: No, I think it has been our policy.
Dr Wilson: The BMA originally called for an appropriate, balanced and planned expansion in medical student numbers accompanied—

Q370 Dr Naysmith: It is inevitable that there are going to be a lot more UK graduates.
Dr Wilson: Forgive me, accompanied by a reform of training and accompanied by a careful and planned expansion in consultant numbers. We come back to the regular statements from the Department of Health that we have more trainees than we need fully qualified doctors. This is not true; we have more trainees than we are prepared to pay for as fully qualified doctors—they are very different things.
Dr Naysmith: Thank you for clarifying that.

Q371 Chairman: Jo, do you see the moral and ethical argument that you put there—and I understand it very well—do you see a difference between somebody who is actually working in this country now and looking to staying here, as opposed to having a policy where people can still come in when we have this position that we have?
**Dr Hilborne:** I think there is a difference between a doctor who has already established themselves, spent the money, brought their family on an expectation, and as long as it is absolutely clear what the position is I have no problem with doctors from anywhere in the world applying to work in the UK. But I think what is really important is that they understand the strictures and the environment, and I think it is reasonable to have different rules for doctors from different places. We are stuck with the European legislation.

**Q375 Dr Stoate:** A question on the same area. Remedy UK have told us that all parties, including BAPIO—and I would also like to know what the BMA feels—feel that there would have to be much tighter restrictions in future on the number of IMGs coming in. Is that a fair position that you are all agreed to?

**Dr Wilson:** The short answer is yes; the slightly longer answer is that there need to be all sorts of plans and restrictions put at all levels, not just at that level. It is unreasonable to focus just on that one. We need some workforce planning.

**Q376 Dr Stoate:** You are saying that we do need some restrictions. So my next question obviously is what is the best way to manage this situation so that we do not get into this mess again?

**Dr Wilson:** I earlier said that expertise comes from all sorts of places and I am fairly certain that our expertise is not in the field of immigration.

**Q377 Dr Stoate:** I am not talking about immigration; I am talking about whether we should have some restrictions on medical graduates. Should there be some entry criteria beyond the ordinary immigration criteria—this is a bit wider than that? Are there ways that we could, for example, limit the number of IMGs coming in? Or should we just do it purely on visas?

**Dr Wilson:** I think we are still straying into territory in which I have no expertise, I am afraid.

**Q378 Dr Stoate:** Fair enough. Ramesh, do you have any views on that?

**Dr Mehta:** We have had discussions with Remedy UK. We cannot really continue in this mess for any longer. If we do not want to be in the mess there has to be some sort of regulation of overseas doctors coming into the country—there has to be some sort of regulation. However, we also need to think of globalisation; the world is changing very fast, the movement of professionals throughout the world is huge. We must think of mediocrity. Professor Tooke mentioned excellence; excellence will come from competition. We as an organisation believe that our home grown graduates are trained extremely well and there is absolutely no reason why they should fear any competition. However, coming back to the question of regulation, of entry of overseas doctors, which should include EU doctors as well—why not? Indian doctors have been the backbone of the National Health Service since its inception and suddenly out of the blue you are saying, “Pack up and go.” This is like saying to somebody who is on the flight to New York, half way through, “Get down.” This is absolutely wrong. There has to be proper workforce planning, there has to be some regulation for the entry of these graduates. We know that British graduates are not very keen to enter in certain specialities; for example, in O&G the application was only 0.5 for each post of the graduates. In certain areas of the country—Wales or in some other regions—some people do not want to go and IMGs are quite happy to work in...
these areas because they want to train in Britain. We need to consider all these aspects. So there are several aspects, and that is why it is so important that the government must consult organisations like ours to understand what is going on and how things could be improved.

Q379 Dr Stote: I entirely agree with you, you are absolutely right that the NHS would never have succeeded at all if it had not been for the huge number of Indian graduates that came in in the 1950s and 1960s, so you are absolutely right. It is just the matter of how we manage the future; that is the difficult bit.

Dr Hilborne: I think it is really important that we do continue to have overseas doctors coming to work in the UK. I think that those links are very beneficial; I think the professional relationships that ensue from them are very important. In terms of how you manage that, first of all you have to know your numbers; you absolutely have to know how many posts you have and how many doctors you have applying because you cannot do anything unless you know your numbers, and that has been a major failing in recent years. I agree with Ramesh, I think it is very appropriate that it should be possible for overseas doctors to compete to come into the UK, and whatever criteria you set for entry to work in the UK as a doctor should then be accessible to anyone who choose to compete for that on merit.

Q380 Chairman: How does that square with EEA doctors, who have the right beyond what the government is able to do as a government to restrict when they have rights of freedom to come in from the European Commission. It is a very complicated picture, is it not?

Dr Hilborne: It is and my understanding is that there is absolutely nothing any of us can do about EEA doctors; that it is an issue about European law and it is a situation we are stuck with. They do have the rights to compete on an equal basis with UK graduates and that is just the way it is. Anything you think you might want to do to make it harder for Polish doctors to get jobs in the UK would instantly be unlawfully discriminatory. So it is just where you are, I think.

Q381 Stephen Hesford: For the BMA what proportion of your membership is IMG?

Dr Hilborne: I have no idea but we could get that information for you.

Dr Mehta: I think it is 40% as far as I understand it.

Q382 Chairman: I would be surprised if it is not that type of figure.

Dr Wilson: It is significant; it is not a small number.

Q383 Chairman: Ramesh, your members; did the majority of your members graduate in the UK or in India, and do most expect to stay in the UK permanently after completing training?

Dr Mehta: Most of our members at the moment are graduated in the Indian Subcontinent. We as an organisation say we are British, basically—we are a British organisation of Indian origin. At the moment 40% of medical students are of Indian origin; they are born and brought up in this country; they are our next generation, which includes my daughter as well. So the reason we said our organisation exists is not only to promote clinical excellence, but also to support these doctors regarding their cultural background. At the moment, yes, the majority of our doctors are trained overseas.

Q384 Chairman: What would be the likely difference in cost to an Indian medical graduate doing postgraduate training in the UK rather than in India?

Dr Mehta: I think it is not right to compare cost in that way because the cost of living here is not the same as the cost of living, for example, in India. I think the perception should be that it is extremely expensive; for a doctor to be trained is hugely expensive, whether it is in India or here. In my submission I have given some figures but I cannot otherwise answer an exact figure in Indian rupees, for example.

Q385 Chairman: Has there been some sort of agreement, transparent or not, between Commonwealth countries like yourselves in terms of having an expectancy of the numbers of doctors coming into the UK for training? Has there been any sort of agreement between government departments and the countries that you know of as being just understood for many years?

Dr Mehta: Thank you for bringing up the Commonwealth. I am sorry; I am digressing a little bit.

Q386 Chairman: No, I am specifically asking about whether there has been anything that is a Commonwealth issue between our countries that meant that we have had 40% of your members at the BMA—I am surprised it is as small as that, quite frankly.

Dr Mehta: The Commonwealth has been connected with the National Health Service since its inception. The EU is connected with the National Health Service very recently. To answer your question, I am not aware of any understanding between the Commonwealth and the UK, but I would like to make a point that it does not make sense that EU graduates can come and work in the UK, without any problem, while they are not really the most suitable doctors to work in the UK, for various reasons including the language, which we know. The Indian medical system was started in the days of Raj, and it is similar to the British system. The language is not a problem and we know that people who come here are bright, the cream of the doctors, who want to get medical training. So whether there is an understanding between the Commonwealth and the UK or not the differentiation between the EU and the Commonwealth is not right for this country.

Chairman: Thank you for a very challenging view. I will move on to Stephen now.
Q387 Stephen Hesford: This question is to Jo. I know you touched upon this earlier on and can I apologise for not being in quite at the beginning of this part of the session. Why did the BMA Junior Doctors Committee support the creation of a run-through training grade? Did you prioritise job security for your members over the flexibility of the new training system?

Dr Hilborne: It has been our policy for at least eight years to support a unified training grade and the basis for this within our policy was always based on a very broad-based entry system. In our policy we have three streams of entry and it starts with very general professional training that gradually focuses you down on to a speciality, so that flexibility to change speciality as you develop and your interests develop and your skills develop was built into the system. Within our policy there is also the requirement for very robust, early and continuing careers guidance, so that the doctors have the abilities, have the skills and the training to make the right choices for their own nature and skills in terms of the speciality they choose. So it has always been our policy to support run-through training from 1999 onwards. Never in any way as a protectionist thing but because we believed this was an appropriate way to train doctors, to give them more job security early on rather than the old system where you changed jobs every six months or a year and never quite knew where your next job was coming from, certainly for the first few years. But also within that security of knowing you were going to be employed to an end point of ability to apply for a consultant job, to still have the information you need to make choices and the flexibility to be able to make those choices as you go through your training. I believe you are referring to something that was said in the Remedy UK evidence session, where I have read some of what they have said, and they talk about protectionism and they talk about us supporting run-through training, and ignoring the fact that for every doctor who got run-through there would be another doctor who did not. I think they were referring specifically to the numbers issues on this particular year with this particular process task where you could pick bits off. In particular Jo has talked about competition at higher entry points and multiple entry points within the original envisaged model of run-through training and how that would be highly flexible. Other parts to that were the vital importance of building in transferability of skills and the absolute importance of having robust assessment that could also manage poorly performing trainees sideways or indeed out. Those were key parts of what the BMA called for, so supporting what Jo said about protectionism. The difficulty was, as I was saying, that not all of that was built into what run-through training became. Jo has more detail and better detail than I on that one.

Q388 Dr Naysmith: Following that up—and probably these questions have really been answered but we will ask them again just to get them on the record—you called on a number of occasions for the implementation of speciality training to be delayed by a year. Why? What was it that made you drop your opposition to implementation in 2007?

Dr Wilson: The point leads on from what Jo was saying before, that the concept of run-through training and other parts of the original genesis of MMC goes back way into the dark ages. As I was saying earlier, it was a package not a shopping list where you could pick bits off. In particular Jo has talked about competition at higher entry points and multiple entry points within the original envisaged model of run-through training and how that would be highly flexible. Other parts to that were the vital importance of building in transferability of skills and the absolute importance of having robust assessment that could also manage poorly performing trainees sideways or indeed out. Those were key parts of what the BMA called for, so supporting what Jo said about protectionism. The difficulty was, as I was saying, that not all of that was built into what run-through training became. Jo has more detail and better detail than I on that one.

Q389 Dr Naysmith: Is he right about that?

Dr Hilborne: Yes, absolutely. You were asking about the call for delay and why we stopped. Let me tell you what happened. We have always had policy—it is still our policy that MTAS 2007 should have been delayed by a year because it was not going to work. Every meeting we went to we said, “Of course, if you delay this then these issues which we are raising will be able to be dealt with in time.” On 12 January the adverts for the run-through training posts appeared in the press and we decided at that point that we would no longer publicly continue to say that it should be delayed because we thought that we would look stupid. We felt that was the point at which we could put our finger down and say, “This is the day on which we know you have now formally ignored our call for delay.” So we did not continue to say, “Of course you should delay it” because we would just look stupid because they had already advertised and of course they are not going to delay. On 26 February when it became clear that the short listing process first of all had been extremely flawed in terms of the process in that consultants had 600 sets of CVs two days before the process was due to close, but the—

Q390 Dr Naysmith: You must have known that was going to happen.
Dr Hilborne: We did not. There was a fortnight for the short listing to happen. Through that fortnight we were getting reports coming in all the time about this problem, that problem and the other problem. On the 26th in the morning all applicants were meant to have been told what interviews they were being offered, and on the 26th it became plain that loads of doctors had not heard, and on the 26th I wrote to the Secretary of State again calling for her to suspend the process, not to start the interviews because it had not worked, and to suspend it until either it could be demonstrated that short listing had been done properly or until a different system could be put into place. So I do not think we ever stopped calling for a delay, apart from that one short period after the ads had gone in when we just thought it would look stupid.

Q391 Dr Naysmith: Would it be fair to say that you made the best of a bad job and it turned out to be even worse than you thought it was going to be?

Dr Hilborne: I do not know whether “made the best of a bad job” is completely fair. What else could we have done? I think we did everything we could and it turned out to be worse than we thought it was going to be.

Q392 Dr Naysmith: Something else that you mentioned a little while ago was about the numbers, you thought the numbers were going to be not too bad but that was because you were focused on the wrong part of the system, is it not? You were focused on the fact that there would be too few training posts created, when in fact it was an excess of applicants that was the real problem, and you were focused on the other end.

Dr Hilborne: I think it was a combination, to be honest. The original announcement of posts in—I cannot remember when it was, but a couple of months prior—had been 9,500 entry points in MTAS and that obviously would be wholly inadequate. I remember being on Radio 4 on the Today programme and being told by Lord Warner to stop panicking because it was all going to be fine, which just goes to show, does it not, how wrong you can be?

Q393 Dr Naysmith: I think you were both wrong, Lord Warner and the BMA.

Dr Hilborne: I guess. We do not have a crystal ball; we do not know what is going to happen. We thought the match between posts and applicants was going to be closer than in the end it was. The trouble is whenever we ask anyone for numbers in government they cannot tell us. How many doctors are employed in the NHS? Try that one; you will not get a right answer. How many SHOs are employed in the NHS? Last year nobody knew that; that data is not collected. How many Trust grade and non-standard grades are employed in the NHS?

Q394 Dr Naysmith: I think some of that is available but it may not have been available to you.

Dr Hilborne: No, they do not collect SHOs; they collect people working at SHO level but that includes Trust grades and non-standard grades. They cannot tell you exactly how many of those are in training posts. So as numbers are very difficult to get hold of it is very difficult to know whether the numbers you are being given (a) are right and (b) are adequate.

Q395 Sandra Gidley: Another question to you, Jo. We were told by officials at an earlier session that the JDC had actually insisted that each candidate should be allowed four applications, even though it was pointed out to the union this would mean that a significant proportion of doctors would not secure an interview. Is that a correct statement of the position?

Dr Hilborne: It is a correct statement but it is rather economical with the reasoning and I will explain the reasoning to you. Originally the proposal was that doctors would be allowed to apply to one job; so one process a year, one job, and if you did not get that job you would go into some kind of clearing process and you would just get anything. We did not believe that that would be acceptable to junior doctors and we negotiated hard to increase the number of jobs that a doctor could apply for through this process to four.

Q396 Sandra Gidley: Why four, having been told that that would mean a lot would not get an interview and that would obviously put quite a lot of stress on a junior doctor if you think you have had your chance?

Dr Hilborne: The only reason you will not get an interview with four choices is if fewer than four people are shortlisted per available place, so to some extent that decision is in the hands of the Dean. If they choose to interview five per post then everyone will almost certainly get an interview. If you are only interviewing two per post and people can make four choices then strong candidates who get four interviews are balanced by weaker candidates who do not get any. However, this would not have been a major problem had things worked as they should have done because the original plan was that round one would happen and that doctors would be appointed through round one; then a round two would happen, which would be a very similar process and the doctors who had not been appointed in round one would have an opportunity to look at the posts that had not been filled in round one, make a new application with a new form to four new jobs out of the ones that were left, and after that process there would be a clearing to mop up what was hoped to be very few people who were left. All of that was meant to have been completed in good time for everything to be ready for 1 August start. So if the process had worked as it should having four interviews may have meant that fewer doctors got interviews in round one but it would have meant that all doctors felt they had a better opportunity to apply for jobs they wanted and not restricted.
Q397 Sandra Gidley: But that was not really communicated very well to the doctors, was it, because it was after round one that MPs were flooded with emails from doctors who had been unsuccessful. Dr Hilborne: Now we are in the difference between what should have happened and what did happen. What I have described is what should have happened; what did happen is some doctors did not get any interviews, but also because of the failing of the short listing process to accurately pick out the doctors what happened was that really strong candidates were not offered interviews.

Q398 Sandra Gidley: That is unfair to blame the Deans—
Dr Hilborne: I am not blaming the Deans; I am blaming the questions and the process.

Q399 Sandra Gidley: But you blamed the short listing process for being unfair. Surely you were part of deciding on the nature of that short listing process, or not? Dr Hilborne: No. The JDC and the BMA had absolutely no input into the design of the application form on which the short listing was based. We were very specifically excluded from the group that was doing that work because they felt that having junior doctor representatives involved in that group might mean that those individuals would be unfairly advantaged or that some doctors, maybe JDC members, might be unfairly advantaged in the application process. So we had absolutely nothing to do with the design of the questions and we were not privy even to the domains that were being questioned about until the form was available online as it was for everybody else.

Q400 Sandra Gidley: So do you accept that having four applications per candidate was a mistake? Dr Hilborne: No, I do not, and I think if you tried to introduce that system with fewer than four, junior doctors on the ground applying—they were distressed enough only to have four and if they had only had one or two it would have been completely inappropriate, it would have been completely impossible.

Q401 Sandra Gidley: But would they not have had more interviews because 17% got four interviews, so did that not skew what was available for the rest? 17% of applicants had four interviews so does that not skew what was available for the rest and a lot of the doctors did not realise that they might have a better chance next time around? Dr Hilborne: That is a communication issue, is it not, and that is the Department of Health communication issue because it is their initiative; it is up to them to explain to doctors what is going on.

Q402 Sandra Gidley: You told us that you were communicating as much as possible—

Dr Hilborne: After it had all gone horribly wrong I think we probably were not communicating as well as we could have done before; but, again, to some extent how much is it our job to tell doctors what the Department of Health is doing?

Q403 Sandra Gidley: I am trying to sum up the Department of Health to the JDC. The Department ignored you when you called for implementation to be delayed to 2008, but officials blamed the JDC for the decision to offer four applications to each doctor. Does this not show a rather fickle and contemptuous attitude towards the profession, or would you not like to comment? I think Ian Wilson might like to comment on that.

Dr Wilson: It is probably appropriate we look at 2007 and if you want to explore 2008 that is a separate question.

Dr Hilborne: I think when we were saying things that the Department agreed with they were happy to do it. The decision about four interviews was actually taken quite early in the process as well. By the time I was involved I think that was already pretty much finished. It was as we got nearer and nearer to go live to January 2007 and we were still continuing to raise grave concerns about how this is not ready, that is not ready, the other is not ready, but they started listening to us less and less—and I think it is because they really had this idea that they absolutely had to do it then—and I am sure they believed there were practical reasons why they could not delay it but I am sure there was an overwhelming political reason why delaying it could not be seen to happen and they just ploughed on regardless.

Q404 Sandra Gidley: So none of you would like to describe the Department of Health as fickle and contemptuous then? Dr Wilson: I will use the words fickle and contemptuous to help you along, yes. That is the way that the Department of Health has responded to the medical profession over a number of years of late, but we have been working increasingly well with them more recently and have much better communications with them than we ever did, so it would not be fair to describe them in that way now. It would be fair to say that I have concerns about process from hereon in. There are dangers of us slipping back into some of the territory where things went wrong in 2007; but fickle and contemptuous is not right for the current period. Engaged, constructive, difficult and being extremely careful with each other.

Q405 Charlotte Atkins: Why did you oppose Remedy UK’s legal challenge to the decisions of the Douglas Review? Who made that decision? Dr Hilborne: There were a lot of aspects of Remedy’s legal challenge that surprised us, to be honest. We were first of all surprised when we heard that they were taking a challenge at all because we had taken extensive legal advice and that had been that there was no reasonable legal challenge that could be made to MTAS. We were again surprised to find that they were not challenging MTAS itself, they were
challenging the review group that was trying to fix what had gone wrong with MTAS, of which the BMA was a member, and we did not feel that we had behaved unlawfully in being a member of that group. The proposals that they were bringing forward as a way of fixing things, the two that were in the documents were to stop everything and start again, or to appoint everybody to one-year posts and do it all again next year better, and after a great deal of heart searching we did not think that we could support those as being in the best interests of the junior doctors who were already by this time—this was in the end of April—well through this difficult and traumatic time. We were surprised again in court when one of the arguments the barrister put forward for only giving temporary posts was that that would allow the BAPIO problem to be dealt with, and we were even more surprised in court when in oral statements they came up with another possible solution, which in fact was one we could have supported if we had had the opportunity to know about it in advance. So in summary there were two main reasons: one was that we had been quoted as an interested party and we were implicated in the group they were bringing the action against, we were involved in that group; two, we did not believe the two suggestions that were in the papers were in the best interests of doctors.

Q406 Charlotte Atkins: What was the reaction of your members? Did they see that as some sort of betrayal of their interests?
Dr Hilborne: I think a lot of members were very upset about it and I think they perceived Remedy as the brave underdog battling against the mighty horror of the government, the DH and MTAS, and I think there were some members who felt that we had let them down. I am sure that there were other members who felt—I know there were members of the committee who felt that they did not want Remedy’s solutions to be implemented, and if we had not gone to court and that had happened I am sure there would have been a cohort of members who would have turned round to us and said, “Why did you not stop this happening? This is horrendous; we do not want this.”

Q407 Charlotte Atkins: Presumably you would know about the opposition of your members because they would have contacted you. I do not believe that doctors are particularly slow in coming forward and presumably at your offices you would have had quite an influx of comments from your members?
Dr Hilborne: Yes, we did.

Q408 Charlotte Atkins: And they were largely opposed, were they, to the BMA position?
Dr Wilson: Can I join in? My recollection, from having looked at some of the letters myself, was that it was fairly mixed, to be honest. We kept a very close eye, as I mentioned before, communicating through Doctors.Net.UK, and there was a mix; it was not entirely balanced but then it is a relatively small number of people that throw in the most forthright comments. We had a significant number of people supporting what the BMA had done.

Q409 Charlotte Atkins: So what was the balance? You said that it was not entirely balanced; so what was the balance, which way was it?
Dr Wilson: Inevitably with these things the criticisms always outweigh the positives, so there were more criticisms than were positive; I could not give you a proportion.
Dr Hilborne: We have talked to Remedy—and Chris is here in the audience—about this afterwards and both sides have acknowledged that both sides could have handled the whole situation better, and I think that afterwards we did maintain a working relationship with them, and we have worked together with them and there have been meetings with them. It has not brought down the shutters; it has not turned into a huge schism between Remedy and ourselves.

Q410 Dr Taylor: Just to relieve you, I have the last set of questions and they are on the absolutely huge topic of the Tooke Review, so I am going to crystallise them. First, I want a very brief comment from each of you on your feelings in response to the Tooke Review and then we will go into detail a little bit about the postgraduate training programme that they recommend. First of all, general comments: do you welcome the Review, do you think it is rubbish?
Dr Mehta: Certainly it is not rubbish and I think Professor Tooke has taken a lot of trouble and done a lot of work on it. There are some very good suggestions and solutions. I think as far as run-through training is concerned our view is that it is a good system. Having had a two-year foundation training and then getting into the speciality so that you have decided what speciality you want and you train in a shorter period is a good idea, and we are quite happy with that system of training. The concept is right. The application of it has been a major problem and the reason for that is that discussions have not been done properly and I think that there has to be some flexibility brought in for earlier years, but on the whole we are very happy with the concept.

Q411 Dr Taylor: Fine; we will come back to postgraduate training. Just a general comment, Ian.
Dr Wilson: Overall it is an excellent report in many, many ways. I have encouraged the people reading it not to simply read the recommendations because the commentary that leads to the recommendations is actually so far more insightful and so more important for people to read than the list of recommendations themselves, many of which are actually well advanced in terms of actioning them. As you would imagine, there are a few bits with which we would take issue, and quite a lot that we would like to know more detail on. That is my brief picture on that.

Q412 Dr Taylor: Thank you; we will come back to the issue bits. Jo.
**Dr Hilborne:** When the Tooke Review was announced we were delighted that the government had heeded our call that it should be a real, thorough independent review of the whole of MMC, and I think that Professor Tooke has done a fantastic job in looking in great depth at the whole idea of MMC. Again, as with Ian, some of the recommendations are more welcome than others but on the whole I think it is an excellent report and it has obviously been really carefully and thoroughly researched.

**Q413 Dr Taylor:** So coming down to the actual postgraduate training details, foundation year cut from two years to one year; comments on that?

**Dr Wilson:** That is one of the areas where we take issue. We actually think that of all this period the foundation year appears to have been one of the successes—the two years. I think we disagree that separating the two parts out would be a good thing. I have read what Sir John wrote in his submissions and I fail, despite repeated readings, to understand the legalities. It was Professor Heard or Professor Crockard who outlined that and I agree entirely with what they say; that it should not be too big a job to finesse the legalities, to make it a two-year post. That year is about assuring quality and assuring a general good standard that we know not just about acute problems and chronic problems, it is actually knowing whether the problems are serious or are less serious. But we would like to stick with the two years.

**Q414 Dr Taylor:** Do you agree with Ramesh who felt that at the end of the two years that is the right time to decide whether you want to specialise and what speciality it is going to be. I think that is what you said, is it not?

**Dr Mehta:** Yes. Could I just also comment very quickly on two years of foundation? I have personal experience: my daughter has just finished the second year of foundation training and starting ST1, and I have been watching her from this general broad viewpoint as to the effect on the training. I know that initially she was quite stressed with being thrown in at the deep end, but I have observed her as growing into a very competent doctor, and I think two years of foundation training is a very good idea. To answer your second point, run-through, we were quite happy with the run-through.

**Q415 Dr Taylor:** Do you not think that Tooke’s core speciality training includes enough of the general stuff to actually cover the second year of foundation training?

**Dr Wilson:** No because he is very early on starting people down the road of sub-specialisation still. I partly agree with what Ramesh said about it being the time for considering specialisation, but it is only the early stages. Whether it is for a run-through system or whether it is a decoupled system becomes irrelevant if you have the first part with enough flexibilities, transferable skills—and I keep emphasising the desperate need to get transferable skills pointed out. And that matters little at that stage. Then there has to be the flexibility to make the choices for the doctor, but far more importantly make sure that you have the right people in there for the patients.

**Dr Hilborne:** There is no evidence that the foundation programme has failed in any way. The two aims of the foundation programme: one, care of the critically ill patient, recognition of the critically ill patient, but also exposure to specialities that you would otherwise maybe not have encountered, not necessarily to know exactly what speciality you want to go into but to give you a bit more of an idea of the range that is available to you. I think both of those are important benefits and I think it merits retention.

**Q416 Dr Taylor:** Coming to the other end of the training, from higher speciality training Tooke goes to specialist consultant and he also includes the Trust registrar job—whatever you call it, the staff grade job, whatever—and allows that a way back in to the training system, which strikes me as a good thing. And the Royal College of Surgeons separately have said that rather than call, as it were, the junior consultant just specialist they would rather call them junior consultant. What are your comments on that end of the training?

**Dr Wilson:** I think that the Royal College of Surgeons are still working up their thinking of this one, and having spoken to Mr Ribeiro very recently on this one I know how changed their position might well be by the time you get the chance to talk to him. The thing that interests me about this, as I said, reading the text rather than the recommendations is important because an awful lot of store has been set by a single diagram in the Tooke Report, and in fact looking at it—and I have it here as well—it is not a recommendation; it does not appear as a recommendation and nor—and I have asked Sir John this direct—is it actually a model for workforce planning, and yet it has been interpreted by many as a model for workforce planning. In many ways, if you simply move the box marked “specialist”, the left hand side of the dotted line, it is simply a statement of fact because once you achieve your CCT you are, in European law, a specialist—one cannot change that. The difference in view we would have with some of the parties is whether you should create a new grade called specialist in order to bring in those people. What we believe and what I understand Sir John is quite sympathetic too—although the final report, I believe, goes to press in the morning—is rather than creating a second grade which actually achieves nothing and delivers nothing and has no place that cannot be dealt with in existing structures is to create a portfolio within the consultant grade, which is something we have called for and certainly something that was central to our thinking throughout the negotiation of the consultant contract, and is certainly something that the BMA is working very hard on persuading employers to use far more effectively. I think that is an answer to your question, but I was rather hoping you might mention the word “governance” to me at some point, but that is your choice!
Q417 Dr Taylor: The table in the edition we have
does say “Inquiry recommendations” but obviously we have to wait for the final edition to see if these are recommendations.

Dr Wilson: Forgive me, what I was actually suggesting is that there is not a numbered recommendation which says, “I believe it should create a sub-consultant grade” and indeed Sir John does not believe, having spoken with him indirectly, that a sub-consultant grade should be created. What he says is that in some areas it has become an inevitability, although I would dispute that, but actually believes in the portfolio model of a consultant career, and certainly that is the work that the Royal College of Surgeons are working on as well with us and others, and the BMA is working very closely with the Department of Health and the Director General of workforce planning to that end.

Q418 Dr Taylor: What do you think of the question of the necessity to break the current fixed link between the numbers of doctors in training and the numbers of consultants in the future workforce?

Dr Wilson: We need flexibility in what we do; there is a clear need that you need to match the skills to the patient. I am not sure that we have ever really and truly had a fixed link, if we are honest—I think there is a perception of one. In practice what we need is to train doctors up to the right standard so that the best skilled doctors with the best portfolio of skills are treating the most complex cases earlier on, and that refers back to what I was saying earlier about numbers of consultants.

Q419 Dr Taylor: Were your comments on governance relevant to this?

Dr Wilson: They are relevant to the Tooke Report; they are relevant to 2008.

Q420 Dr Taylor: Very quickly to the Tooke and 2008.

Dr Wilson: Tooke makes it very clear that he was extremely concerned about the governance arrangements in 2007 and we must never allow that to happen again. I think there are many members of the current 2008 programme board, the clinical side in particular, that have grave concerns that the governance of 2008 has dangers—it is not there yet—is in danger of slipping back into some of the territory that 2007 slipped into. If I may, I have asked on many occasions what exactly is the role of the Chief Medical officer in the board in 2008 and have been specific saying, “If we get into the circumstances we are currently in and if your Committee were unfortunate enough to have to look at this again in 2008 would the answer of the Chief Medical Officer be the same as he gave you when you interviewed him fairly recently?” I see no direction of travel within the Department to appoint a Director for Medical Education or for standards of quality in training, and I see grave concerns amongst my College colleagues that we are slipping back to the 2008 board being about workforce rather than about standards and quality. I do not think that is irreversible but I have concerns that that is the way things are slipping. Being at the table does not necessarily mean that we are making the decisions as clinicians.

Q421 Dr Taylor: What should our recommendation be for 2008, in a nutshell?

Dr Wilson: Much clearer governance involving a senior clinical within the Department and that this should be about quality and standards and not about workforce planning and that the clinicians around the table should actually be part of the decision-making process, not simply turning up to agree or disagree with Department of Health driven policies.

Q422 Dr Taylor: So we are back to independent medical leadership that is really taken notice as opposed to Professor Crockard?

Dr Wilson: I think we have the potential to get back there but I am worried that we need to make those moves now, and I really mean within days and weeks and not within months.

Q423 Chairman: Does that not contradict what you said earlier about the lack of workforce planning as far as doctors are concerned?

Dr Wilson: Not at all. I think we need robust workforce planning but I think that the 2008 board should be about quality and standards and building on the frameworks that have been outlined that Tooke has suggested, not simply and only about delivering on a workforce model that is decided by others.

Q424 Chairman: Workforce planning is important in all these respects.

Dr Wilson: Workforce planning is vital but the board should not be about turning up to agree the decisions of what strategic health authorities have decided they will allow us to do in terms of numbers.

Q425 Dr Naysmith: That is just not fair to say that because training is an intrinsic part of the workforce planning in the National Health Service and the two are inextricably linked.

Dr Hilborne: That is the point I am about to make. The whole idea of training up junior doctors you have to be training the workforce that you need, but you also have to be training them to a standard and with training methods that are appropriate in skills that they need to have and assessing them as they go along. The two are essential.

Q426 Dr Naysmith: It is the three because you are actually using them as a workforce whilst they are being trained.

Dr Hilborne: Absolutely, but what we perceive is a shifting of the balance too far towards workforce and away from the importance of training itself and standards and education.

Dr Wilson: Forgive me, I am not suggesting at all that workforce should not enter into these discussions; I am suggesting that I have a concern and I know that the Presidents of the Colleges have a concern that it has shifted entirely to workforce.
Dr Naysmith: I would disagree with that.
Chairman: We will have a look and see comes out of this because this is an issue about workforce planning and quality of training as well and that is how we got here and that is how we got the lost tribe and everything else. Let us see what Professor Tooke makes of it and us in due time. Could I thank all three of you for coming along and giving evidence before us this morning?

Witness: Mr Mark Johnston, Managing Director, Methods Consulting, gave evidence.

Q427 Chairman: Welcome. First of all, can I apologise for the lateness of this start. For the sake of the record, I wonder if you can give us your name and the position you hold.
Mr Johnston: Certainly. My name is Mark Johnston. I am Managing Director of Methods Consulting.

Q428 Chairman: When you were initially contracted to provide the software to support the MTAS application process, how long were you given to build and test the new software? What was the timescale on all this like?
Mr Johnston: The contract was signed on 8 March and the first deliverable was the Foundation supporting the software. That went live in October, so from May through to October to get the Foundation element started. Then in terms of Specialty, the applicant side of that went live in January. Prior to that it was the elements of the software to allow the posts to be put on and so on. I cannot exactly recall the date of that.

Q429 Chairman: How many applications were you originally asked to design the system for? Did the number change while you were building the system?
Mr Johnston: Yes, it did indeed. The number of applications per round was contracted to be 15,000. In Specialty there was originally planned to be two rounds plus a clearing round. There were various other metrics in terms of volumes as well. I can check the date, but partway through we were asked whether that could be increased to cope with 40,000 applications in a round. We did an assessment on that and we came up with an increase in the specification of the hardware predominantly and that was created and implemented.

Q430 Chairman: I know enough about technology to know that you need to put more memory into a system if you need to hold more information. What were the implications for lifting up the number of applications in the way you have just described in terms of the contract? Were there any time constraints or pressures created by that?
Mr Johnston: Not directly by that, no. Clearly a larger number of applications means more tension in terms of those applying, which is a completely separate issue, but it was a fairly straightforward change at a cost of, off the top of my head, about £10,000, so not a significant change.

Q431 Chairman: As far as the Foundation programme is concerned, that is up and running and still running now as I understand it.

Q432 Chairman: It is the Specialty one. Was it that the system for selecting candidates for Specialty Training was more sophisticated or what were the problems which came along with it from your perspective of getting it up and running?
Mr Johnston: It is probably worth putting it in context in terms of the MTAS project itself because there are a lot of things described as MTAS which have got into general terms but, in fact, the MTAS project itself was there to design, build and run a solution against a set of detailed requirements which would be provided into the project, things like rules, processes, questions on the application form, methods being used for the selection, advice and guidance given to applicants, overall timetable, the behaviour of deaneries and everybody else who are participating, so the overall approach was all to come into the project. In terms of our challenges, it is fair to say, as you say, that the Specialty software was more complex than Foundation, although there are shared elements clearly in that. There was a timetable to build those elements, but they completely relied on us receiving those detailed elements which we required by certain dates. Our largest challenge was getting that information to us in those dates. Fundamentally, technically, no particular challenges should have faced us which could not have been delivered on time.

Q433 Sandra Gidley: What did you think of the project management arrangements at the Department of Health?
Mr Johnston: I can only talk in an informed way about the project itself and that was run in a very formal way according to PRINCE 2 project management methodologies. There were project initiation documents, formal timetables, progress reports, risk and issue logs very formally run as you would expect.

Q434 Sandra Gidley: There was a formal timetable, was it adhered to? How frequently were you asked to change it? How frequently was something added in from the initial specification?
Mr Johnston: It is fair to say that as time went on more and more changes were coming in to us. In terms of how we managed the project, it was very formal for much of the project. I cannot comment on the overall arrangements other than, as Tooke makes clear, they were very complicated. Our concern was from wherever in that set-up we needed in what we needed to get our part of the project done. It is fair to say those things throughout the project at various times arrived and were changed later or because of all the other...
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Mr Johnston: The MTAS project itself was a Department of Health project and I think that was chaired by the Deputy Director of Workforce Capacity.

Q435 Sandra Gidley: You did not quite answer my question about how frequently were you asked to change something, and were you ever put under pressure that you felt, as someone having to deliver the project, it was undeliverable but you obviously tried hard to please your paymaster?

Mr Johnston: We will always try and please our clients, but we will always try and work within a structured project management. If you take Foundation, for instance, there were a few things which were not delivered on time, however we saw that was going to be the case and we took mitigating arrangements to say, “Yes, if we re-arrange this and this we can still do Foundation successfully”. We knew what we were doing on both sides. Those changes in timetable of delivery in to us were accommodated and that element went live and ran right through. In Specialty the same applied, that in September we were supposed to have a set of detailed requirements which we could work against, that we could then do a design activity, so the difference between requirements and design, design being, “Well, if that is all the things the application form has to have on it, et cetera et cetera, this is exactly how it should look and feel on the system”. When we ran our design exercise it became clear that quite a lot of those requirements had not really been thought through in enough detail or were still subject to external issues. From that point onwards we were faced with changes. We did assess the impact of that. We re-organised the project to say, “If you can give us these decisions, we can get this part of the project built, which is the first part that would be used”. That is an acceptable approach to start with. It is fair to say that as time went on and we got into December, January time, those changes were becoming somewhat overwhelming and then the Douglas Review effectively stopped formal project management because then decisions were coming on a daily basis, you might say.

Q436 Sandra Gidley: Your company obviously provides systems to other paymasters. Would you say there was an unusual level of churn and change in what the Department of Health required of you during this project or does that always happen?

Mr Johnston: No, there will always be changes in a project for sure.

Q437 Sandra Gidley: Or an unusual degree of change? I accept there is always change.

Mr Johnston: Yes, I would say there was definitely an unusual degree of change towards the back end of this, very unusual.

Q438 Sandra Gidley: You mentioned the Tooke Review and in that the governance arrangements for the MMC and MTAS were criticised. Who do you report to at the Department? Did you have any contact with the MMC team itself?

Mr Johnston: The MTAS project itself was a Department of Health project and I think that was chaired by the Deputy Director of Workforce Capacity.

Q439 Sandra Gidley: Is that who you reported to?

Mr Johnston: Yes, that was the senior responsible officer for that project and that was who we reported to. In terms of more informal engagement, yes, at various times we might have been talking to lots of other groups. Probably the one we were most regularly in contact with was the Rules Group who was there to define the process and that sort of thing, but project management-wise, it was a very formal defined process.

Q440 Sandra Gidley: There was not any formal contact with the MMC, if anything it was a bit more informal?

Mr Johnston: When I say informal, I mean as part of the process we may have engaged in a workshop or whatever.

Q441 Sandra Gidley: Can you say categorically for certain whether you did or you did not have contact with the MMC team?

Mr Johnston: Yes, I am sure we had contact with the MMC as part of the project. I am making a distinction between our project management reporting lines and the involvement in design activities or whatever with the MMC.

Q442 Sandra Gidley: Would it be possible for you to clarify the contact you had because it sounds a bit vague.

Mr Johnston: Certainly. I am not avoiding the question, I am just pointing out that it is quite a wide area of governance and I am not altogether sure about all the people we contacted, but certainly we can do that.

Q443 Dr Naysmith: On that last question, how many times did you personally go to the Department of Health and speak to the people involved?

Mr Johnston: My role was as senior supplier. The project itself was headed by one of our very senior project managers who was not physically there every day but was involved every single day. I would have been there formally once a month and at various times there would be a meeting in between that.

Q444 Dr Naysmith: You did not take part in meetings at the Department?

Mr Johnston: I personally was not involved in things like the design sessions and that sort of thing. no.

Q445 Dr Naysmith: You were there once a month to talk about things?

Mr Johnston: There was a formal project board once a month.

Q446 Dr Naysmith: That is where you were, you were there once a month?
Mr Johnston: That is correct, yes.

Q447 Dr Naysmith: Can we move on to the question of piloting. Was there any attempt to pilot the Specialty Training selection software before it was used? Is it good practice to run pilots, is it not?

Mr Johnston: It can be. It is not necessarily a silver bullet to all solutions. The decision in terms of piloting was taken even before our involvement. We got involved when there was a tender to deliver the project against certain timelines.

Q448 Dr Naysmith: Was there piloting or was there not?

Mr Johnston: There was no piloting of the project, however it was our understanding that elements of what had been done in terms of concepts had already been piloted in a certain way, such as Foundation had been tried out using a different system, but the concepts had in terms of white space, the concepts had questions not in our area of expertise but we understood that had been done before.

Q449 Dr Naysmith: You were staking your reputation on something which you were taking somebody else’s assurance on that it had been tried out before. Is that sensible?

Mr Johnston: As a company we would always like to be involved from the start in solving a business problem, however every client is different and every project is different and you make an assessment as to whether you are being asked to do is doable. Our assessment at that time was, yes, it was doable because we understood the discussions about Specialty and Foundation had been going on a long time before even the tender came out.

Q450 Dr Naysmith: There were some stories about how the software was not very user-friendly. For instance, when you set up a candidate’s application, the number only appeared on the front page and did not appear on subsequent pages, which meant there was a possibility of confusion between applications or people had to laboriously add the number on to each page to make sure because these things would be read by lots of people. Is that not a fairly simple thing to pick up early on?

Mr Johnston: Undoubtedly, like all systems when you go live, you will always find things that you can improve on.

Q451 Dr Naysmith: You sort them out usually by piloting and testing them.

Mr Johnston: Some things could have been improved if this had been gone through but, bear in mind, a pilot would have been live anyway, it would have been with live people.

Q452 Dr Naysmith: Yes, but they would not have their careers on the line, would they? They might have done, but they would be piloting the system.

Mr Johnston: I do not know how you could have piloted it unless you used real people. Therefore, if you think about the challenges, everybody would have been able to apply to even a piloted system. As I say, it was not my call to pilot or not, but a pilot still would have been open to the entire set of people who applied this time to a pilot.

Q453 Chairman: With a pilot you could try it out in small sections, could you not?

Mr Johnston: Yes. I am only making the point that you can restrict the number of applications that go on but you cannot restrict the number of people who apply, so any pilot would have potentially involved just as many people applying, et cetera.

Q454 Dr Naysmith: The Tooke Report shows that the MTAS system was given a red risk rating by officials from May 2006 onwards. Were you aware of this at the time?

Mr Johnston: I personally was not aware of a red risk in May 2006.

Q455 Dr Naysmith: Do you not think you should have been?

Mr Johnston: The project itself?

Q456 Dr Naysmith: Maybe you should have been made aware of it.

Mr Johnston: Possibly. What I would say is the project itself had its own risk assessment on an ongoing basis. I was aware of a red flag set in September 2006 which was around Foundation predominantly in terms of, first of all, there not being a date set by which an alternative arrangement should be decided, in other words a go/no-go date and, secondly, one of the items we required into the project had not been delivered on time, but we had already come up with a mitigation approach to that and resolved it. That is the only red I was aware of.

Q457 Dr Naysmith: You are saying you did not know until September 2006 that there was a red risk when it became known to some people in May.

Mr Johnston: I am saying I am fairly sure I did not know that. I am fairly categorical that I did not know that.

Q458 Dr Naysmith: You did not become aware that the project was seen by the Department as seriously at risk until six months after they said it was?

Mr Johnston: Not that I can recall because May was when the contract was let.

Q459 Dr Naysmith: Was anybody doing anything to mitigate that in May 2006, somebody in your organisation who may not have told you?

Mr Johnston: In May 2006 when the project started, the project was formally initiated, it had a formal risk log and an issues log and within that each risk was assessed in terms of impact and potential likelihood with a mitigation approach. That was formally run right through from May onwards and the risks evolved over time, so the risks started mainly around Foundation and then they moved towards Specialty. That’s the way, as you would expect within the MTAS project itself, those risks were managed.
Q460 Dr Naysmith: Are you saying the risk which was drawn attention to by the Tooke Report is what you are talking about now or was it something similar?

Mr Johnston: I cannot comment on May. I can only say that the risks which were identified were at a reasonably detailed level, as you would expect, and mitigation was put against them. What I am aware of is the September 2006 red.

Q461 Dr Naysmith: We will go from there then. We know the system was thought to be risky by officials, what was being done to lessen the risk and mitigate the risk?

Mr Johnston: There is no question, all projects have a risk. The main risks were that we required elements of the requirements by certain dates. The other risks are more traditional in terms of making sure the development happens on time, et cetera. There were formal project management activities put in place to ensure that, so there were very clear timescales by which we needed decisions.

Q462 Dr Naysmith: Finally, you are saying that all projects have a risk, a risk rating or are a bit risky, did you think this was a more risky project than any others you had worked on?

Mr Johnston: I think in hindsight that the environment in which this project was being undertaken, which was not necessarily imparted to ourselves to start with, meant that there was undoubtedly a risk that there would be an adverse reaction, regardless of what happened on the system, to what the system was trying to achieve. That was a much higher risk than most projects we work on. Other than that, on the actual implementation side of things, no, there was no additional risk from our perspective in terms of the time we had to develop the software and things like that.

Q463 Stephen Hesford: Mr Johnson, can I check some dates because they are crucial to the question I am about to ask you. If we do not nail them down, my question becomes slightly irrelevant. When did your company first become involved?

Mr Johnston: The contract was let on 8 May. We were tendering for it prior to that, but we signed the contract on 8 May 2006.

Q464 Stephen Hesford: By the time there were security breaches a year later, your company was still involved?

Mr Johnston: Yes.

Q465 Stephen Hesford: Your company was in control of the project as you would want them to be at that time?

Mr Johnston: As I said, it is important to understand the scope of that project and our deliverables, the technical elements of the project to do whatever had been decided to be done, yes, that is correct.

Q466 Stephen Hesford: There were two breaches in April on consecutive days, when did you become aware of those breaches?

Mr Johnson: Immediately as they happened, within two or three minutes.

Q467 Stephen Hesford: Were you surprised by those breaches?

Mr Johnston: Yes, very surprised.

Q468 Stephen Hesford: Why did they come about?

Mr Johnston: First of all, I would like to apologise that there was a security breach, and the feature of the system which allowed people to see things, although not particularly of any use, had it been spotted in testing would have been changed. It is clearly not something we would have wished to happen. The context of it happening was that by the time these came about there were a huge number of changes coming our way which could not really be subject to a formal change control process or anything else, we were in the midst of days count and I guess our choice by that time, in fact for some time, was either to have walked away from this in terms of, “Sorry, we’re not responsible for this” or to try and work at the problem along with everybody else to get through it. It did mean I had a team that was working extremely hard—and I am not making excuses for this—and really had been working around the clock. We had a situation where information needed to get to the medical schools or the deaneries, I apologise, I am not altogether sure which. The original methods had been that they would be able to access the system, but there was no agreement on standard formats for doing that in terms of the programmes themselves, therefore we needed to get that information out. The method we used to provide that information, which was an acceptable method, had problems at the far end in terms of the ability for these organisations to take that information, in some cases because of their security arrangements, unfortunately. There was an alternative arrangement put in place for these files to be obtained and through a very untypical mistake a senior member of my team put them in place in a way which was not secure enough because they did not check enough as to what they had done. It was a simple mistake in terms of he made a call in doing something, which was very untypical of him and he was very tired from working very hard, and that is what caused it.

Q469 Stephen Hesford: Was that the same for both?

Mr Johnston: The second one is slightly different. The second one is the ability, if somebody so chose, to go in and manipulate the web address while they are logged into the system and see other messages. Those messages are anonymous and you cannot choose what individuals would have seen them and they are of no value to anybody. However, had it been picked up in our testing or user acceptance testing, it is fair to say we would have probably said, “No, let’s change that to make sure somebody can’t do it”.

Q470 Stephen Hesford: They were very embarrassing breaches.
Mr Johnston: Clearly, yes.

Q471 Stephen Hesford: Because you understand the sensitivity of the whole MTAS thing, we all do now, MTAS was suspended and never reopened for selection purposes. Do you think that was a reasonable response to these security breaches?

Mr Johnston: The applicant side was suspended, the system itself continued to be used. I think by that time these were on top of a great many issues in terms of the likes or dislikes of the agreement as to the whole approach to this in terms of how selection was being done and everything else, and I think that we had already gone past the point of the original concept of everything happening on the rounds and everything happening on the same day. At that point a suspension did not have huge implications in terms of being able to complete the round which was being done, so I think it probably was a sensible thing to do. In the context of that, plus everything else, the heat had got such that there was not a lot of choice.

Q472 Chairman: There was an inquiry about the heat had got such that there was not a lot of choice. Have you ever completed the round which was being done, and everything else, and I think that we had already gone past the point of the original concept of everything happening on the rounds and everything happening on the same day. At that point a suspension did not have huge implications in terms of being able to complete the round which was being done, so I think it probably was a sensible thing to do. In the context of that, plus everything else, the heat had got such that there was not a lot of choice.

Mr Johnston: The conclusions were almost as I have stated, that was the functionality which existed and it was changed very quickly.

Q473 Chairman: They were not trying to find the second breach which you mentioned. Did that ever come to any conclusion or did it just die out?

Mr Johnston: The applicant side was suspended, the system itself continued to be used. I think by that time these were on top of a great many issues in terms of the likes or dislikes of the agreement as to the whole approach to this in terms of how selection was being done and everything else, and I think that we had already gone past the point of the original concept of everything happening on the rounds and everything happening on the same day. At that point a suspension did not have huge implications in terms of being able to complete the round which was being done, so I think it probably was a sensible thing to do. In the context of that, plus everything else, the heat had got such that there was not a lot of choice.

Mr Johnston: That I do not know because that investigation was taken over by the Department.

Q474 Dr Naysmith: The Department has decided not to use the central computer system for this current year, this 2008 application process, but they have said they are going to look at using a similar system again in 2009. Do you think that was a fair judgment or decision given the problems experienced by the system in the first year of its operation?

Mr Johnston: An awful lot has been attributed to “the system” which is not “the system”, it is the way the system is used or the rules which the system applied. I think it is fair because there is no common agreement as to how this should be done and, unless there is, no system of any sort can support it. That is the central issue and that is what became quite apparent as we got close to going live and after we went live, that there were deep-seated disagreements as to exactly how it should work.

Q475 Dr Naysmith: As in it was not fit for the purpose that it was going to be used for?

Mr Johnston: No, this system was fit for purpose.

Q476 Dr Naysmith: Why not use it once it is fixed?

Mr Johnston: Because there is no agreed process against which that system could be used. There are too many nuances and too many other things. To put it in context, there may be agreements at a higher level, but actually when you look at the detail of exactly how this works, that detail is not necessarily agreed, therefore there is no agreed process this year which could be systemised, so to speak, so I think it is absolutely the right decision.

Q477 Dr Naysmith: Do you have any ongoing contracts with the Department?

Mr Johnston: Yes, we do. We continue to provide this service. The application side of Foundation has just completed using this system. The system is still used for the information which it has on it from last year.

Q478 Dr Naysmith: Do you intend to seek to be involved in developing the system for 2009?

Mr Johnston: That is the Department’s call. We have a contract to provide it.

Q479 Dr Naysmith: You already have a contract to provide it in 2009, do you?

Mr Johnston: Yes, the contract was for a period of five years. If you look at the lowest risk approach, if a national solution is right the lowest approach is the one which has already gone through this exercise that now has a security level which is very far above what would normally be required and with a team that really has a very deep understanding of a lot of the issues. As I say, the system itself in the round was delivered on time and performed as it should have and as it was asked to.

Q480 Dr Naysmith: You are being paid to run the system in 2008 or have it up and ready to run even though it is not being used, is that what you are saying?

Mr Johnston: It is being used, it is being used for the Foundation.

Q481 Dr Naysmith: That is a fairly simple exercise compared with what it was for.

Mr Johnston: It is not necessarily simple, it still requires to have the whole application process running through it and so on. To a certain extent, the number of applications that come through is not the defining element of costing.

Q482 Dr Naysmith: Sorry if I am dense, but you have got a contract for five years to run something and you are still running it even though it is not being used for the Specialist impact?

Mr Johnston: That is correct.

Q483 Dr Naysmith: You are still getting paid the same as you would have been getting paid if it had been running.

Mr Johnston: Not quite the same. There are elements which are attached to running a “round” but, in general, yes, the system is there and it is being used.

Q484 Dr Naysmith: It is really for the Department to use but it has chosen not to use it, so they have got to pay you for the system.

Mr Johnston: What our contract is for is for the build and running of the systems which can support any round and it is being used actively just now.
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Q485 Chairman: The information it has got in relation to the Specialist Training is available for deaneries and everybody else, but it is not doing it in the way which was envisaged earlier this year, that is what you are saying basically, Mr Johnston.

Mr Johnston: Correct, as well as running Foundation.

Q486 Chairman: I realise that is ongoing. Can I thank you very much indeed for coming along here and helping us with our inquiry this morning. It is probably not something a company of your size does every day, every week or every year!

Mr Johnston: We are a reasonable sized firm but it certainly has been a first.

Chairman: You will be able to put it on your CV anyway! Thank you very much.
Thursday 17 January 2008

Members present

Rt Hon Kevin Barron, in the Chair

Charlotte Atkins  Dr Doug Naysmith
Mr Peter Bone           Mr Lee Scott
Jim Dowd                Dr Howard Stoate
Sandra Gidley           Dr Richard Taylor

Witnesses: Professor Dame Carol Black, Chair, Academy of Medical Royal Colleges, Mr Bernard Ribeiro, President, Royal College of Surgeons, and Dr Bill Reith, Chair of Postgraduate Training Board, Royal College of General Practitioners, gave evidence.

Q487 Chairman: I welcome you to the fourth evidence session of our inquiry into modernising medical careers. For the sake of the record, perhaps you would introduce yourselves and tell us the positions you hold currently.

Mr Ribeiro: I am Bernard Ribeiro, president of the Royal College of Surgeons. I am a general surgeon.

Professor Black: I am Carol Black, chairman of the Academy of Medical Royal Colleges.

Dr Reith: I am Bill Reith, a general practitioner in Aberdeen. I chair the postgraduate training board of the Royal College of General Practitioners.

Q488 Chairman: To start with, I ask a general question of all of you. What role did the royal colleges play in the design and implementation of the MMC reforms from 2003 onwards?

Mr Ribeiro: It is fairly common knowledge—it emerged in the CMO’s report—that certainly one of our specialties, urology, expressed the view that it wished to change the way it was training trainees. Its perception was that there was not the same need for specialist consultants as in the past and early overtures were made to the department to see how that should be done. The report Unfinished Business which followed in 2003 was one which our college fully supported and the five principles enumerated in the Tooke report, that is, broad-based training, were those to which we all signed up. From 2004 onwards our college put forward proposals for training that would move from foundation to a common stem of four areas of acute care very much as now listed in the Tooke report. We also made recommendations that there should be two points of selection: from foundation to specialty and into core training, which would be the four broad-based stems, and then further selection into the chosen specialty. We also believed that with the large number of SHOs in surgery there was no possibility of progressing those people without a transition over five years. Those were the views we expressed to the department at the time and that was our position until Next Steps came along and the movement from broad-based training to run-through emerged. When run-through training was introduced it was across all the 57 surgical and medical specialties. That was something we had not recommended. Even the BMA in its original presentation on selection in 2001—you probably have that document—identified three pathways: a direct pathway, which is the one that urology and neurosurgery opted for; a broad-based pathway; and then a systems-based pathway which would involve medical and surgical people working together. That was something of which we were all very supportive. Therefore, we supported the initial principles of MMC in Unfinished Business but not what happened subsequently; it was imposed. Many of the comments that our college made were ignored in this situation.

Q489 Chairman: Dame Carol, do you have a wider view of all the colleges in relation to MMC?

Professor Black: It would be quite useful to separate foundation from what happened afterwards. All the colleges and, through them, the academy were involved at both stages. For example, we were very involved in the writing of the curriculum for the foundation. That was the part of MMC that we all colleges had an educational role: to define specialist training, the curriculum and assessment against specific standards which would meet the requirements of PMETB. There was an attempt to ensure that the original principles of broad-based flexibility and structured training in MMC were continued. We know of the problems that arose after that. We probably did not do this as a corporate entity. Each college naturally was concerned with its own training programmes. It was rather like several colleges being reasonably concerned with their own training programmes, so we did not necessarily go in a corporate way to represent ourselves at the department. In the reverse direction, many members of the MMC team had regular contacts—for example, Professors Crockard and Heard—with the colleges. I do not know whether you want to consider MTAS now.

Q490 Chairman: We shall move on to that in a few minutes. Dr Reith, do you have anything to add?

Dr Reith: One of the problems of MMC is that it has become muddled up with MTAS which clearly is a difficulty particularly for MMC. As a college we were supportive of the underlying principles of MMC, and continue to be so. General practice is different in some ways, certainly in the way that historically training has been organised. Because
the aim of our college is to promote high standards of patient care we have always helped to develop standards of training, curricula and so on for general practice training, but it is implemented in a rather different way. There is a professional cohort of what are called directors of postgraduate general practice education and that group of individuals, known at that time by a different name, was set up in the early 1970s when vocational training was first established. One of the reasons we signed up to the principles of MMC was that the extension of the pre-registration house officer year to a two-year foundation programme seemed to us to provide a better opportunity to ensure that at the end of that programme doctors were competent in certain generic skills. Clearly, we were delighted that general practice was to be a key component of that mostly in the second foundation year. However, historically only about 50% of doctors entering general practice had been through a three-year programme—had done that kind of vocational training programme. The legislation at the time allowed a mix of doctors to do a patchwork, if you like, of hospital jobs and then 12 months in general practice to become GPs. To us that was not logical, so MMC with the run-through programme allowed us the opportunity to make sure that everybody had a proper integrated programme. Therefore, the main reasons were: the competencies that it would provide to doctors at the end of FY2 and also the benefits to us of having an integrated programme.

Q491 Chairman: Moving to the development of the MTAS recruitment system, is it a correct analysis that the royal colleges supported the introduction of a national centralised recruitment system?

Mr Ribeiro: I am not so sure about that statement. I think that in answer to Q312 Alan Crockard in his evidence to you said that his responsibility within the department was for MMC and he was not involved in the early committee structure for MTAS which was the national selection programme. He also went on to say that it was almost a given that this would happen. Therefore, I believe it was a departmental decision to have a one bang national selection process through MTAS. I had warned the previous secretary of state at one point that we had a problem with MDAP, which was the system used for foundation, when some 200 UK doctors had not been placed. I expressed the hope that that would not happen in the specialty system. Therefore, this was presented to us as a fait accompli rather than that the colleges welcomed a national programme.

Q492 Chairman: Did they accept it?

Mr Ribeiro: Yes.

Q493 Chairman: They did not say they did not want it?

Mr Ribeiro: We accepted it on the assurance that it would work.

Q494 Chairman: That is what happens with most things in life. Dame Carol, did the academy have a view about what the royal colleges thought about MTAS?

Professor Black: There was a group called JACSTAG.

Q495 Chairman: Could you spell that out?

Professor Black: Briefly, it was a joint academy postgraduate dean group. Therefore, it brought together the deans and presidents of the academy in order to discuss such issues as MTAS. It acquired membership from the Department of Health. If you read the minutes of that particular group it is quite obvious that every college had major concerns. It is well recorded that these concerns were repeatedly brought to the attention of the Department of Health. There were repeated assurances to all of the questions. It is worth recording that I do not believe any college ever saw the completed application form. I believe it saw parts of it, but I do not think that as an application form it ever went to all the colleges for their approval. People saw things in bits. It was discussed and certainly many questions were asked, but I understand that at the final meeting of JACSTAG there was overwhelming support particularly on the part of the deans to proceed, but many of the presidents had severe reservations.

Q496 Chairman: Do you agree with that, Dr Reith?

Dr Reith: General practice was different. We had been working on a national selection process for many years, again through the directors of postgraduate general practice education. Each postgraduate deanery in the UK as well as having a postgraduate dean has a director of postgraduate general practice education. They have very close links with the college and all are members or fellows of the college but they are not ours, as it were; they are not employed by the college they are employed by the strategic health authorities. They are responsible for implementing training in general practice. Over a number of years they had developed a national programme for recruitment which all the directors of postgraduate general practice had bought into. I believe that is one of the key features. It had been developed and had been brought over by them. It used a computer system successfully for a couple of years before MTAS came in and it had worked successfully. It is suggested that in many ways things have worked very well for general practice, though it is not without its glitches, and therefore it can be just translated for other specialties. I caution against that. Some of the principles would be similar. Obviously, some of the other colleges have tried to work to those principles, but there are differences. Basically, what the directors did with us was work out the defining competencies of a GP and they then set about designing an appropriate assessment method so that standards could be set and everybody who got into a GP programme went through a national assessment process which was the same throughout the UK, not just in England.
There was piloting and validation of the GP process and it was delivered online. There has been agreement that as from August 2008 we should revert to that system and there is confidence in it. I highlight the number of years in development—it was not rushed—and also the corporacy within general practice certainly for that but also the assessment process that went on prior to entry to the specialty.

**Mr Ribeiro:** Perhaps I may clarify my earlier statement. This is a minute from our council meeting of March 2006: “Council received a copy of a letter to The Times which had been signed by 86 eminent doctors and outlined concerns about the electronic selection of foundation trainees. The process of F2 did appear to be problematic, and council strongly discouraged the electronic selection process in the short term.” Therefore, we had concerns in March 2006 about the introduction of an electronic system.

**Q497 Chairman:** It would be fair to say that colleges had concern but accepted the decision of the department to go ahead with MTAS. Do you think the colleges should accept any responsibility for what happened last year in relation to recruitment? It was a bit of a disaster, to say the least.

**Mr Ribeiro:** It would be silly to say that we should not accept some responsibility as colleges because perhaps by not being as vociferous as we could have been it might be said we were complicit in allowing it to go ahead. We could have aborted the whole process. I gave an interview in June 2006 to Gateway which is referred in Alan Crockard’s evidence. I was asked for my view on MMC and I said I believed that the curriculum which the surgical colleges had developed was up and running and would be ready in time for 2007 and for that reason alone I felt the process should continue. I however outlined concerns which I had about the numbers; I said that surgery as a specialty had a large number of SHOs, which was unprecedented, who would not be able to get through the system.

At that stage we had no evidence that there would be a problem with the MTAS process, so again, separating out MMC from MTAS, I was prepared to give the go-ahead for MMC even though I had reservations about transition and selection. Nonetheless, we felt we had a curriculum which could cope with it.

**Professor Black:** Every college did its very best with MMC to meet its individual needs. What was missing was that they did not act together in unity as an academy. We would then have had a more powerful voice, so we could have helped each other much more and, therefore, would probably have been better co-ordinated in our response. That is a very definite lesson to learn from this. I believe that everybody was doing their very best which on this occasion was not enough.

**Q498 Chairman:** You believe that you have some responsibility for what happened last year?

**Professor Black:** I think there is some responsibility in that perhaps we did not pool our resources in a united way that would have brought us together as a single voice.

**Q499 Chairman:** Dr Reith, do you agree with that? **Dr Reith:** Yes, largely. As ever, hindsight is a wonderful tool. I think that in terms of responsibility there is no one body or organisation that is ultimately responsible for what happened, but many will share that responsibility, as I am sure you have heard. We are still of the view that MMC as a way of reforming postgraduate training had much merit. The MTAS system clearly had significant problems. I mentioned earlier that previously general practice had an online system. We and other specialties had concerns about MTAS and at least in relation to the way the online system was set up and we sought to change it. As a doctor I tend always to look for solutions to things and move things forward. I am sure that is true of all of us. While at times we will challenge if we are given certain reassurances we will assume they will be delivered and sometimes they are and sometimes not. It seemed somewhat strange to us that in the midst of all of this the postgraduate deaneries were reformed and reviewed. The fact that the Department of Health decided to reorganise the SHAs and deaneries—the very people who would be delivering it on the ground—must have had an impact. As far as concern the colleges, clearly we were doing a huge amount of work on this, but equally all the colleges were working to PMETB’s timetable for the development of curricula and assessments. There was a huge amount of activity going on. Perhaps the colleges were looking to their own specialties rather than to others, but for PMETB—it is highly appropriate and I do not criticise it for one moment—we had to be specialty-minded because they were looking for a curriculum from each specialty, so perhaps at times we did take our eye off the ball.

**Q500 Jim Dowd:** Mr Ribeiro, you have already made reference to Mr Crockard. He put it to us that “initially all royal colleges ‘signed up’ to MMC. They only reverted when it became clear that MTAS would not deliver.” Is that an accurate picture?

**Mr Ribeiro:** It is a question of how you interpret the MMC. We were all totally signed up to the underlying principles of MMC in Unfinished Business. The change over to Next Steps which moved to run-through training was not something to which we were all signed up. In the BMA diagram to which I referred earlier in terms of direct access to training the only specialty identified at that time was neurosurgery; that was the one that went through. I believe that in his evidence to you the CMO indicated, first, that in retrospect the introduction of MMC should have been staggered or phased and, second, the process of run-through training was expected to be done specialty by specialty, but in the end the department imposed it
on all specialties to happen at the same time. Therefore, it is wrong to say that we were totally supportive of the concept of MMC because not all of us supported run-through training for every single specialty.

Q501 Jim Dowd: Does anybody else wish to add to that?

Professor Black: I believe that the word used by Professor Crockard was “withdrawal” which suggests a planned, organised action.

Q502 Jim Dowd: The word he used was “reverted”. Professor Black: It was not like that at all because MMC changed its educational direction, not with one big bang but somewhat more slowly.

Q503 Jim Dowd: Do you say that you were never signed up to it?

Professor Black: No. If I may continue, I believe that MMC encountered workforce need and constantly throughout those years and at the time I was President of the Royal College of Physicians I had numerous meetings with Professor Crockard. For physicians run-through training was not appropriate. I together with the educational team in the RCP spent two years trying to preserve core training and specialty training. As Mr Ribeiro indicated, in the end with numerous reassurances we managed to preserve core and then specialty training, but it was in the context of what was called run-through. I do not believe that we withdrew at all; we were trying all the time to influence a system that was losing its educational intent.

Q504 Jim Dowd: Therefore, it was not a question of being signed up to it in toto; you had reservations from the off, but you wound up in a position where perhaps you were resigned to it. Is that accurate?

Professor Black: We felt we had a greater opportunity if we were inside to collaborate and influence the process in the interests of our trainees.

Q505 Jim Dowd: Therefore, you do not agree that there has been a lack of consistent leadership on the part of the royal colleges during the MTAS process?

Professor Black: All of the royal colleges tried extremely hard to show leadership in the best way they could for their own particular trainees. It was an extremely difficult road along which to travel. Dr Reith: I think it is clear from what I and my colleagues have said this morning that the colleges were signed up to the principles of MMC and I do not think we have withdrawn from that. Quite clearly, the colleges were not intimately involved in day-to-day implementation and could not be, and that may be where some withdrawal is perceived, but we did change things. Certainly, from our point of view run-through training had many advantages for us. Historically, one of the problems we have is that of all the specialties general practice has the most ludicrously short training programme for what is one of most complex specialties. That was originally cast in legislation and to some extent still is. Tooke suggests a five-year programme, which is what we have been suggesting as a college for 40 years.

Q506 Chairman: We may move into that area a bit later.

Dr Reith: It is important to remember that. Although MMC did a lot for us it has not delivered everything that we think patients deserve.

Mr Ribeiro: For clarification, as a college of surgeons we proposed that national training numbers should not be given at ST1 level but should be allocated and confirmed at ST3 level because as a craft specialty we wanted to be absolutely sure that those trainees had all the necessary skills to be able to practise safely for patients. That proposal was put forward to the deans and, through them, to the department. Again, it was rejected. Professor Shelley Heard is in the audience today. I know that a lot of the early work that surrounded the Gold Guide had that thinking in it within the concept of core training. Again, the decision was made, I believe through the offices of PMETB, that there would be selection into ST1 from foundation and it would guarantee run-through training all the way through. Therefore, all the objections that we had as colleges about having a second point of selection were completely removed. As a consequence of that we called for one-year transitional training until such time as this could be resolved, but again it was rejected.

Q507 Dr Taylor: I want to follow up the Postgraduate Medical Education and Training Board and the effect that it had on the colleges. I remember that as a practising physician one of the most important functions of the colleges was the inspection. We had to have everything absolutely correct, and even individual patients’ notes would be looked at to see what the quality of care was like. What I should like you to do is to list the effects that PMETB had on the education role of the royal colleges. I do not know who wants to start.

Mr Ribeiro: The poisoned chalice! One of the significant matters was a document from PMETB in about July 2005 on standards for entry into specialist training. One of the first things it said, which even the deans objected to at the time, was that experience should not be a criterion for selection. Mindful of the fact that this is a process that involved two different groups of trainees, those coming through from foundation training, who clearly would not have had experience of the specialty into which they were going, and several thousand SHOs, many with five or six years’ experience, a process of selection was being designed which would not take account of experience. We know how that factored in subsequently in terms of the forms. We sent a letter to Professor Rubin saying: “Surgery is an extremely popular specialty and the number of aspirants greatly exceeds the number of posts. The number
of posts in ST1 would need significantly to exceed the number of posts in SAC-defined surgical specialties. A means must therefore be found to reduce the number of trainees in ST1 through a robust selection process based on surgical aptitude and demonstrable skills.” We put forward proposals to have selection centres that would look at manual skills, dexterity, aptitude and all those things and we said we did not feel we could provide a selection process that was robust until September 2007. That was why we asked for a delay, but the rules set out by PMETB created a rigidity in the process that made it difficult. The other matter that made it difficult for us with the PMETB criteria was the principle of open competition. Under 7.3 they said that, “Selection should be on the basis of open competition to meet current and accepted human resource practice.” There was a procedure whereby up until 2006 or thereabouts we had two categories of trainees: type 1 trainees who were selected from a recognised pool of SHOs, many of whom were already in college-recognised posts, and type 2 trainees who were in non-training posts, many of those being overseas doctors in those posts. There was a clear distinction that the type 1 trainees would be the ones who would get full training and apply for consultant posts. If you then expand that to all categories it stands to reason we would have the problem that we encountered in 2007 because you have enlarged the pool of trainees who are applying for what is still a very limited number of higher surgical or medical training posts.

Q508 Dr Taylor: To go back to the educational role of the colleges, did they take over some of that?  
Mr Ribeiro: The PMETB has always said it is there to establish standards for entry and exit and that the curriculum and what happens in the middle is for the colleges and specialist associations to define. As a principle that is correct, but we had repeatedly to go back to PMETB over lots of issues, many of them protracted in terms of educational principles. Of course, every discipline is different. What we were faced with were standards across all 57 specialists which were expected to be the same. I believe that was the inherent problem.  
Professor Black: You are right that until PMETB was established the colleges took responsibility for standards, curricula, assessment and quality assurance, so it was quite a shock. I still remember that at the very beginning of PMETB the colleges argued as vigorously as they could to ensure that their views and experience were imbedded in the new statutory body. It is perhaps worth going back to what was reflected in the constitution of the board: “In exercising its functions the board shall co-operate wherever reasonably practicable with any body that appears to it to be representative of the medical royal colleges in the United Kingdom.” Therefore, there was a duty on PMETB to collaborate. It would be silly of me to sit here and tell you that has not been a challenging relationship; it has, but the colleges have provided curricula in all their specialties up to the standards of PMETB. I believe that we are now working much more constructively on quality assurance. Therefore, it has been a relationship that has sorted itself out. We have had some very challenging times, but I think it has improved particularly in the past six months.

Q509 Dr Taylor: Dr Reith, do you have anything to add?  
Dr Reith: The gestation and birth of any organisation which has a complex range of activities or roles will always be difficult, and that was true of PMETB. It is perhaps worth remembering what the climate was like in the lead-up to PMETB when there had been a number of very significant medical scandals, if you like, and concerns about training and so on. General practice at the time, like other colleges, had some misgivings about PMETB but it thought that things were reasonable. Within general practice we had our own regulatory body in the form of the joint committee on postgraduate training for general practice which predated the specialist regulatory body by about 20 years. It had developed a way of working that we thought was improving all the time but at least assured certain standards of training and patient care. But the one great advantage to us of the order was that it brought general practice into the main stream. There had always been a question about whether general practice was a specialty. Legally as well as psychologically it now is, but that question has always arisen. In certain documents you will see a reference to “all specialties (including general practice)”. We must get away from that. We are a specialty with all the other 55 or 56, or whatever it is. That was a big plus for us. It brought us into that. I believe that PMETB has done a huge amount of good. There is a requirement that each college produces a curriculum that is more explicit than it was before—clearly, there were curricula before but not subject to the same external scrutiny that PMETB has provided—and similarly for assessment. All of the colleges have found that a challenge to meet PMETB’s principles, but ultimately it has been to the good. I believe that now the curricula are clearer and assessments will be much more robust, so they are benefits. Yes, there have been swings. Dame Carol has mentioned the requirement of PMETB to consult with the colleges. There was perhaps a feeling initially that they were not doing that as much as they might have done, but I think we are now back to where there is good discussion.

Q510 Dr Taylor: Therefore, you probably do not agree with the representative of Fidelio who told us that the establishment of PMETB was a direct attack upon the medical profession and in particular its royal colleges?  
Mr Ribeiro: One needs to go one stage beyond that and look at what happened in 1995.  
Q511 Chairman: With all respect, we are about a third of the way through our questions for this session but over half-way through the time
allocated to it. I am sure it would be very interesting to know what happened in 1995, but I wonder whether you could be a little sharper in terms of the questions and answers relating to this inquiry.

Mr Ribeiro: I think the main threat, therefore, was that before PMETB was the Specialty Training Authority which had major representation from the colleges. When PMETB was set up our main concern was that responsibility for PMETB was to the secretary of state, not Parliament. We felt that at a stroke we were creating a body that was directly responsible to the government of the day rather than an independent organisation as we would have wished it to be. That was where the conflict arose.

Q512 Dr Taylor: Tooke proposes that PMETB should be absorbed with the GMC. What are your comments on that?

Mr Ribeiro: I am entirely supportive of that. It does not make any sense to have the early part of the regulation of medical students and the latter half for consultants under one body, the GMC, and the bit in the middle under somebody else. I heartily support the Tooke recommendations that that be merged under the GMC.

Professor Black: I support the principle of seamless regulation and planning of undergraduate and postgraduate medical training, so there should be one body.

Dr Reith: In many ways it makes sense, but PMETB is due to be reviewed in 2011 anyway. It is not that long ago that the GMC was itself fairly heavily criticised for some of its inaction rather than action. It is interesting how fortunes turn. I can see a place for a joint body, but it may be a little bit early yet.

Q513 Dr Stoate: For the avoidance of any doubt, perhaps I should put on record that I am still a practising GP, a fellow of the Royal College of General Practitioners and I was previously a GP trainer and an examiner for the royal college. I have a very simple question for Dr Reith. You have already answered part of it by saying that the system for general practitioners seems to have been a lot more successful than it has for the other colleges. Can you briefly explain why you believe it has been so much more successful? Do you think the colleges could learn anything from what general practice has managed to achieve?

Dr Reith: I think that we are now talking about MTAS as opposed to MMC.

Q514 Dr Stoate: We are talking about both but it is mainly to do with MTAS.

Dr Reith: The benefit of MMC is that it gave us many of the things that we had been trying to achieve for many years, that is, an integrated programme of training over the course of the full period—the run-through—and also the opportunity for all those wanting to enter general practice to undergo that training, whereas before that many had to make do and mend as it were by arranging their own training scheme. As far as concerns MTAS it had been in evolution for a number of years, fortuitously as it happened. Obviously, when we started out with national selection we did not know that all of this would happen. There was the buy-in from all of those involved in the specialty—the directors, the college and so on—and also the opportunity, therefore, to pilot and validate it. Further, although successful clearly it was costly in terms of resources and the assessment one had to undergo to get into specialty training. Significant numbers of people did not get through; they were not found to be of a sufficient level of knowledge or competence to be ready for general practice training.

Q515 Dr Stoate: Are you saying that it is more a matter of luck than judgment that it happens to have worked in favour of GPs? What I am trying to get at is whether you took a slightly different approach to the whole process and perhaps other colleges could have learned from you?

Dr Reith: The other colleges are aware of what happened, as was MTAS. To an extent it was fortuitous. What we did hold out for—there was quite a lot of resistance to our doing so—was the assessment process. Pretty much everybody else said that we could not have an assessment process. To give the directors their due, they have stuck to their guns and I believe that was a major part of our success.

Q516 Dr Naysmith: Already in this inquiry we have heard a number of witnesses and the question of a crisis in the leadership of the medical profession has been raised with us. This morning various things have been said, for example that the application form was not seen before MTAS began, that you did not all work together in unity, you knew right from the start that run-through training was not appropriate and you should have preserved the core and objections were aired at the time, but still the disaster went ahead. Do you agree with the opinion of some that in the past year there has been a real crisis in the leadership of the medical profession? I am not talking about individuals but about a structure which provides an easily identifiable leadership for the profession. Perhaps Dame Carol would like to start.

Professor Black: This is a point that Sir John has also brought up very forcibly. I agree that effective medical leadership is absolutely essential. The challenge for us is: what is the most effective way to do it? Medicine is a very broad church and a widely differentiated profession, so whether it is possible to have one overarching body is a very challenging question.

Q517 Dr Naysmith: I shall ask about Sir John Tooke’s recommendation in a minute. Before we get to that, why do you think we have got into this crisis? Why has it happened?

Professor Black: There are probably many reasons why we are where we are now. One of those reasons was the feeling in the medical profession long
before the MMC and MTAS debacle of it being rather suppressed. There was a definite increased loss of empowerment and morale. That would have been noticeable to most of those who led professional bodies. I believe that background existed long before we arrived at this crisis.

Q518 Dr Naysmith: We will come to the solution in a minute. Mr Ribeiro, do you think there has been a crisis?

Mr Ribeiro: Yes, but I think you are wrong in your interpretation of why that crisis occurred.

Q519 Dr Naysmith: I did not say anything about why it occurred; I asked you to tell me.

Mr Ribeiro: You are asking me why it occurred. The problem in 2007 was the management of process. What happened in 2007 was that the department faced the problem of accommodating 5,000 trainees coming off the foundation programme. It had to find posts for them and educational principles were sidelined to deal with workforce problems.

Q520 Dr Naysmith: It is your job to protect these educational principles, is it not?

Mr Ribeiro: It is exactly our job to protect them, and that was why we asked for a staggered introduction. I have already explained to you why we did that. If you take your mind back to the introduction of Calman, surgery was a vanguard specialty that started the process in 1996. We were the first specialty to do it. The whole transition occurred over 18 months. This was a big bang which occurred at one stage.

Q521 Dr Naysmith: But my point is: why did you not stop this big bang? Your profession was the one that had the ability to do it.

Mr Ribeiro: The point is that the department was determined to do it. This was a departmental edict to get the thing through and to get these people employed. It has been very clear to me that the department has been obsessed with dealing with process. You have had it here before you to give evidence. In evidence it said that a selection process was initially commissioned for some 6,000 trainees, and that was because the initial process was to deal specifically with those coming out of foundation. When you add to it the whole cohort of SHOs it expands further and you then add in the IMGs.

Q522 Dr Naysmith: Why did you or somebody else—Dame Carol or others—not have the ability to say this must be stopped and there should be a return to the old system for a year until it was all sorted out?

Mr Ribeiro: This may be where the problem arises. My specialty of surgery which had the biggest competition ratios did that consistently. I have documents relating to meetings with the secretary of state and others here that go back to October 2005 putting forward my plans for a transition over three years and extra posts for trainees to get them through this process. It is on record and I will leave it for you today when I go. That is the position.

Q523 Dr Naysmith: Could you not have gone for the nuclear option, that is, that you would not recognise people trained under the new system unless it was done properly?

Mr Ribeiro: In retrospect, I think that would have been a very sensible thing to say.

Q524 Dr Naysmith: Why did it not happen?

Mr Ribeiro: But the power for recognition is with PMETB because it gives the final certificate which is the CCT. It is all very well to say that the colleges had the power to stop it. To give an example, on 1 March when the so-called Birmingham 12 surgeons decided to walk out of the interview I was rung up that weekend and asked whether I would support them in doing that. I told them to go ahead and do their interviews. They decided that they could not do it because it was wrong to interview a group of people whom they believed had come through a flawed process. It was that argument that we took to the secretary of state on the afternoon of 5 March. I made the point to her that if that was the situation with the surgeons in Birmingham it was likely to be the situation for all surgeons throughout the country unless something was done to revise the selection process. That was why we got the Douglas review and subsequently the Tooke review.

Q525 Dr Naysmith: Dame Carol, do you think you could have done anything to stop it?

Professor Black: I think that each individual college was trying very hard. I come back to the point I tried to make at the beginning. I think you have much more power to influence if you have a united voice. That is the matter on which we should now concentrate if we wish to influence government and the department.

Q526 Dr Naysmith: We come to Sir John Tooke’s proposal that there should be a body set up to do that, but in some respects that is what should already happen with the body which you chair?

Professor Black: Indeed, but it is important to understand that although since 1976 there has been an academy of medical royal colleges it was in a rather rudimentary form to do the things that you would require it to do. I hope and believe that we are now putting in place a more effective mechanism and we have better infrastructure. I believe that it was there but not in a form which enabled it to do the very necessary things about which you are asking us.

Q527 Dr Naysmith: Therefore, do you believe that the Tooke proposal is desirable and we should move?

Mr Ribeiro: I support Tooke. I think there is a real problem in that there is a vacuum of medical input at the Department of Health. I do not refer to what has been brought in by Lord Darzi and Sir Bruce
Keogh but in the educational sense there is a vacuum. Why is that? The deputy medical officer has now left. Within the department in terms of the new MMC board on which I sit there is no medical leadership in terms of departmental responsibility. What the Tooke proposal will do is appoint a senior officer with responsibility for education who is not influenced by the need to deal with the workforce. He would be able to protect the educational principles that we need to produce the excellent doctors that this country desires. That is the reason for creating this.

Q528 Dr Naysmith: Dr Reith, do you have anything to add to that?

Dr Reith: Medicine like politics is a complex profession and has many leaders. It is difficult to see how one person or, some might suggest, one body would deal with all of that. We disagree with Tooke’s suggestion that there should be a new body. We think there is already a body in existence, namely the academy, which brings together leaders of the different specialties. I can say that; Dame Carol cannot. I do not know her view but it may be similar. I believe that the academy needs to do some work to review its process and so on, but it is already doing it. For me, that would be the starter anyway. I should like to emphasise the way in which the department has changed. The Department of Health used to have a very effective medical education section containing a number of professionals. I believe that all departments in the UK, not just the Department of Health, have seen a decline in the number of medical professionals occupying significant positions. In addition, Dame Carol has already suggested that many within medicine feel that the views of doctors in senior management have been dumbed down in recent years and there is a general view within the profession that that is to the detriment of everyone.

Q529 Dr Naysmith: What do you think of that, Dame Carol? Further, the Chief Medical Officer has been widely criticised in all this for failing to provide leadership and oversight during the implementation of MMC and for denying the scale of the problems which arose in 2007, and yet in May of last year you expressed confidence in the Chief Medical Officer to the extent you have outlined this morning, that is, the principles of MMC and the academy needs to do some work to review its process and so on, but it is already doing it. For me, that would be the starter anyway. I should like to emphasise the way in which the department has changed. The Department of Health used to have a very effective medical education section containing a number of professionals. I believe that all departments in the UK, not just the Department of Health, have seen a decline in the number of medical professionals occupying significant positions. In addition, Dame Carol has already suggested that many within medicine feel that the views of doctors in senior management have been dumbed down in recent years and there is a general view within the profession that that is to the detriment of everyone.

Q531 Dr Naysmith: Do you still have confidence in the Chief Medical Officer?

Professor Black: I believe that you are referring to a certain letter which appeared in The Times last year. It may be worthwhile putting on record how that letter came about. It was simply an attempt at unity which obviously did not work well. When the Douglas review was doing its work the chairman of that body asked the academy and BMA together to produce a letter which would be supportive of that review and would also correct some of the inaccuracies already in the press about it. It was a genuine attempt to see whether two bodies which perhaps are quite separate could come together, and in supporting the CMO we were supporting the principles as expounded by MMC and Unfinished Business. As you have heard from witnesses here, those principles have never lost the support of the colleges. Therefore, that statement was support for the principles of MMC through the CMO.

Q532 Dr Naysmith: Is it fair to say that you still have confidence in the Chief Medical Officer to the extent you have outlined this morning, that is, the principles of MMC?

Professor Black: I think the colleges have continued to support the principles of MMC.

Q533 Mr Bone: I apologise in advance to the witnesses that I shall go after I have asked my questions. It is not intended as a discourtesy or reflection on anything you might say. My first question requires just a yes or no. Do you generally agree with the analysis and recommendations set out in the Tooke review?

Mr Ribeiro: Yes.

Professor Black: Yes.

Dr Reith: Yes.

Q534 Mr Bone: That is very interesting because through consultation there appears to be 87% approval of the Tooke review. Are you surprised that the Chief Medical Officer is not implementing this and is still going for wider consultation, because everybody seems to think that these recommendations are a good idea?

Mr Ribeiro: I heard and read what he said in his summation here. I personally expressed concerns to the secretary of state that the 87% support for this recommendation demonstrated the strength of feeling of the profession that something needed to be done. I indicated that if we did not get a speedy response from the department there would be a reaction from the profession. He told me yesterday that there would be an announcement by the Department of Health about the Tooke report by
the end of February. I hope that that indicates a determination on his part, if not necessarily the department’s part, to come up with some answers to that recommendation.

**Professor Black:** There is unease in the profession that there has been no Department of Health response. I would like to think that it is in part because this Committee is still in session and Darzi has not reported, but there is an urgent need for the department to make a response to Tooke.

**Dr Reith:** If you allowed me two words, I would say “yes but”. There are some significant elements of Tooke with which we disagree, for example the dismantling of the foundation programme. Within general practice that seems to have been a success and there is not yet evidence upon it. We come back again to the lack of evidence. As yet there is not a lot of evidence one way or the other about foundation, but the early evidence we have seen suggests there is benefit in the two-year programme. We also have some concerns about the potential impact of everybody undertaking core training on general practice training because we have just now achieved integrated training which may well go by the board. We have to make sure that it does not go by the board as we move through to core training. There are therefore some significant qualifications. The way in which the profession has responded is in part to do with morale. People see so many things happening to them and not being able to influence them. Clearly, there is great disquiet among the profession that junior doctors and the next generation of GPs and consultants have had the most appalling experience. We hear that numbers have emigrated and are doing things that they would prefer not to be doing. I think their confidence has been shattered. All of these things come into play.

Q535 Mr Scott: The department has played down the problems experienced in 2007 and is non-committal about the Tooke recommendations. Meanwhile, the 2008 recruitment round has begun with three applicants for every training post. Is not the medical education system sleepwalking into another disaster?

**Mr Ribeiro:** In a word, yes. I hope that you saw my letter in *The Times* on Tuesday because that was intended to raise the question which has not been asked. I have written again to the secretary of state and others making the point that certainly in surgery those competition ratios are considerably greater than that. I give you some figures. I sit on the MMC programme board. Although this may be privileged information I shall give it to you. In surgery I refer to the second year of training and the fixed term training posts for trainees who do not have a training number. If they do not get a number next year effectively they will not get into specialist training and will have to do something else. There are 555 of those trainees currently in FTSTA2 posts. We estimate that there are 1,661 college members who have their MRCS and who are eligible for appointment to this grade (ST3). The figures that I have been given by the department indicate that there is a potential in surgery of a minimum of 90 and a maximum of 130 posts in 2008 in ST3. If you take the maximum that represents a ratio of 13:1; if you take the minimum it is a ratio of 19:1. For surgery a lot of trainees will not get training numbers. It is too easy to say to these people that they can go and do psychiatry.

Yesterday at the diploma ceremony at the college I spoke to one of the doctors who had just passed his MRCS exam. I asked him what he would do if he did not get a training number. He said that he would leave medicine. I said that surely he could find something in medicine to do and he said that he was passionate about and dedicated to surgery and if he could not do it he would not continue in the profession. It is very glib to say these doctors can do something else. Many of them have invested four, five or six years in progressing. We know that 50% of them in the past did not get through and therefore they will have to make some painful choices, but in the past the difference was that next month and the month after and so on there would be another job for which they could apply. This time we do not have that luxury.

**Professor Black:** There is a huge problem with numbers not just this year but ongoing. We could discuss that in greater detail if we have the time, but we have a particular problem in the transition period with young people trying to get in at ST3 and ST4 level, which is really what Mr Ribeiro has been emphasising. I should like to emphasise the importance of returning researchers. The quality of the medicine today is dependent on making sure that you have a steady stream of very good clinical academics. I think we have about 350—maybe more—returning this year who will come into that transition group. Will we be able to accommodate them? We have a major problem with numbers.

**Dr Reith:** We are certainly in a time of considerable uncertainty and 2008 is probably less certain than 2007. I have already hinted at the impact of that particularly on young doctors who are embarking on a career in medicine but also on the service and patients. We have people who are already in specialty training and who are doing something different from those who are a bit further on in the specialty training. We will now have a third cohort doing something else. It will be very difficult to work out which doctors have which competencies. That is potentially quite risky for the service. It is however not an easy thing to sort out and we have to proceed as best we can. Tooke is a good pointer. For example, we very much support the five-year programme of training for general practice that is suggested. My two colleagues have mentioned numbers. We have a huge numbers problem. In Scotland. August 2008 there are more entries into general practice training at ST1 than all the other specialties put together. That is the scale of it. We are heading for a shortfall of GPs in the UK particularly in England because of the way the system has worked, and we need access to more hospital placements so we can expand the number of GP training programmes. That will go some of the way to help things, bearing in mind what Mr Ribeiro said about it.
Q536 Mr Scott: Officials have hinted that the Tooke recommendations will be considered as part of the NHS Next Stage Review. Is this appropriate? Is it not Lord Darzi’s remit to look at the provision of clinical services rather than medical education?

Professor Black: I think it is inappropriate that the Tooke review should be subsumed into the Darzi review. I can see that there are interlinking parts where service requirements and education meet and obviously they must be considered, but I believe it would be wrong for this excellent review to be dealt with in the context of the Darzi review.

Mr Ribeiro: I would say the same. Once again, one is trying to merge education with workforce and we must bear in mind that the recommendation that has been made deals specifically with education.

Q537 Chairman: Do you agree with that, Dr Reith?

Dr Reith: Yes. It is clear that there is a significant interplay between education and service, but you can imagine the response when an independent review is commissioned and that is then subsumed by a departmental review.

Chairman: We get the message.

Q538 Charlotte Atkins: We have already heard about the Department of Health wanting to create the arm’s length body NHS Medical Education England. Why cannot responsibility for postgraduate education be devolved directly to the postgraduate deaneries and strategic health authorities? Why does there have to be a separate body?

Mr Ribeiro: Independence would be one thought on that. Do not forget that the deaneries are subsumed currently within the SHAs and therefore are answerable to the department. I believe that when I gave evidence to the workforce group I made the case that last year there was a significant raiding of deanery budgets from the SHAs to pay off the Department of Health’s deficit which was heading for £1 billion. That has a significant effect on training. One of the effects is that our college put forward proposals to the deans to have a five-station selection centre to select trainees. We said that this could not happen until September 2007. We were told that, first, the process had to start in February with everybody else and, second, there was not the money to allow the development of the selection. That is one of the problems you have when there is a body directly answerable to the department whose funding may be withdrawn. Therefore, one recommendation in Tooke is that this funding should be ring-fenced for education.

Q539 Charlotte Atkins: Are you saying that the separate body would create some sort of independence, but would not the department automatically interfere? Is it not perhaps over-optimistic to suggest such a separate body would be independent of Department of Health interference?

Mr Ribeiro: Of course, where money is concerned ultimately no organisation can be independent of government and the department, but what is important is to have the focus on education with a senior responsible officer with whom we can interact acting in an advisory capacity on workforce in the department but not being subsumed by it. At the moment the danger is that within the current structure whereby there is a vacuum in the department—there is currently no deputy chief medical officer and we are in a transitional process for trainees for 2008—there is a lack of cohesion within the department to come up with those decisions. I think that it would help us as colleges to have an identified senior responsible officer for education with whom we could interact on those particular issues and also to know that the funding to deliver the training was protected.

Q540 Charlotte Atkins: What impact do you think that body would have on the role of the royal colleges in medical education? Would it be entirely beneficial?

Mr Ribeiro: I think it would be beneficial and I shall explain why. Before the present government came in in 1997 there used to be an organisation called the Standing Medical Advisory Committee. That body consisted of college representatives who advised the CMO on matters of education and to some degree, through the workforce element of it, on matters of workforce. There was also another sub-group. These advisory committees provided the CMO directly with the views of the colleges. That mechanism has now disappeared. I have to make an appointment to see the CMO to discuss workforce issues, so I see this as a return to a structure that will allow us to meet with the person responsible for education and put our points of view corporately.

Dr Reith: Within Scotland we have such a body, NHS Education for Scotland. That was set up following a review of postgraduate education in Scotland. I believe that that has done a huge amount of work and has helped in the way some of the things have gone in Scotland, which seems to have fared fairly well in relation to some other parts of the UK. I agree with Mr Ribeiro that the main difference is that the focus is on medical education. I think that particularly within general practice, although clearly within other specialties, we have seen some strategic health authorities raid GP budgets; they have cut training places for GP registrars. It is very easy to chop a year’s salary times whatever the number to save money. We are now in the ridiculous situation where we are not producing enough. There is a national policy to produce x GPs. The SHAs should be buying into that. We are told that they are performance managed to do it, but we do not see any evidence of performance review going on. There are so many things for SHAs to be doing that, frankly, it seems that for some education does not have the priority that it merits, so we certainly support an independent special health authority of some kind.

Professor Black: If you look at a number of recommendations in the Tooke review many are intertwined and interdependent and I believe their successful implementation requires a new coherent
approach to medical education. That is one very good reason for his body. Experience shows that the Department of Health has not been able, given its resources and design, to provide such coherence. In the interests of time I shall give just those two reasons.

**Q541 Dr Stoate:** Dr Reith, from what you said earlier it appears that you are very much in favour of extending GP education from three to five years. That is something for which I have been calling for many years and I am pleased to hear you say that.

Do you have any estimate of how much that might cost the NHS?

**Dr Reith:** At the moment I do not because it depends on how it is configured, but the question I put to you is: what would be the cost of not doing it given all the government’s policies of shifting more care into the community, the complexity of the curriculum and the degree of experience that doctors going into general practice need to acquire?

From our point of view, moving to five years is a priority. We anticipate working closely with all the doctors and the department to bring that about.

Part of it is that we have to be open about the cost. At the moment the costs of general practice training are identified differently from the costs of hospital speciality training. There is an element that comes through for the GP part of training which is very open and that is the bit that can be easily picked off. The hospital placement side tends to be hidden more in deanery budgets and is not within our control. If we had budgeting for the whole of the integrated programme we would be able to facilitate shifting around different hospital placements and improve on them from our experience.

**Q542 Dr Stoate:** You think that is a good idea and it can be done?

**Dr Reith:** Yes.

**Q543 Dr Taylor:** Mr Ribeiro, we are a bit confused about the college’s position on the sub-consultant or junior consultant grade. What is it currently?

**Mr Ribeiro:** Currently, all trainees once they reach the end of training with CCT are eligible to apply for a consultant appointment. We in surgery would require them also to have passed their intercollegiate examination in surgery. The combination of those two things makes them eligible for consultant appointment. Over the past year there has been a freeze on consultant appointments which has led to quite a few trainees finding themselves with CCTs and no jobs to go to. There were discussions with the department early last year and the year before, with Andrew Foster and later Nick Greenfield, about how to deal with the consultant level. It was agreed that the concept of sub-consultant grade should not be encouraged and that within the consultant grade we should look for ways to determine the progression of consultants throughout their careers; in other words, to put forward a portfolio of attainment to allow progression. As one can imagine, the BMA had views on that and those talks collapsed. One of the things I said at the time was that it was unfortunate we had not come to a decision about this because I felt that by default those people who had not gone through the training programme would be appointed by trusts, mainly foundation trusts, if they were thought to be competent to become the new specialists, if you like, and that by default the term “specialist” would occur and we might well find people who were not able to get jobs being pushed into those posts.

Therefore, my concern is that there is likely to be such a category anyway. The original report of Tooke demonstrated two distinct groups, specialists and those moving on to consultant posts. In the early diagrams in MMC that was also shown. We are more inclined—this was what Dr Wilson alluded to when he said I might be changing my view—to look at how we can take the established consultant body and look at means of progression, not take the view that a consultant appointed at 35 will practise in the same way throughout the whole of his career. He will have to demonstrate why that progression should occur.

That might well give some structure to the consultant level. That is our position. Having said that, somebody coming from Europe who has not gone through our training programme may still be employed by a trust and given the title of trust specialist.

**Q544 Dr Taylor:** Dame Carol, do you agree with progression as a consultant?

**Professor Black:** I think there is already the possibility within the consultant contract to do the progression to which Mr Ribeiro refers. We have it in academic medicine. One becomes a lecturer, senior lecturer, reader and then professor. That progression is absolutely acceptable. There is the machinery for us to think about an equivalent progression in the consultant grade.

**Q545 Dr Naysmith:** One matter associated with the business we have been discussing this morning—MMC and MTAS—is the failure to manage properly the number of international medical graduates who apply for UK training posts. Dame Carol, you have described it as a calamitous situation. Why do you think this calamity came about, and what can we do about it now?

**Professor Black:** I think it is a calamitous situation. I think it came about because in 1997 the government decided we should become more self-sufficient in the production of doctors. That was the time when they should have been in discussion with the Home Office and other relevant departments of government to ensure that a transition, (if you just do the numbers assuming that we wish to look after our own graduates), was made such that the international medical graduates on whom we have relied so much and who have given us so much good service to us would not be disadvantaged in the way we find them disadvantaged today. I think it is a failure of two policies to come together. I have read very carefully what other witnesses have told you.
It is quite obvious from reading that evidence that none of us has a good answer to this situation, its morality and practicality. How do we solve this, which I do believe to be a calamitous situation which is a failure of policies which should have been developed several years ago? We are now trying to deal with an immediate situation for which there is no easy answer.

Q546 Dr Naysmith: Referring to the decision of the Court of Appeal, there was evidence of confusion among the Home Office, Treasury and the Department of Health. Is it that to which you refer? Professor Black: I am referring to the fact that once a high-level policy decision had been made for us to become self-sufficient, or close to it, that had obvious implications for those who come to us from overseas.

Q547 Dr Naysmith: In this Committee it has already been suggested that the immigration rules should be changed in order to limit the number of overseas doctors. Do you believe that is possible or desirable? Professor Black: I think that what may need to be looked at, and I have not given this a good deal of thought, is that it is of interest that many of our international medical graduates now come in through the highly skilled migrant route, but somehow the numbers do not add up. Should we have so many highly skilled migrants coming into medicine—if you are coming in to a training programme how highly skilled are you? Obviously it needs a great deal of thought, but in the meantime we need to give due care and concern to those people who have served our country very well.

Mr Ribeiro: As I am the only member of this panel who was born overseas you may say that I have a different view on this. Coming from a third-world country where you see resources being removed in the way of doctors—I come from Ghana where most doctors leave the country and the health service in a poorer state—I am not keen on IMGs coming to the UK to support first world services, thank you very much. You should produce your own doctors to do it. My position is very firm on that. I believe that what caused the problem was the open door policy that everybody could apply. I have already alluded to type 1 and type 2 training which restricted the number of overseas doctors who could get into training programmes. Just like D-Day when the weather caused Eisenhower to delay the landing, the Department of Health had the opportunity in February 2007 to delay the implementation of the whole process by waiting for the result of the judicial review. It would have had to wait only about three days, but it chose not to do so. Because the “go” button had been pressed it felt unable to do so. That was where there was lack of leadership. If you are looking for a lack of leadership amongst the colleges you must ask the question: why was there no leadership shown to make a decision which brought 10,500 people into a process which clearly was going to fail? They were told by Alan Crockard and Shelley Heard that the whole process would not work if the IMGs were included. I wrote to the secretary of state about it and, if you will give me a few minutes, I shall read it out to you. My solution was: “The position with regard to overseas doctors, particularly those who have qualified in developing countries, is different from those in the EU [for whom there are no restrictions]. I believe that we have an obligation to help them meet the health needs of their countries and any training opportunities that are provided here should be in the short term with a requirement for those trainees to return home.” My view is that we should encourage and make arrangements for overseas doctors, who are already half-way through their training, to come over here for enhanced training for two years as specialists and then go home. What we should not be doing is bringing them here at a junior level to shore up the NHS.

Q548 Dr Naysmith: That is a very straightforward view. Dr Reith, you come from a country whose doctors have traditionally populated half the Commonwealth and the rest of the world. What are your views on that? Dr Reith: I would agree with my colleagues that sadly there seems to be a lack of joined-up thinking within some government departments, unfortunately not for the first time. Dame Carol mentioned morality. I think that as a wealthy country we need to look to how we support or do not support third-world countries. To offer training here to shore up our service seems to be morally questionable. By all means, if doctors from third-world countries can receive training here which will then be of benefit at home that is worthwhile. The impact of IMGs on the whole system is probably a significant factor in the debacle that we have since seen.

Q549 Dr Naysmith: Dame Carol, do you want the last word? Professor Black: No. I believe I have said all I have to say.

Q550 Chairman: Dame Carol, if you have any thoughts on this matter that you would like to share with us on paper in the next few weeks we would be more than happy to see it. Mr Ribeiro, would you also share that letter with us? Mr Ribeiro: I have a dossier of all those papers for you here because I thought you might ask me that question.

Dr Naysmith: It would be better if you read the whole lot out.

Q551 Chairman: I do not want you to read it all out at this stage. I thank all three witnesses very much for coming along to help us with this inquiry. I know we have run a few minutes over, but I think your evidence will be invaluable to the outcome of this inquiry.
Mr Ribeiro: Perhaps I may take the opportunity to thank you and the Committee for dealing with this in a courteous manner. We have solutions and want them listened to, and we shall continue to interact with the department in the hope that we can make this happen.

Witnesses: Professor Elisabeth Paice, Dean Director, London Deanery, and Chair, Conference of Postgraduate Medical Deans, Professor David Sowden, Dean, East Midlands Healthcare Workforce Deanery and Senior Responsible Officer for MMC, Department of Health (from January 2008), and Professor Sarah Thomas, Dean, South Yorkshire and South Humber Postgraduate Deanery, gave evidence.

Q552 Chairman: I welcome you to the second part of the fourth evidence session of our inquiry into the MMC. I apologise for the late start. Perhaps for the sake of the record you would introduce yourselves and the positions you currently hold.

Professor Paice: I am Elisabeth Paice, dean director of the London Deanery and I am chair of COPMeD.

Professor Thomas: I am Sarah Thomas, postgraduate dean for South Yorkshire and South Humber.

Professor Sowden: I am David Sowden, dean director of East Midlands Healthcare Workforce Deanery and since the beginning of January I have been seconded to the Department of Health as senior responsible officer for MMC.

Q553 Chairman: I should like to start with a question to you, Professor Paice. What is the remit of the Conference of Postgraduate Medical Deans, and what powers does it have? How does COPMeD co-ordinate the deaneries when each individual dean is responsible to his or her local strategic health authorities?

Professor Paice: In England?

Q554 Chairman: Yes.

Professor Paice: COPMeD is a UK body, as opposed to the body for English deans which has to deal with the issue of the SHAs. COPMeD UK is a conference or forum in which the deans gather to share good practice, to discuss educational initiatives and to work in a co-ordinated, corporate way. For example, COPMeD was the body with which Ken Culman dealt in order to implement his reforms and the body which introduced the reforms relating to the pre-registration house officer year, implemented the foundation programme and so on. There is therefore a good deal of co-ordinated activity. As with any body of that sort, if there are strong disagreements relating to the relationship that each dean has with the employing body obviously one cannot move forward; there must be a consensus.

Q555 Chairman: Professor Sowden, can you tell us how English Deans is different from COPMeD and why you think these two separate organisations are necessary, if that is your view?

Professor Sowden: I certainly think they are necessary. English Deans as a corporate body has existed for only a relatively short period and it is related more to the creation of devolved administrations in Scotland, Wales and Northern Ireland. It became increasingly apparent to us that previously COPMeD had dealt not just with strategic discussions and common business, best practice and so on but also with operational issues across the United Kingdom in terms of the delivery of postgraduate medical education. With the creation of the devolved administrations that became increasingly difficult because we found that English operational business began to dominate proceedings to the frustration and annoyance of our colleagues from the Celtic countries. As a result, we decided that English Deans needed to be established in a more formal sense to deal with many of the common operational issues that we faced in England working in the postgraduate medical education arena but also with regard to our interface with the strategic health authorities both before the recent changes and subsequent to them. I think it has worked very well in that particular environment, but I agree with Professor Paice that we are not in a position where English Deans, any more than COPMeD, can tell its members what to do. That is very much about the personal relationship between the deans and their managers who are the strategic health authorities. Despite that, we manage to achieve a remarkable degree of unanimity. Whilst we have differences they are usually handled with good spirit and in the best interests of patients and seldom to the detriment of postgraduate medical education.

Q556 Dr Naysmith: Do you agree that the transition to the new specialty training arrangements which began in 2007 was a disaster for many specialties? If so, what caused that crisis?

Professor Thomas: It is said that if you started again you would not start from here. Largely the problems were to do with timing and resourcing and therefore there was a lack of piloting. There was an unexpectedly high volume of applications. The design of the initial process was always supposed to exclude IMGs. It was well recognised that that was an unquantifiable part of the system and you would never be able to calculate exactly how many applicants you would have if there was global recruitment and it was open to the whole world.

Q557 Dr Naysmith: To what extent do you think that the deaneries themselves either corporately or individually have some responsibility to bear for this?

Professor Thomas: The deaneries which did the recruitment for doctors in training signed up to a national system but the agreement was that the volume would be controlled. When they signed up
they were told that that would be sorted out and the number of posts recruited would largely match the number of applicants. Therefore, it would be more of an allocation than a high volume competition as it became.

Q558 Dr Naysmith: But has it not always been the case that in some specialties there are a lot more applicants than places?

Professor Thomas: That is absolutely right.

Q559 Dr Naysmith: Therefore, it cannot have come as a total surprise?

Professor Thomas: No, but if a system was to be designed with a fixed number of training opportunities in a whole variety of specialties there would be some very popular specialties with high competition ratios; others would be much less popular, and some parts of the country are much less popular. There is less than one applicant per post in some specialties in some parts of the country, but the quantifiable part is how many applicants you will have and how many posts you will need to fill. If you make that recruitment global you just do not know how high the volume of applications will be. That was a significant factor.

Q560 Dr Naysmith: Professor Paice, do you have anything to add? No one will deny that it was a pretty awful situation.

Professor Paice: Absolutely. What Professor Thomas said about the IMGs is very important. It was designed so there would be phasing, that is, first there would be an accommodation of those people with the right of residence within the UK—one can call them “UK graduates” for short—and, following that, because there would be more posts than people, there would be a second phase for the IMGs. It was not an attempt to exclude IMGs but to do it in phases. The first phase was designed very much along the lines of the successful matching scheme that had been applied in foundation which was where this was being piloted, if you like. The outcome—that everybody was in the first round—came as a shock and it was not going to work without a metric of some sort which would provide some way to sift the applicants electronically before consultants had to do this short-listing exercise.

Q561 Dr Naysmith: That did not happen?

Professor Paice: It did not happen. It was one of the things originally planned to happen. In the academy’s statement of 2006 it was said there would be a knowledge test, but that was one of the things that became lost by the wayside. The GPs maintained that machine-markable test but without that there was no way to manage huge volumes and it became an undouble task.

Q562 Dr Naysmith: Professor Sowden, the Tooke review showed that project management for the MTAS process was extremely weak. Clearly, COPMeD has a key role in the project arrangements, so what went wrong? What lessons has COPMeD learned from the debacle of 2007? Perhaps you would also answer the other question I put?

Professor Sowden: The second question is slightly more tricky. To follow on from what my colleagues have said, we also need to emphasise that there were very substantial geographic differences in the experience of the selection and recruitment process.

Q563 Dr Naysmith: It worked quite well in some areas?

Professor Sowden: Yes. For reasons that are not entirely apparent, my area of East Midlands is a relatively unpopular place to come to. As a consequence of that the numbers with which we were faced were manageable, but because of the IMG issue two areas of the country in particular, West Midlands and London, were absolutely swamped. I do not believe that was predictable in terms of scale, particularly on the basis we had been told that the IMG situation would be sorted out prior to the process starting. To turn to the issue of project management, in the evidence I presented on behalf of English Deans I said I believed that the MTAS process and other aspects of MCC were exceptionally poor. The point is that that was not in the gift or control of COPMeD to any great extent. We and many other parties, including the colleges, were involved in some of the decisions reached, but the process of project management should have rested with the department and it was there where many of the deficiencies became manifest as this began to unfold. You may think “He would say that,” wouldn’t he?” because of the role I have now but, to be fair, I believe that the project management systems that have now been put in place as a result of the problems of last year are considerably more robust. Time will tell whether they are absolutely ideal, but to me they appear to be considerably stronger and have learnt from that experience.

Q564 Dr Naysmith: Professor Thomas, you were closely involved in the design of the MTAS system, as I understand it. Do you accept that the project management and governance arrangements were not adequate?

Professor Thomas: The governance arrangements were wholly inadequate.

Q565 Dr Naysmith: Who is to blame for that?

Professor Thomas: MTAS is described as covering everything. There were two parts to this system: one was the electronic portal, the procurement, design and delivery of which were wholly the concern of the Department of Health; they had nothing to do with COPMeD. The other part, which was COPMeD’s bit, was the selection and how to short-list and interview all selected people face to face.

Q566 Dr Naysmith: Was that the bit in which you were involved?

Professor Thomas: Yes, but they could never be separate in the way they were managed separately because in order to design an appropriate electronic system and for it to work properly they needed to
have all the information from the other part. Unfortunately, there was not very good communication between MTAS and the electronic portal end of it and the MMC team; they were very much separated. There was better communication between the COPMeD recruitment and selection steering group which had members representing everybody on it. Even so, the governance of all those areas was confusing, to say the least. I think it was poor and severely under-resourced; there just were not enough people working on it full time or the money to pay them. This was at a time when the resources put through to the deaneries by SHAs were being severely restricted.

Q567 Charlotte Atkins: Professor Thomas, do you accept that the part of the process in which you were involved relating to short-listing was inadequate? As a result, was the selection system fundamental unfair?
Professor Thomas: I do not think it was unfair as a result. We need data to support that. Some evaluation was made of the system and outcomes of the selection process, but, to put it into context, the procurement happened in May 2006 and the professional team contracted by the Department of Health to design the selection process started in June and they had to have it finished by December of that year. The specification for that work was materially different from what they ended up having to do. They had to expand enormously the amount of work that they needed to do and were required to do by the Department of Health. The design of the IT system did not start until half-way through September 2006. Despite asking for the IT system for foundation and specialty to be designed in parallel so that it would go together the decision was made that for the system the IT system would happen after the one for foundation had been done. It left very little time to get it all finished. Having said that, they did finish it.

Q568 Charlotte Atkins: Given that you predicted all these problems, why did you not say it should be scrapped?
Professor Thomas: I together with my colleagues attended all of the high-level decision-making committees. This was certainly discussed because the BMA had great reservations and wrote in and asked for a delay of a year. Its letter was given serious consideration at the highest level at the UK MMC recruitment system, so why were lessons not learned from that more successful process?
Professor Thomas: We wanted to do a knowledge test for specialty selection. That was very unpopular among some members of the COPMeD steering, selection and recruitment group.

Q570 Charlotte Atkins: Why do you believe there was no proper piloting of this process?
Professor Thomas: Piloting was asked for by COPMeD two years earlier. It was clear that MMC was about changing all of medical training, not just foundation. Many of us had done pilots for foundation and some had done pilots for specialty selection. We did so in my deanery. My deanery had pioneered the GP selection process. We made proposals two years earlier to do more extensive piloting and no resources were made available; they were not supported.

Q571 Charlotte Atkins: You were involved in the GP recruitment system, so why were lessons not learned from that more successful process?
Professor Thomas: The BMA and trainees in particular were vehemently opposed to it. They sent in a three-page official letter, not just an email, and it was minuted at the meetings that they absolutely would not support any kind of knowledge test. They then wrote in to confirm that. Therefore, we had no support from the trainees at all.

Q572 Charlotte Atkins: Why?
Professor Thomas: The BMA and trainees in particular were vehemently opposed to it. They sent in a three-page official letter, not just an email, and it was minuted at the meetings that they absolutely would not support any kind of knowledge test. They then wrote in to confirm that. Therefore, we had no support from the trainees at all.

Q573 Charlotte Atkins: Why were they so adamantly against a knowledge test?
Professor Thomas: They felt they had been tested at medical school and the way they were to be assessed should not include further knowledge tests to get over a first hurdle.

Q574 Charlotte Atkins: “We know best; we are above all this”?
Professor Thomas: Yes. Having said that, we had GP membership on that steering group and it was accepted that because the GP process had piloted the knowledge test first hurdle extensively and rolled it out nationally that would continue, but they would not agree to doing that for specialty; they were very much opposed to it.

Professor Sowden: I believe the argument they made—there is an issue about it—was to do with the extent to which the knowledge test was predictive of people’s subsequent performance in training. The big advantage of the GP piloting and evaluation work was that we had direct knowledge that their performance prior to training in the knowledge test and subsequently the situational judgment test linked both to their performance in training and to some extent their performance at the end of training. The juniors’ objection was problematic because it
was fundamental, but I believe they did have a legitimate argument when they said it had not been proven for other specialty areas; in other words, what element of knowledge do you test which is predictive of future performance? All three of us would have liked to see those pilots and the evaluations conducted, but they are very expensive and that issue was continually put back to us as a reason not to proceed immediately down that line.

Q575 Dr Naysmith: Surely, there is evidence from other parts of the world for predicting performance. The States is a perfect example; it uses it regularly. Why not use it here?

Professor Sowden: The argument put forward by the juniors was, if I remember correctly, that there might be something different about the United Kingdom.

Q576 Charlotte Atkins: Professor Paice, do you want to come in?

Professor Paice: Only to support that point very strongly. Past performance predicts future performance usually very adequately and this kind of test does not just test knowledge but rewards commitment and conscientiousness and provides a level playing field, which we otherwise would not have, between people who apply out of e.g. F2 and those who have e.g. 10 years’ experience obtained abroad. It was not a level playing field and a good part of the application form was designed to try to bring some levelling to it, but it would have been much better had it been done on something as concrete as knowledge as opposed to what was felt to be very waffly competency questions.

Q577 Charlotte Atkins: Professor Sowden, you said earlier that the MTAS system worked better in less popular areas. You referred to the East Midlands as being unaccountably less popular than other areas. Do you think that overall the MTAS problems were exaggerated in 2007, or do you think you were just a lucky region?

Professor Sowden: It is very difficult to say that the concerns were exaggerated. I do not believe that any of us sitting here, or perhaps those who spoke before, would want to underestimate the distress caused to a significant proportion of junior doctors. Much of what has been said about MTAS, however, has been anecdotal. Obviously, bad news travels incredibly fast and good news is quite difficult to obtain. If you speak to the junior doctors who had a positive experience—in my patch there are a lot of them—they are reluctant to speak out because of the opprobrium heaped upon them by their junior colleagues. It is very difficult to be positive about something that everybody else says is absolutely hopeless. I do not believe that even with the review of Professor Douglas and subsequently by Professor Tooke we have quantified the scale of badness and goodness. We are still very reliant on anecdote. I do not believe that is a reason to say that MTAS was a success. There are elements of success in the sense that DGHs, which historically outside the South East in particular have had real difficulty in recruiting good quality staff, are singing the praises of the people they have recently appointed. Speaking to my specialty training committees, many say that this is the best cohort of trainees they have ever had in postgraduate training, not that they did not have stars before but the spread has been narrowed. These people are almost universally very good whereas before you had the excellent through to the relatively poor.

Q578 Charlotte Atkins: Therefore, the East Midlands was the beneficiary of this. Can you quote other areas as having had a good experience?

Professor Thomas: There are hospitals in Yorkshire and the Humber that run on international medical graduates because usually UK graduates just do not apply to them. In particular, Hull has said it has the best doctors that it has ever seen and many others have said the same, particularly DGHs across Yorkshire and the Humber which have had difficulties in recruiting doctors. This year they have had much better recruits.

Professor Sowden: North West and Northern, that is, Mersey and Manchester and over towards Newcastle, have also reported.

Q579 Charlotte Atkins: But did West Midlands have a problem because of the IMGs?

Professor Sowden: They were just swamped by numbers. It is very difficult to judge in that environment the extent to which the outcomes have been good. I suspect there are areas such as Burton and Stoke which may well have benefited from this, but because of its size—it is an extremely large deanery—West Midlands was just swamped. Therefore, the experience of MTAS there as a process was not a positive one. It was not uniformly negative, but there were areas in particular specialties where competition had always been high and they really struggled for understandable reasons.

Q580 Charlotte Atkins: One would expect places like Stoke perhaps to benefit given the experience of East Midlands, Yorkshire and Humberside. Professor Paice, is there anything that you want to say?

Professor Paice: Obviously, the experience in London would be different. Good processes had been in place for some time previously and they had been developed with the profession. Consultants and trainees understood it. They formed the basis of some of the work done nationally. The timescales were not appropriate for the volume; 23,000 applications is a lot to process. We prepared for that kind of volume, but at the last minute things had to be changed and timescales got shorter and things that we thought would be delivered and their functionality did not happen. The consequence was that we ended up trying to move things along too quickly, which in turn caused a crisis of confidence in the performance of the short-listers. That in turn delayed some things. We ended up with the intolerable situation where we had appointable people left on the list and vacancies to fill and the bell went. We were unable to put those together.
Obviously, those people turned up elsewhere and are doing extremely well. It is good for patients that good people are all over the country, but it is very sad for individual doctors who perhaps have set their heart on particular placements. One of the outcomes is that people have applied for jobs and have got them but feel very distressed at the outcome. That is a weird situation in which to find oneself.

**Q581 Dr Stoate:** It is funny that you never read the good news in newspapers; you just read the bad bits. I am very pleased you have all put on record that there were some significant wins, albeit with significant problems as well. I want to talk about the IMGs, in particular the highly skilled migrant programme. What sort of numbers do you expect this year given that there is now no restriction imposed that has actually worked?

**Professor Paice:** I have contacted the postgraduate deans to see how things are going. In general practice it looks as though the numbers are pretty much like what they were last year and the year before. The prediction is 7,000 or 8,000. In the deaneries that have closed the numbers are what you might call manageable. Because there is no restriction either on the IMGs or the number of applications that an individual can make one might have feared a tidal wave of applications, but that has not happened. Obviously, people are targeting the post they want and not applying for things they do not want, but they are spreading their applications so that across the country people are getting applications in the thousands, though not tens of thousands. Therefore, so far so good. It is hard work for the applicants because they have to make a separate application for each deanery and specialty. On the other hand, obviously they are putting a lot of thought into it and spreading their applications. As far as one can see at this early stage there is a spread.

**Q582 Dr Stoate:** But you are not expecting a huge meltdown in terms of vast numbers?

**Professor Paice:** Not so far, but do remember that what is on offer this year is not what was on offer last year. Last year what was on offer was the best possible thing to get. If you got run-through training to take you through to CCT in the specialty you wanted that was a terrific offer. That is not what is on offer this year.

**Q583 Dr Stoate:** You are saying that last year was genuinely unique. What you are trying to tease out is not that this is something that will happen year on year but that last year was a very special year?

**Professor Paice:** It was a very special offer that was attractive internationally.

**Q584 Dr Stoate:** As far as you can tell, is it not likely to be repeated?

**Professor Paice:** Not if the recommendations in the Tooke report are implemented because it recommends uncoupling. It is the run-through training that is such a good offer.

**Q585 Dr Stoate:** One of the things we were told by Shelley Heard, the former clinical adviser to MMC, was that the deaneries would not implement the Department of Health’s guidance anyway because you knew it was illegal. Is that right?

**Professor Paice:** We were told by the Department of Health that this guidance was that the HSMPs should not be in the first round of applications if they did not have enough time on their passports to complete the whole programme. We then got a message in an email from the Home Office, which you have probably seen, to say we could not do that because it would not be legal. Next, we got a message to ignore that because the department’s advice was more important. Then we were told it was really up to local decision. We decided that we had to have very clear instructions about what was the right thing to do and in the meantime we would include the HSMPs in the first round of application and we would tell them, as we did, that their appointment was subject to continuing eligibility under immigration rules. What we did not want to do was to find ourselves acting some kind of quasi-immigration department. We could not do that.

**Q586 Dr Stoate:** If everybody seemed to know that it would fall foul of the court how come the Department of Health was the last one to find out?

**Professor Paice:** I do not think we or the department knew that. We wanted a much firmer lead than we were getting.

**Q587 Dr Stoate:** So, it is unfair to say that you should have warned the Department of Health that there were problems with it?

**Professor Paice:** We certainly did; we were in communication with the department, but we are not immigration experts. How could we know it was illegal? We just did not accept the situation in which we were told, “Here is some guidance; it is your choice locally.” That did not seem right.

**Q588 Chairman:** Professor Paice, you told us about the interaction you had in correspondence. Can you let the Committee have that correspondence?

**Professor Paice:** I have email correspondence and I can give that to the Committee.

**Q589 Dr Stoate:** Looking to the future, do you agree that something needs to be done to restrict the number of IMGs, particularly under the highly skilled migrants programme?

**Professor Paice:** In my view it is appropriate. Either you have a policy of self-sufficiency or an open-door policy but you cannot have both. We have already invested pretty heavily in the self-sufficiency policy, but it is not sufficient just to do that because we are in Europe. We need a level playing field and I feel passionately that we need something along the lines of what the Americans do. Therefore, there should be some kind of test that provides a baseline; otherwise, we cannot cope with volume applications, and we are likely to get them from within Europe if we make our training as good as we would like it to be.
Q590 Dr Stoate: Effectively, you want to raise the bar for non-EEA graduates?
Professor Paice: It might not even be a matter of raising the bar. I would just like there to be a bar so we know what the situation is and we can sift. The Americans recommend that students apply widely from the things they really want to do to the things that they are just about prepared to do; they do not worry about the volume because it does not impinge on any senior doctor’s time. You just sift electronically and you can start to do short-listing in the assessment and selection centres with skilled staff, but you cannot manage that if you have unsuitable volumes of applicants.

Q591 Dr Taylor: Professor Sowden, I want to look to the future. First, did you volunteer for this poisoned chalice, or is it not a poisoned chalice?
Professor Sowden: I think the degree of toxicity will be determined over time and it is difficult to judge at the moment. For my sins, I said I would be prepared to do it as a secondment for a short period. I believed that the job was worth doing. My predecessor had left to take up another post. There are some particular issues within the department which would have made it difficult for them to make a permanent appointment over the next six to nine months. It seemed important that there was somebody in place who could take forward the 2008 process and lead on the development for 2009.

Q592 Dr Taylor: So, you are safe in post until after the 2008 process has been completed?
Professor Sowden: Pretty much so, yes; I am certainly in post until August/September.

Q593 Dr Taylor: Is it true that, according to the figures we have been given, there are three applicants for every post?
Professor Sowden: It is difficult to tell. That is the prediction in terms of the number of UK graduates who are in the system and those we expect in terms of IMGs. We have not had back any information to suggest that is wrong, but it is an average which means that, for example, at entry to ST1, the first stage of training, that ratio is less than three to one, whereas at ST3 in some specialties it is considerably more, perhaps as much as 20 to one. There is a danger that people think that strange; in other words, that it is a function of this process. It is not. Many specialties have always been intensely competitive. I suspect from your experience and mine over the past 20 or 30 years there have been some careers which have been immensely difficult and the majority of people fail to get into them.

Q594 Dr Taylor: Therefore, competition quite rightly has always been a part of the job. Do you think that inevitably competition will be greater? Mr Ribeiro talked of a ratio of 19 to one as an example. It will be pretty tough in those specialties.
Professor Sowden: Yes. Surgery is a particular case. Historically, it has had a very large population of intermediate grade junior doctors, the traditional SHO grade, who provide an important patient service, but only a small number ever leave the sump of SHO training to get into SPR training, as it were. They were the ones who often trained in the SHO grade for very long periods, say, six or seven years. The worst example we found was someone who had been in post for 14 years. One would query the validity of training somebody at that level for that long. How much more can you learn in that grade? Many of them realise during that process of attrition that they will not make progress. The difference between then and now is that they are confronted with their failure as a stark reality and they cannot make progress. There is nowhere else to go; they have to find somewhere else. That is very difficult for a group of young people who up until now have had only the experience of success, that is, success at A-levels, at university and so on. It is very difficult for them to adjust to that.

Q595 Dr Taylor: Can you give us a thumbnail sketch of your plans to make it work this year?
Professor Sowden: In terms of how it will work, the big thing is the process of allowing the deaneries to manage the selection and recruitment process at a local level. The reason for it is that you then have some control over the process you put in place. You are managing the consultant staff situation with trusts with which you are familiar and you do not have the added complexity of an IT system that in the event does not work particularly well for the reasons you have already heard. It does not necessarily mean that the final outcomes for a certain group of junior doctors will be better, but their experience of the process may be and should be considerably improved and up until now it feels better.

Q596 Dr Taylor: So, short-listing will be left to deaneries?
Professor Sowden: Yes; it is all done at a local level. The long-listing, short-listing and interview are done locally with the exception of a small number of specialties where we have had agreement to go national, but they have already piloted or they are small and it is possible to do it.

Q597 Dr Taylor: One of the main reasons for MTAS was to try to make the short-listing process a little less time-consuming for everybody. How will you cope with short-listing this time?
Professor Paice: It did not make the short-listing any easier for anyone. Every application form had to be looked at by at least eight consultants. What we are doing this time to make things easier is to ensure we have a great deal more time for people to go through the forms and to recruit a large number of consultants, making sure that each does not have an excessive number of application forms to score. We are really working on the timescales and numbers of people involved rather than what we talked about before, which is some way of taking the work away from consultants.

Q598 Dr Taylor: How do you give consultants more time to do it?
Professor Paice: For example, in London where volumes are big we are stretching out the whole process over a prolonged period of time. We knew that we had no hope of trying to do things so we could get in first. We are just making sure that we have got three weeks for short-listing wherever we possibly can to allow people to pace their work. Different people take different times, but we know approximately what sort of time it takes to short-list and we can make sure people are not overloaded.

Q599 Dr Taylor: Therefore, they will have old-fashioned application forms to go through?
Professor Paice: That is correct. They are not CVs; they are CV-based application forms that we have been using for 10 years in London. Everybody is used to them. Obviously, they are modified to make sure they fit in the latest person specs, but it is a familiar exercise.

Q600 Dr Taylor: Therefore, the stories we heard about people being faced with a huge pile on a Friday and having to go through it by the end of the weekend will be avoided?
Professor Paice: I refer in particular to the 650 forms. It is worth remembering that that was one question and there were 150 words to score on each form. It was not 650 CVs. If you like, because it is one-tenth of the form it is the equivalent of 65 CVs to mark. That is the kind of number that we would be looking at, and not over a weekend but over three weeks. Anything from 50 to 100 will probably be the burden. It is not a trivial burden, but it is the sort of number that people would be expecting.

Q601 Dr Taylor: We shall be watching with interest how you get on this year.
Professor Sowden: You can tell me afterwards whether or not it was a poisoned chalice.

Q602 Chairman: I want to ask about the Tooke review. What is your overall response to the findings and recommendations of that review?
Professor Sowden: Obviously, we respect it as an excellent piece of work. The vast majority of the recommendations are ones that we wish to support in full. Certainly, there is very little difficulty with the eight principles he has established with the interim report and has added to very slightly in the final report, but they are largely unchanged. Obviously, there are some recommendations that require very careful consideration, not the least of which are the two new recommendations added to the final report. From a deanery perspective, there are also particular issues around the proposals on foundation programme training and its linkage to the guarantee of employment for UK graduates. There is some doubt about the legality of that particular statement and therefore we are concerned about it. Most of it is wholly supportable, and the bottom line of the Tooke review is that for some recommendations the devil is in the detail which need to be worked through both in terms of the departmental response which will come out by the end of February but also in terms of how the profession as a whole—the colleges and deaneries—respond to some of the details. Some of this requires fundamental reworking, for example the specialty curricula, which should not be underestimated. It will take not an inconsiderable time to implement.

Professor Thomas: I would reflect the same view.
Professor Paice: In general postgraduate deans are very sad about the proposals to break up the foundation year and I would not like anyone to think otherwise. We are all united on that. We believe that the foundation has been good and we are sorry to see it uncoupled. One must not lose sight of the problem that MMC was trying to fix. It was not just a bright idea that people had. I should like to make sure that when the Tooke recommendations are implemented those things are fixed, for example the issues around whether or not too much of the service is being provided by people in training and whether the people you are training have what it takes to provide a modern health service with safe patient care and they are reliable and competent. We need excellence absolutely but they must be reliably competent. We should like to make sure that we do not develop another process of milling and queuing between core and higher specialty training. That is the detail, if you like. I would also be very unhappy if there was any distancing between medical workforce planning, financial planning and service planning because that would be a retrograde step. I am sure that is not the intent, but there are ways to read the recommendations that might give rise to that. That is the anxiety I have.

Q603 Chairman: Professor Sowden, you said the devil was in the detail. Sir John told us that the medical profession supported his recommendations. He said that he received 87% support during consultations and it appears that he has united the medical profession. Are you surprised by such comments?
Professor Sowden: There are different interpretations of statistics. What we do not have is what the 87% of respondents mean. We know, for example, that the directors who represent all the foundation programme schools responded as a group. If they are treated as one negative responder against a single person’s response obviously the 87% is not a meaningful representation of feeling out there. One needs to have access to the core data to be absolutely certain that the 87% looks as it is presented. I do not suggest there is a misrepresentation here, but we all know sitting here that there were a lot of responses to suggest that the foundation programme recommendation was premature in advance of formal evaluation of that programme. We would be concerned that that 87% response rate was not reviewed in the light of the possibility that it did not reflect a total professional view of what is going on.

Q604 Chairman: Do you think that a more open debate about the proposals would have been a healthier outcome? It does not appear to be the case at this stage; it will be subsumed by the department and handed out at some stage.
**Professor Paice:** The postgraduate deans have been debating this so vigorously that they do not feel they have failed to consider this one. Perhaps that is a feeling that others have.

**Q605 Chairman:** Professor Paice, you mentioned the issue of splitting up the two-year foundation scheme and introducing a three-year core specialty training programme, and that is on top of the changes that have taken place in the provision of training, foundation and specialty training established recently. What effect will this have in terms of these two areas?

**Professor Paice:** Every time you restructure a lot of energy goes into it, as we have seen, because a lot of what we have been talking about has been the impact of the restructured training and then recruiting into it. There is so much else that needs attention, for example the content of training, implementing new curricula and keeping them up to date with a continuing dialogue with the service about whether the curricula are fit for purpose.

Another matter is the way we deliver training. With the European working time directive and so many changes in the health service the way we deliver training has to change; and we have to change the way in which we assess people so be more reliable and robust. A lot of this change is being driven, rightly, by PMETB and the standards set by it. My anxiety is that in restructuring some momentum that has been gained will be lost. I would be sorry to see that happen. I am sure it can happen without losing momentum, but it is a worry.

**Q606 Chairman:** Do the other witness want to add to that?

**Professor Thomas:** The problem is that it may prove a distraction.

**Professor Sowden:** It is clear from the Tooke recommendations that the foundation programme training split is there to provide a first year of secure employment. If that is not forthcoming as a legal option—it may well not be—there is much to be said for looking at how we can allow the foundation programme to evolve. There was already a plan to have a fundamental curricula rethink before 2010. There are issues to deal with the first couple of years’ training in specialties to see how we can create more flexibility, but those are all about evolutionary change, not revolutionary structural change. We need to be very careful about structural change because we have all experienced it ad nauseam in the NHS over the past 20 years and often it distracts you from what really matters. What matters in postgraduate training is the outcome for patients and trainees.

**Q607 Dr Taylor:** I want to turn to recommendation 47 and the suggestion as to NHS Medical Education England. What are your feelings about it?

**Professor Paice:** It cannot be a bad thing to have medicine speaking with one voice. Whether it is the academy or this body, to have an arena that brings together the medics to discuss and agree things has huge appeal. There are however a number of details within that concept with which I would struggle. It comes back to what I said before. Given the descriptions of what that body would do, there is a risk that you would separate the financing of medical education. Ring-fencing has been referred to. I would hate to see medical isolationism as the outcome of this and a step backwards from the integration of service strategy and financial planning, using medical education, if you like, as an enabler for service change and reform. The tension is always between education and service but that is really tension between service today and service tomorrow. I should like to see the postgraduate deans of training helping to drive the way the service should look tomorrow. Therefore, I would worry about too much separation of workforce and education.

**Q608 Dr Taylor:** Do you think that the academy could take on this role?

**Professor Paice:** It depends what the role is. If the role is to speak with one voice then the academy is ideally placed to do it; if the role is to hold a very large budget obviously that would not be the sort of structure you would put in place to manage sums of money.

**Q609 Dr Taylor:** What do you see as the role of the SRO for medical education? Sir John thinks there would be an SRO responsible for this. Would that SRO be, as you are, a member of the Department of Health or would he or she be completely independent?

**Professor Sowden:** That depends very much on how you deliver the concept of the MEE. Certainly, the SRO is designed to be a director of medical education sitting within the Department of Health potentially but not confirmed as a deputy CMO position. That gives considerable authority within the profession. Whilst I acknowledge there are issues about perceived independence, those can be dealt with within an appropriate framework of accountability for the establishment of the body. I think the points Professor Paice has made are critical and without them being sorted out it is a little difficult to be explicit about what the role of the director of medical education or SRO ought to be or could be. I hope that does not sound too vague, but it is very difficult to see a way through the fog at the moment.

**Q610 Dr Taylor:** If I may go back to Professor Paice, workforce, finance and service must all be kept together?

**Professor Paice:** I would have thought it made sense if you were planning to improve and reform the service to make it more patient-centred, safe and of high quality. You would want to bring into that every aspect of what care is about. The trainees are absolutely central and critical to delivering care as well as being trained and educated today, but they are the trained workforce of the future. It makes sense to ensure that all of that is considered and taken into account and is integrated and joined up rather than that education is seen as being slightly
out on the side. I am sure Sir John never had any intention of anything like that happening. I am just saying that it raises a concern that that might be a possible danger to be avoided.

Q611 Dr Taylor: Therefore, you do not believe that the Department of Health can be stripped of all its responsibilities for medical training?

Professor Paice: I do not see how it could be.

Q612 Charlotte Atkins: Given the different size of the deaneries, do you think all of them have the capacity to plan for and implement such complex reforms as the MMC? It seems to me that the events of 2007 indicate that such capacity does not exist right across the board.

Professor Paice: I would draw a different conclusion from that. It can get too big to manage. One of the successes in Scotland and Wales as a result of this is that they were able to make decisions that worked locally. I believe that the events of round two and what is happening this time round show that some things are better managed on a smaller scale than a huge scale.

Q613 Charlotte Atkins: Why do you think that Tooke recommended a new co-ordinating body?

Professor Paice: The idea of getting a joined-up agreed medical voice is an extremely appealing one. When educational initiatives are taken or changes made everyone is absolutely signed up and if there are dissenting voices they are listened to carefully because there may well be something very important being said by the dissenter. A corporate view in itself is no good unless what comes out of it is definitely the right way forward. It is often that voice from the side to which people need to listen.

Q614 Charlotte Atkins: You refer to a co-ordinated voice, but do you think the fact there are two organisations, COPMeD and the deaneries, mean they cannot speak with one voice? Do you believe that is a problem?

Professor Paice: I think we have been speaking absolutely with one voice through what has been an extremely difficult time. It is correct that the experience has been different. If one asked whether this had been smooth one would get two answers, yes and no, but that is not the same as not being together in what we are trying to achieve. We had a shared goal and understanding of what we were trying to do and why we were trying to do it. We all worked together to do our very best, so this did not fail because we could not agree with each other.

Q615 Charlotte Atkins: Is that a common view?

Professor Sowden: Yes; I agree. To go back to your earlier point about the size of deaneries, I agree with Professor Paice. We have gone through a process of rationalisation of the deaneries and two of us sitting here are the bi-products of that. I was originally in a smaller deanery; I am now in a much bigger one that is coterminous with an SHA. Professor Thomas has literally just gone through that experience. But there is a size beyond which you begin to get too big. Having moved from a relatively small deanery to one twice its size, it is about as big as I would like it to get. It is very difficult to maintain those key personal relationships with clinicians and trusts as one way of leveraging change behind the scenes without having to get out the big guns and so on. I do not want that to sound as if it is Machiavellian or underhand, but those personal relationships are important. The bigger you get the more difficult they are to maintain.

Q616 Charlotte Atkins: At the moment there are some quite small deaneries, like the size of Oxford, and others that cover the whole area of a strategic health authority. Is it time for all the deaneries to be coterminous with SHA boundaries?

Professor Sowden: You could aspire to that but I think it would be very difficult. I have one particular example in mind: the South West. The reason it was split into two deaneries was that the geography did not work. It was so huge that you could not meaningfully run Cornwall from Bristol, which was what happened. We have to recognise that there are patches in England where that is different or difficult. You can aspire to one model but you have to accept that that model must not be the only one because there are exceptions to it. I recognise however that there are oddities in the system that might warrant review in due course.

Professor Paice: The experience of London Deanery working with five SHAs and working with one, NHS London, has been a revelation. It has been infinitely better to work to the same agenda and with the same span, concept and goals. I would not wish to turn back that clock.

Q617 Charlotte Atkins: The fact that you have the same geographical area does not mean that you have the same agenda.

Professor Paice: No, but, interestingly enough, it has not felt like that; it has felt like having one agenda.

Professor Thomas: Patients throughout England and the UK need consistency of delivery of healthcare and therefore we ought to be doing things in a consistent manner across the SHAs and deaneries. This is supposed to be about common national standards and consistency of delivery and I would not want to lose that.

Chairman: I thank all of you for coming along to help us this morning. This has been a comprehensive and wide debate. Some of us represent areas of the country and do not recognise the national debate. It is nice to know that we do not represent other planets but actually do represent parts of the UK.
Health Committee: Evidence

Thursday 24 January 2008

Members present

Mr Kevin Barron, Chairman
Charlotte Atkins Mr Lee Scott
Mr Peter Bone Dr Howard Stoate
Dr Doug Naysmith Dr Richard Taylor

Witnesses: Professor Peter Rubin, Chair, Postgraduate Medical Education and Training Board, Professor Neil Douglas, Head, MTAS Review Group, and Professor Sir Nick Wright, Warden, Barts and the London School of Medicine and Dentistry, gave evidence.

Q618 Chairman: Could I first of all welcome you and then ask you to give us your names and the current positions that you hold.
Professor Rubin: Professor Peter Rubin and I am here as Chairman of PMETB.
Professor Douglas: Neil Douglas, President of the Royal College of Physicians of Edinburgh. Here, I believe, as past chairman of the MTAS Review Group.

Q619 Chairman: I have an interest to declare. I do know Peter Rubin. I am a lay member of the General Medical Council and Peter sits on the Medical Council as Chair of its Education Committee. Perhaps I could start by asking a couple of questions about the role of PMETB. It began work in 2005, the year the first MMC reforms were introduced. Was PMETB set up specifically to provide quality assurance for the MMC reforms or was the timing an absolute coincidence?
Professor Rubin: The timing was largely coincidence. I should qualify that by saying that I was not involved in the establishment of PMETB. I came on the scene somewhat later than the establishment process, which was earlier on. Inquiries and reviews going back to 1970 recommended that postgraduate medical education should be regulated, as undergraduate medical education has been since 1858. The most recent of those reviews was the Bristol heart inquiry and in that review Ian Kennedy very clearly recommended that postgraduate education should be regulated and PMETB was a consequence. MMC was developing in parallel with all that. One of the issues that has been all too apparent to us is that, because the MMC came on the scene at much the same time, there has been a lot of confusion about what the two organisations do.

Q620 Chairman: What are the extent of and limitations to PMETB’s responsibilities for postgraduate medical training? It has been put to us that the creation of PMETB was a “direct attack” on the medical Royal Colleges. Do you agree with that?
Professor Rubin: Perhaps I could tell you what PMETB is intended to do and then I will comment on the Royal Colleges. The role of PMETB is to protect the public by determining the standards necessary for a doctor to go on the specialist or the GP registers. We do that in two ways. For doctors who undertake a regular UK training programme, PMETB determines the content of the outcomes of that training: we ensure that the exams are fit for purpose and we quality assure the standards of training. For doctors who train outside the EU or for doctors who undergo an unconventional training programme in the UK, we establish that those doctors have knowledge and skills equivalent to those who have done a regular training programme, and through the article 11/article 14 rules we establish whether they are fit to go on to the specialist and GP registers. That is what PMETB does. With regard to whether PMETB was established to undermine the medical Royal Colleges—and I should say that I was not involved in establishing PMETB—I think it best to respond in this way. Undergraduate medical education in medical schools in this country has been regulated since 1858. Their reputation is high; the reputation of medical education in the UK is very high. I do not think anyone would say that being regulated has damaged the medical schools in this country. I think it is therefore a rather flawed argument to say that, just because the colleges are being regulated, there is an attempt to undermine them or devalue what they do. I have certainly never taken that view.

Q621 Chairman: Why do you think PMETB’s role seems to be so poorly understood by other stakeholders within medical education?
Professor Rubin: I really do not know. There has been a lot of genuine misunderstanding and, also, I think, some wilful misunderstanding about the role of PMETB. I think some of that goes back, as you have implied, to the unhappiness around the establishment of PMETB. I think there is an attempt to undermine them or devalue what they do. I have certainly never taken that view.

Q622 Chairman: Could I also welcome Professor Sir Nick Wright.
Professor Sir Nick Wright: I do apologise. My lateness was due to the vagaries of the District Line.
Q623 Chairman: Okay. I did ask for the names of our other two witnesses. Perhaps you could just tell us the position that you hold.

Professor Sir Nick Wright: I am the warden of Barts and the London School of Medicine and Dentistry in Whitechapel and Smithfield.

Q624 Chairman: Back to PMETB. You say that PMETB is not responsible for recruitment and selection to medical training posts. In evidence to us, the Chief Medical Officer told us that PMETB has “responsibilities for approving, not just the curricula of the new speciality training programmes, but also the applications procedure”. Who is right?

Professor Rubin: The CMO is incorrect. Having looked at the transcript, I think Dr Marshall, who was at the time the DCMO, tried rather diplomatically to correct that rather quickly. That was my interpretation of the transcript. PMETB’s role in the selection process is, again, prescribed in statute—so it is not a mystery, hidden anywhere—and our role is to determine the standards that a doctor must have reached in order to go into specialist training; in other words, to determine that the processes used can distinguish the eligible from those who are not eligible. It is not our job—nor, I think, should it properly be the job of a regulator—to get involved in telling those who are running training programmes how to pick the best candidate. That is for them. They know what their programme involves and it is for them to decide who is the most excellent of the applicants. Our job is simply to determine that the processes can distinguish the eligible from the ineligible, so it is a pretty minor role.

Q625 Chairman: The Department of Health included a letter in its evidence showing that PMETB received a presentation on plans for the MTAS system in September 2006 and was broadly happy with the proposals. Why did you inspect the MTAS system if you are not responsible for recruitment and selection?

Professor Rubin: The meeting was in August, the letter that we sent was in September. The background to the meeting was that the MTAS team asked to see us. We did not ask to see them. We had not intended to see them. As I have said, our role is pretty small, and we were going to pick up our limited role in the selection as part of our regular QA processes. They asked to see us, and we wished to be helpful—I mean, we realised everything was new and we did not want to be unhelpful—so they came along and gave a very high level presentation. It was not overflowing with any detail. For example, the application form, the electronic form that has been much criticised, was not ready and so we did not see it. They gave a very high level presentation in which they assured us that they would be consulting with interested parties (that is, the Junior Doctors Committee of the BMA and the medical Royal Colleges) on the form when it was ready. So they gave us a very high level presentation and we gave, as you will see, a very high level response, saying, “Broadly speaking, what you are proposing to do, in principle, seems to meet our requirements for the process.” So it was all very high level and, I have to say, rather general stuff.

Q626 Chairman: You stated in September 2006 that the MTAS system “broadly meets the relevant section of PMETB Generic Standards for Training”. What was this judgment based on? With hindsight, do you think you were correct in saying that?

Professor Rubin: We thought that, broadly, it would meet the requirement to distinguish the eligible from the ineligible. Despite all that has happened since, I believe that Professor Tooke’s inquiry did not find that there was any evidence that it failed to distinguish the eligible from the ineligible. There were a lot of arguments over whether the best candidates were selected and so on, but that was not the regulator’s role, to get into that particular aspect of the selection process.

Q627 Dr Naysmith: I do not think you answered the Chairman’s previous question. He asked you why you took part in this procedure when it is not your responsibility and you said you were invited by them to see them. What was the purpose of this? You could have said, “It is really nothing to do with us. What are you telling us this for?” Presumably a number of highly paid individuals sat around a table and gave this great presentation which was, in your view, unnecessary. Why did you go through with it?

Professor Rubin: Because we wanted to be helpful. We were very conscious that a lot of new things were happening. A lot of new things were happening. MTAS was new, MMC was new, we were new, and we felt that to say, “No, we don’t want to meet you” would be unhelpful, basically. It was as simple as that. We were clear to them—we were very clear and the letter was very carefully worded—that we were not approving anything. The word “approve” does not appear in that letter quite deliberately—quite deliberately. Equally, we thought it would have been gratuitously unhelpful to say, “We don’t want to know.”

Q628 Dr Taylor: I am rather struggling with the feeling that selecting the eligible from the ineligible is only a minor role. It would seem to me to be absolutely crucial.

Professor Rubin: The eligible, for example, going into the first year of specialist training, will be somebody who has completed the foundation programme or has experience overseas of the equivalent to the foundation programme. The arguments around MTAS and the selection process, the arguments that have raged since last spring, have been about whether the very best candidates were being short-listed and the very best were being appointed to the posts. When I use the term “minor” that is minor in comparison to our major responsibilities for delivering the content of 57 curricula, examinations in 57 specialties, and quality assuring postgraduate medical education...
throughout the UK. That is big stuff. In contrast to that, our responsibilities for selection are really quite small.

Q629 Dr Taylor: I understand that. Do you feel that the Department of Health and the Royal Colleges have tried to make PMETB a scapegoat for what happened?

Professor Rubin: The first thing to say is that people use the term “colleges” as if there is a homogeneous organisation called colleges. They are not homogeneous.

Q630 Dr Taylor: Although the Academy surely tries to speak for all of them.

Professor Rubin: The Academy tries very hard to speak for them but there have been some examples of wilful misunderstanding surrounding the MTAS process. Since you ask the question, Dr Taylor, let me give you one very striking example concerning the Royal College of Surgeons of England in their evidence to Professor Tooke. In their evidence, which was in the public domain on the website, they made the most extraordinary claim, which was that PMETB did not approve of having a clinical component to their flagship MRCS exam, their postgraduate exam. That was an extraordinary misrepresentation. The truth was that, as part of our regulatory functions, we had established that their flagship exam, the MRCS, had serious problems. We had established that the clinical and oral components of the exam were subject to deep uncertainty as to the level of the exam, uncertainty even as to what was being tested—and what was being tested seemed to be different in different parts of the UK—and uncertainty in the minds of examiners as to how to allocate grades for different levels of achievement. We, as regulator, said what you would expect us to say: “You’ve got to clean up your act. You must produce an exam that is fit for purpose and do it in a very short timeframe.” That was misrepresented in their written evidence to the Tooke inquiry as saying: “PMETB does not agree with us having a clinical assessment,” sending a completely different message. Clearly I wrote to Professor Tooke to put the record straight and so on, but that is an example of what I would regard as wilful misrepresentation to try to make PMETB look something that it is not.

Q631 Dr Taylor: You were obviously aware of the problems and the crisis emerging. Should you not have been the first to point this out?

Professor Rubin: From the very beginning, it was clear to me that, at the heart, the problem was one of a huge mismatch between the number of applicants and the number of places. That was clear very, very early on. Workforce is not something that PMETB does. We do not do workforce. That, at the heart, was the problem. Certainly there were issues around the application form and so on, but, had there been less of a mismatch between applicants and places, the problems that were there with the form would have been much more easily manageable at a local level. It was clear to us that the heart of the problem was a numbers problem. It is hard now, perhaps, to remember that there was a cacophony of conflicting anecdotes circling around—and, as a regulator, you need evidence, not anecdote. For everyone claiming that the brightest in the generation were not being short-listed there were counterclaims that the brightest in the generation had been so careless in completing the form that they had managed to conceal their brightness very effectively. There really was a maelstrom of conflicting anecdote. It was my judgment call. The board at PMETB was not united on this: there were many members of the board who wanted me to be up there campaigning. It was my call on this, and my call was that, as a regulator, it was not our job to get into the maelstrom of conflicting anecdotes.

Q632 Dr Taylor: You have really answered my next question. You do not feel as Chair of PMETB responsible for what happened in any way.

Professor Rubin: The answer is no. I do not feel responsible. I will draw your attention to Professor Tooke’s report, in that PMETB is about the only organisation that is not criticised—and, of course, he took very extensive evidence. I should say, Dr Taylor, however, that, as with all regulators, what I did behind the scenes was often very different from what I was doing in the public arena. I gave various bits of advice to various officials at that time, to the Department of Health at various times, but there is a difference between what you will say privately to somebody and what you will say in public when you are a regulator.

Dr Taylor: Thank you.

Q633 Mr Bone: Basically you are saying that what you say in public is not what you are doing in private, then.

Professor Rubin: In the advice that you give to, say, a senior official in the Department of Health, when the timeframe is absolutely electric and when you realise that there are a lot of people who are having to make snap judgments, I think it is perfectly appropriate for the regulator, in my case as the Chairman of a regulatory board, to give advice to say, “I hear that you are planning to do A; I think you should do B”. That is personal advice given by the Chairman of the regulatory body. I was not claiming then to be acting for the board. I think, therefore, because I was not acting for the board, I did not have board approval for the advice I gave, it would have been quite wrong for me to go in the public domain with that kind of advice.

Q634 Dr Naysmith: You did say the system was broadly okay in 2006. At that time you broadly appeared to distinguish eligible from ineligible, but you had not seen the application form. How could you say that if you had not seen the application form?
Professor Rubin: The wording of the letter, as I said, was carefully chosen to say: “You have presented us with very high level principles and these high level principles seem to meet our requirements.” But it was very high level stuff.

Q635 Dr Naysmith: You are admitting, basically, that, without seeing the application form, you just believed what they said, that they were going—

Professor Rubin: We said that we were pleased to note that they were going to check the application form with the Junior Doctors Committee of the BMA, with the medical Royal Colleges, and we pointed out to them—although we did not use these words—that they had a mountain to climb because they were talking to us in August and they still did not have the application form ready. The background to the meeting, as I said, was for us trying to be helpful, to say, “Okay, you have told us how far you have got and, in principle, where you have got to seems to be okay but that is a long way from implementation, of course.”

Q636 Dr Stoate: If everything is going so well at PMETB, then why do Professor Tooke and the CMO both call for it to be absorbed by the GMC?

Professor Rubin: I think the reason is an administrative reason that it makes sense. I should preface that by saying, as Kevin has already mentioned, that I Chair the Education Committee at the GMC and I am in a clear conflict of interest position. For that reason, I have stood back from the responses of both PMETB and GMC to the structural issue. But, if I can answer your question as to why they are saying that, I think it is the administrative and strategic argument that there is sense in having all medical education, undergraduate and postgraduate, CPD, regulated by one organisation. I would make the point, though—I am here as Chairman of PMETB—that, despite a dreadful start—I am sure you know the first chairman left and the first chief executive—PMETB is now a functional organisation that has major achievements.

Q638 Dr Stoate: In a nutshell, then, you are not happy about it being absorbed. At one stage you said it was an administrative process and therefore it did not seem to make much difference. Now you are saying it would have a disastrous effect.

Professor Rubin: I did not use the word “disastrous”.

Q639 Dr Stoate: No, but it was what you were implying.

Professor Rubin: I repeat that I have stood back from the views of both organisations about the structural issue of a merger but I would like to make the point that PMETB has made significant improvements to the quality of postgraduate medical education in the UK.

Q640 Dr Stoate: But I still want to get to the point: Do you think it is a good idea for this to happen or are you opposed to it?

Professor Rubin: I really do not think I should answer that because of the conflict of interest position that I am in. The thing with conflicts of interest is, if you declare them, you must stand by them and I am in a conflict of interest position.

Q641 Dr Stoate: Do either of the other two witnesses have a view on this, because it is rather important?

Professor Douglas: I am a PMETB board member as of a year ago, so I cannot say anything.

Professor Sir Nick Wright: Speaking as someone who was head of a medical school when PMETB was set up, many of my colleagues and myself had grave reservations about the fact that you had a statutory body that was reporting to the secretary of state and yet was still responsible for setting the standards of postgraduate education, so the secretary of state was ultimately controlling everything. The one thing about the Royal Colleges, whatever their defects which Professor Rubin has pointed out, was that they were regarded as being independent. They inspected hospitals to see if there were appropriate training facilities and they were independent of the secretary of state; whereas the secretary of state now, theoretically, is in charge of both inspection and the provision of those facilities. We saw this as a retrograde step because the independence of inspection and the setting of standards was not being underpinned. It is rather ironic, when we are abandoning these visits by Royal Colleges, that in Scandinavia they are saying that they think it is a very good idea so they are setting this up to inspect training premises. It is really the question of the divorce of the facilities and the training from the regulation in which I would be very much in favour. Moving this to the General Medical Council would show that there is independence in regulation outwith the secretary of state’s purview.

Q642 Dr Stoate: You are basically in favour, then.

Professor Sir Nick Wright: Yes.

Dr Stoate: That is the point I wanted to get to. That is fine. Thank you, Chairman
Q643 Dr Naysmith: Professor Wright, from a medical school perspective does it make sense to have a single cradle-to-grave regulator for the whole of the medical profession?

Professor Sir Nick Wright: Yes. The reason for that is, as Peter said, that the reputation of the General Medical Council in regulating and examining standards of undergraduate medical education is nonpareil in the world generally. It has very, very high standards. Anybody who has undergone a GMC visit to either the dental school (GDC) or medical school knows the stringency of the high standards which the General Medical Council sets in education. If that could be translated into their regulation of postgraduate education, as I suspect it would be, because the General Medical Council has a tradition for excellence—notwithstanding the fact that it has been berated in other avenues, education standards are extremely high—I have every confidence the GMC could produce the goods.

Q644 Dr Naysmith: Do you think it has the skills and capacity to take on postgraduate—

Professor Sir Nick Wright: Not currently. I think it would need certainly more staffing and more finance. It would be the question of organisation that they would have to approach, so, yes, I think they could do it, given the appropriate facilities.

Q645 Dr Naysmith: Is it not inevitable that they have been dragged into this current crisis that is going on in postgraduate education at the moment?

Professor Sir Nick Wright: I think it is rather unfortunate that bodies like PMETB, the MMC board and also the Tooke Review were not dragged into sorting out this current process. One of the criticisms I would have of the Tooke report is that they deliberately restricted their remit to not looking at the current problems in postgraduate education that we were facing last year and this year. They say similar things about the MMC would have been moving on afterwards. In general terms, do you agree with the analysis and recommendations set out in the Tooke Review?

Professor Rubin: Strongly.

Professor Douglas: I agree.

Professor Sir Nick Wright: I would agree with that.

Q646 Dr Naysmith: Who do you think should sort it out?

Professor Sir Nick Wright: I think the Tooke report should have taken this under its belt, to try to produce suggestions that could change the way in which we link training decisions, consultant decisions. As you probably heard before, it was a Fidelio suggestion that the link between junior staff numbers and consultant specialist numbers should be broken, and there should be a gradation of specialists, specialists and senior specialists, so the number of recruits into these jobs was not linked with the number of consultant vacancies. Add to that the fact that we are, I understand, 21st in the world in terms of doctor:patient per head of population ratio, and it argues for a big expansion of both grades. I would look askance at the Tooke report for not looking at that in some detail.

Q647 Dr Naysmith: Do you think you are talking on behalf of most medical schools is that just your personal view?

Professor Sir Nick Wright: I think quite a number of my colleagues would share my view.

Chairman: We are going to move on to the question of the Tooke Review now.

Q648 Mr Bone: The first question is just a yes/no answer because of the way it is phrased but we will be moving on afterwards. In general terms, do you agree with the analysis and recommendations set out in the Tooke Review?

Professor Rubin: I was surprised that that particular analysis was used. The point has been made to you before that a group of people who are deeply involved in it, who have been designing or running part of the programme, were counted as one vote whereas an individual might be counted one vote, so I thought the analysis was a bit simplistic. But the overall messages put out, that the vast majority of the profession supported the vast majority of the recommendations, is absolutely correct and also not terribly surprising.

Professor Rubin: Would it be appropriate to mention what I consider to be the most important recommendation, about NHS Medical Education England, or do you want to keep it more general?

Q649 Mr Bone: In the consultation programme you have approval for the review in something like the terms you might get for a presidential election in one of the African democratic republics: 87% approval. Are you surprised at the medical profession, in that everybody thinks it is the best thing since sliced bread?

Professor Douglas: I was surprised that that particular analysis was used. The point has been made to you before that a group of people who are deeply involved in it, who have been designing or running part of the programme, were counted as one vote whereas an individual might be counted one vote, so I thought the analysis was a bit simplistic. But the overall messages put out, that the vast majority of the profession supported the vast majority of the recommendations, is absolutely correct and also not terribly surprising.

Professor Rubin: Would it be appropriate to mention what I consider to be the most important recommendation, about NHS Medical Education England, or do you want to keep it more general?

Q650 Mr Bone: We have sort of moved on and Professor Wright did that at the start. I was going to ask if you were surprised at the fact that it was not more critically scrutinised. Are there bits that need more debate and would that be helpful?

Professor Rubin: I think the MMC and MTAS events were a defining moment in the relationship between the medical profession and the Government. It was the moment when a lot of members of the profession said, “Enough”—rightly or wrong. It was the moment when a lot of members of the profession felt that the voice of reason, which they thought was their voice, had not been heard. Rightly or wrongly—I am not saying—that was the moment. In his report Professor Tooke has enunciated many of the feelings of the medical profession in this country and that is why I think those who respond to him were so positive in their
response. When you get into the detail, of course, then a lot of things need a lot of careful consideration.

**Professor Sir Nick Wright:** The Tooke report took evidence from a large number of people. Most people in my position, for example, helped the Medical Schools Council in their report. I was part of the Academy of Medical Sciences consultations, through my own Royal College, through my own Medical School, and I also appeared before the Tooke Committee for Fidelio. Most people had multiple channels into the committee, and if you look at the response to the consultation they were uniform in their views on the consultation document. No, I am not surprised and, together with the things Peter has said, I would not be at all surprised if there is uniformity.

Q651 Mr Bone: Mr Chairman, this is the sort of evidence we are gathering. It surprises me that because this report seems to have done a very good job and seems to have represented people’s opinion, the Government is doing very little, job and seems to have represented people’s opinion. It surprises me that the evidence we are gathering. It surprises me that the Tooke report seems to have done a very good job and seems to have represented people’s opinion.

**Professor Rubin:** If the major recommendations in Professor’s Tooke’s report are adopted, they will have far reaching consequences. With the best will in the world, it would be unrealistic for any government to say by return post, “That’s great. Let’s do it.” I just do not think that would be realistic. Some of the implications of the report are very far reaching—and quite rightly so. To put it into context, speaking now both for GMC and PMETB, we are UK-wide bodies and in that UK-wide we have worked with NHS Education Scotland and have been very impressed by NHS Education Scotland. By its very existence it sends a message that education is important in the health arena. Just by existing it sends that message. It has the budget. The golden rule applies, does it not? He who has the gold rules and it really does have a big impact on health education in Scotland. Our view as regulators, speaking both for GMC and PMETB, is that the establishment of NHS Medical Education England, with a ring-fenced budget for medical education, with a sophisticated workforce machinery and workforce planning machinery, would by itself go a long way to ensure that we do not have a repeat in the future of the MTAS/MMC problems. That is a view that is shared not just by the regulators but by the Academy of Medical Sciences, by the Medical Schools Council, by the Academy of the Royal Colleges. It is a widely held view by all those who represent different aspects of the medical profession.

**Professor Sir Nick Wright:** I think the heads of the medical schools feel very strongly that the Department of Health has ridden roughshod over the ten key principles that link the Department of Health and the Department of Education and medical schools working together. There is a whole list within the Tooke report of reasons why the Department of Health is disengaging from the academic education agenda: the lack of effectiveness of SELAR (Strategic Learning and Research Advisory Group), for example: the loss of workforce confederations with academic representation; the absolute refusal of Derek Nicholson to accept the representations from the Medical Schools Council that there should be a statutory academic representative on Special Health Authorities. I understand that only three of them have that. We lobbied very strongly to get that but got a very dark brown answer from him. It has always been the tradition in this country. The Special Health Authorities, the previous Strategic Health Authorities, the teaching hospital Trusts always had a non-executive director who is an academic. That has been lost.

Q652 Mr Bone: I think we are going to ask about that later.

**Professor Sir Nick Wright:** As Peter says, having a national body for medical education in England perhaps controlling the budget—the main budget and all the other budgets which the Department of Health or certainly SHAs have clawed back to prop up their own financial problems—would send a very strong signal that education within the National Health Service is a pivotal part of it—as, of course, it should be.

**Professor Douglas:** Speaking with a different hat on, that as Chair of the Academy of Medical Royal Colleges Education and Training Committee, I would entirely agree with Peter that recommendation 47 is the key one in the new version of Tooke. I work very closely with NHS Education Scotland in Edinburgh. They are an extremely effective organisation, controlling the funds is critical to properly planning the training for the juniors. If anything gets enacted, it has to be recommendation 47. I am very concerned that I am not seeing evidence that this is necessarily going to go through very readily.

Q653 Mr Scott: Obviously you are all in favour of the NHS Medical Education England, but do you really think it is necessary for the new body to be set up? Could it not be devolved to postgraduate deaneries and Strategic Health Authorities?

**Professor Douglas:** My own view is that it is necessary to have a new body set up. The controlling of the funds by other bodies whose prime interest is not in training is a key issue and, also, because of the fact that there are numerous deaneries which work slightly disconnectedly sometimes, it would be very helpful. That is what has happened in Scotland: the deaneries are connected through NES. I think it would really make a very positive difference to training of the juniors in England.

**Professor Sir Nick Wright:** I would be very strongly against what you suggest. If you go around and talk to my colleagues in London, we have had reduction in the educational levies which have affected us somewhat but, for example, in Leicester they faced the removal, because of a problem with their SHA, of a minimum of £20 million of support for their academics. They were going to lose a
significant number of staff in their school and it was only by intervention centrally that this was stopped. If the SHAs control the educational levy in the budget and they run into financial problems again—it is not ring-fenced; we thought it was—they could claw it back and use it for other purposes, and I have no confidence they would not do that.

Professor Rubin: I feel very strongly that there needs to be a national body. There are a number of reasons for that but perhaps I could give an example of one of the problems that led to the mismatch between applicants and places. As I am sure you have heard in other evidence, on the one hand we had the Home Office and the Treasury having an open door policy and trying to encourage doctors to come to this country, and then we had the Department of Health saying that we must be self-sufficient in doctors and produce all the doctors we need internally. Those were two mutually incompatible policies. It needs a national oversight to ensure that policies in different parts of government are genuinely joined up. Just staying on the subject of workforce planning: we can be sure that we will get workforce planning wrong because we always have, so that is something about which we can absolutely confident. But I think we will get it less wrong if we have some serious brains working on it at the national level, looking at all the issues involved. To try to duplicate really high quality workforce planning around each of the SHAs will be an unnecessary duplication of activity. As Neil and Nick have both said, there is the important issue that, with the best will in the world, I am sure if you sat down any SHA chief executive or Trust chief executive and said, “Is education and training important to the NHS?” of course they would say yes, but they are under pressure to deliver on short-term, here-and-now targets. I think it needs a body outside the heat and pressure to deliver on short-term, here-and-now course they would say yes, but they are under education and training important to the NHS?” of executive or Trust chief executive and said, “Is the important issue that, with the best will in the world, I am sure if you sat down any SHA chief executive or Trust chief executive and said, “Is education and training important to the NHS?” of course they would say yes, but they are under pressure to deliver on short-term, here-and-now targets. I think it needs a body outside the heat and pressure to deliver on short-term, here-and-now course they would say yes, but they are under education and training important to the NHS?” of executive or Trust chief executive and said, “Is

Q655 Charlotte Atkins: Professor Wright, did MTAS cause any particular problems for academic trainees? Have these been addressed in the Tooke report?

Professor Sir Nick Wright: Yes, I think they have. It was our understanding before this all came out, that the academic applications would be processed before the general applications—and this would have been all right—but they were not. They were caught up within the turmoil of general applications, so you had people who were high-flying academics not being interviewed and not being short-listed through the scandalous way in which this process was done. There would not necessarily be a repeat of the evidence that very good academics were not short-listed or even dropped because, as you probably know, Fidelio have kept quite a large database of the people who had these major problems. Bringing academic applications into the general thing was an absolute disaster, so they did suffer through that, yes. I think this has been addressed in the current round because they are being done before, which is a good thing. Also, if you look at Tooke report and go through it, a great deal of thought has been given to academic trainees, to the concept of the academic team: the fellows, for example, being managed by the deaneries of the medical schools jointly, which I would certainly approve of, and also, if in fact you do get the abolition of run-through training, to making sure that the academic FY2 positions are maintained because they have been a success. I think the Tooke report has given considerable thought to that and I would have no worries, as long as those were adhered to, about the academic recruitment in the future.

Q656 Charlotte Atkins: Should the foundation schemes be split to allow the Medical Schools to meet their legal obligations to guarantee students work until they achieve GMC registration?

Professor Sir Nick Wright: It is the view of the Medical Schools Council, which is why we agreed that it should be split. We have not referred to the MDAP problems of the year before, the Multi-Deanery Application Process, which was also an unmitigated disaster. We now have the situation where, when we admit students for medical school, there is a sort of contract that we get them medically qualified and we get them medically registered and, because of that, they have to get an FY1 position. In the old days, we used to have a matching scheme that made sure we could control to some extent where our students went, particularly locally, so that we matched our students to the jobs we had and that worked very well. With the advent of EC legislation and equality of opportunity, we cannot do that any more. My responsibility under the Medical Act is to make sure that my graduates are fit for purpose and, also, that their FY1 positions are suitable for them. If
they are going up to Blackpool or Inverness. I have limited ability to make sure those jobs are appropriate. Also, we are responsible for the FY1 year within the medical school. Similarly, we know that there are individuals within medical school who do qualify but they may need special attention during their FY1 year. Again, we used to make sure these people got very good positions so that they could be looked after properly. Now, we cannot do that any more. I have to say that the foundation applications have worked better this year but, because of equality of applications, for example, from overseas and elsewhere, we would like to control the FY1 positions to make sure that our students who have got FY1 jobs are registered. That is the main reason behind that.

Q657 Charlotte Atkins: You agree with the splitting of the two-year foundation scheme.

Professor Sir Nick Wright: I do.

Q658 Charlotte Atkins: And the creating of a three-year core speciality training programme.

Professor Sir Nick Wright: As long as there is sufficient flexibility within that core specialty training, yes.

Q659 Mr Bone: Does anyone else want to come in on that?

Professor Douglas: I think foundation is a slightly difficult issue. In the original interim version of Tooke some of us were surprised that the recommendation to split F1 and F2 was not really compatible with recommendation 2, which is that everything should be evidence based, because the evidence is not in. We know that foundation has worked very, very well in some areas of the country and done very badly in others. I would agree entirely with the principles behind what John Tooke has recommended in his final report: namely, that people should be guaranteed F1 jobs; that we should select into foundation and to subsequent speciality training on merit, absolutely; and that we should not hinder the progress of people who are clearly committed to a specialty and have the ability to practise that speciality. How exactly you do that? It does not matter to my mind whether you split F1 and F2 or you have the same content on either side of a different divide. That is open to debate.

Q660 Dr Naysmith: Before I come on to the role of the medical schools, could I pick up on the F1 and F2 issue we have been discussing. Why do you think it is really successful in some places and not others? In my own area, in the Avon and Somerset Deanery, they have written to me saying, “Please do what you can to protect the foundation two-year course because it operates so well and is the best bit of the whole procedure. Why is it that it operates so well around Bristol and operates badly elsewhere?”

Professor Rubin: PMETB and GMC are jointly responsible for quality assuring the foundation programme. Perhaps I might give you some evidence, but I should emphasise that this evidence is as a result of interim analysis. One of the things that PMETB has introduced—and we did it for the first time last year and we are now doing a second one this year—is a trainee survey. Last year we had a 64% response to our training survey, for example—which by survey standards is pretty mega. This year we are halfway through it and we have had just over 2,500 responses from those who did the foundation programme last year. Of the 2,500 who did foundation programme last year, 75% of them thought it was very good and that F2 added significantly in terms of value to what they had learned in F1. There is a significant majority of people out there saying F2 is rather good. Where it is not that good will be down to local implementation—as is often the case here. I would agree with what Neil has just said. We are getting deep into structural issues here, but whatever happens to foundation there is clearly something of considerable value in F2 and we must be careful not to lose that value, whatever happens in any rearrangements that subsequently happen.

Q661 Dr Naysmith: The other thing Professor Douglas also said is that the evidence is not really in yet.

Professor Rubin: Exactly.

Professor Sir Nick Wright: From a medical school view, where foundation schools and medical schools have worked in close collaboration I think the foundation has been a success, but sometimes they have not. For example, under Tomorrow’s Doctors medical schools are constrained to teach communication with patients to a high level. You do not want to see that replicated in the foundation programme. If you concentrate on the care of the acutely ill patient, a major thing in the undergraduate curriculum, you do not want to see that replicated in the foundation years. If there is collaboration between the medical school and the foundation school, I think everybody is satisfied. But where there is a disjointed approach, I think there will be problems.

Q662 Dr Naysmith: I am going to go on to ask some questions on the role of medical schools. Some of matters may have been touched on, so excuse me if you sense we are going over old ground. The Tooke report commented on the growing divergence between the health and the education sectors and between medical schools and the deaneries. In your experience as the head of a London medical school, do you agree with this? What problems has it caused?

Professor Sir Nick Wright: I think we are very privileged in London because the London deanery is certainly not dysfunctional, it is very good. Apart from the way in which the London deanery is engaged in sort of nationally promoted activity like MTAS and MDAP, I have had no complaints at all. We have an associate dean, Professor Joe Herzberg, who attends my senior management team twice a term. We have very close relations with him. He reports to us on the inspections he is
doing on the FY1, any problems he has, if it goes well with the foundation school—we often get him together with our foundation school head—and through Lis Paice and through the heads of the London medical schools committee, with which he works regularly, we have a very cordial and good relationship with the London Deanery. Speaking as a London medical school dean, I have had very little cause for complaint over our relationship with the deanery. I know this is not so in other parts of the country. I hear my colleagues complain continuously about the poor relations between themselves and the deanery in relation to many, many items: particularly for trying to arrange out of service time for people to do PhDs and things like that, and lack of flexibility and lack of cooperation with joint funding initiatives. I know that certain deaneries outside London are very dysfunctional and certainly need a great deal more work, but I would emphasise that in London it has worked extremely well—because I think we were determined to make it work well.

Q663 Dr Naysmith: You are saying there is nothing wrong with the system.

Professor Sir Nick Wright: Not at all.

Q664 Dr Naysmith: It is just that in certain places they do not operate the system well.

Professor Sir Nick Wright: We work very effectively with the system, because we have frequent contact with both our associate deans in the London medical schools and frequent contact with Lis Paice for the London Deanery. I probably see Lis Paice once every three weeks and if there is any problem we can sort it out because we have multiple venues at which we meet.

Professor Rubin: This is another example of what NHS Medical Education England would improve on.

Q665 Dr Naysmith: It is interesting that you mentioned Lis Paice because when she was here last week she was very much in favour of introducing a medical licensing examination, such as the one that goes on in the States, at the end of medical school training. Do you think it is a good idea?

Professor Sir Nick Wright: I think you find heads of medical schools would be very strongly against a national examination taken at the end of the undergraduate curriculum. We pride ourselves in this country on the diversity of the medical education we give. For example, in Imperial College, Cambridge, you would expect there to be a very, very academic education. We would look for those people, most of them, many of them, to go into academic medicine, to be high-flyers, to be very good. Then you look at a medical school like College, Cambridge, you would expect there to be a very, very academic education. We would look for purpose and only three of those were UK graduates.

Professor Sir Nick Wright: Yes.

Q667 Dr Naysmith: Also, there are many academic excellence centres in the United States as well.

Professor Sir Nick Wright: The whole thing is competence based. We all have a competence-based curriculum. If we had that at the end of the undergraduate curriculum, it would not show us a great deal. Professor Rubin will back me up on this, when the General Medical Council, I think it was, did a survey of all FY1 positions a couple of years ago, only 19 FY1 doctors were found not to be fit for purpose and only three of those were UK graduates.

Q668 Dr Naysmith: If that is the case, what would be wrong with it?

Professor Sir Nick Wright: It would change behaviours. It would change the way we approach things. We have a very diverse medical education system.

Q669 Dr Naysmith: Is there any evidence that the American medical professional produces doctors who are significantly worse?

Professor Sir Nick Wright: No. The timing at the end of the undergraduate curriculum would not receive support from the Medical Schools Council and neither probably would a national examination at the end of the FY1 year. Certainly, in their evidence to the Tooke Committee, their view was that local selection into core training programmes, with a portfolio and a CV et cetera, was the way to do it, and then into specialist training would be part of a national examination, possibly replacing the Colleges part 1 examination. Medical schools are not against national examinations: it is the timing of them. In their evidence to the Tooke Committee they suggested it might well be at the end of core specialist training, so we are certainly not against that. And if it did come into operation, then medical schools, I hope, would be invited to set part of that agenda. We are certainly not against a national examination.

Professor Douglas: I am strongly in favour of national examinations. We desperately need one to be fair to the trainees. There are very good trainees in bad medical schools and vice versa. The MRCP has published, this year, evidence showing differences in performance between medical schools. We need to have this as part of the selection process. I advocated it to MMC England in June 2005 and it was howled down by the postgraduate deans and the tutors at that stage as being undoable but I think it is an essential part of the selection process.

Q670 Mr Bone: Would that not lead to a dumbing down? If everybody is passing at the moment—and the medical colleges I think probably do a good job—if you have a national standard, and you are saying that some are not very good at the moment, to get the same numbers through you would have to dumb down a bit, would you not?


*Professor Douglas:* No. I am saying that the standard is good overall but some are absolutely excellent and some are just good. The people who are excellent deserve to be credited with being excellent.

**Q671 Mr Bone:** Is that not exactly the point I am making. Would a national exam not allow that to be clear?

*Professor Douglas:* It would allow that to be clear, provided it is a ranking exam—that is, not a pass/fail exam. It is one of the many signals we should be feeding into selection. Indeed, there is an argument for placing it in F2, if F2 existed, because you could then make everybody, whether they are from the UK or from outside, sit this test as one component—not the critical component because clinical skills and communication skills are also vital—but one component for selection into specialty.

**Q672 Dr Taylor:** Perhaps we could turn now to the Douglas Review and, first of all, to MTAS. It is clear now that MTAS was a spectacular disaster. A lot of us think it was clear in March that it was going to be a spectacular disaster, certainly from the letters that we as MPs received. Why did the Douglas Review not call a halt right at the beginning of March, when really people were writing to us and saying, “There is time to go back to the old system just for this year”?

*Professor Douglas:* The Academy met on 5 March. At that stage we took information from all the colleges—this was, as you say, early in the process, a week into the interviews—and the messages we got from each of the colleges and faculties was that there were many excellent candidates who were coming forward and who had got themselves into a position to be appointed. The view of the colleges was that we should continue to go forward and not disadvantage those people who had got themselves into a position to be appointed and put in a huge amount of time to their applications, and also a huge amount of time had been put in by the HR staff of the deaneries and by consultants—that should not be underestimated: the amount of time that consultants and GPs put into the appointments process—provided that some of the most obvious faults were fixed immediately. We asked for a meeting with Patricia Hewitt that night and got it, and she agreed to fix some of the obvious faults: CVs had to be available from then on; full, probing questioning would be allowed and not just formulaic interviews; and only very appointable candidates were appointed to try to leave some jobs for later on. And the review was set up. Once the review was in place, we had several heated debates as to whether we should keep going forward. The consensus from the colleges and from the BMA and from the postgraduate deans—those being the members of the medical profession on the team—was always, at the end of the meeting—not always at the beginning—that we should continue to go forward but it was a very close call on several occasions.

**Q673 Dr Taylor:** We have certainly had the feelings from the colleges that they were pressurised, and certainly Liam Donaldson, when he came to see us, said it was absolutely clear that the colleges agreed to go ahead. We got the impression that colleges had rather been steamrollered by the department. Is that fair or not?

*Professor Douglas:* It is entirely unfair. There is no doubt that the department would have liked it to go forward but we were independent and we debated it independently. Indeed, I took the medical members of the committee out of the room to debate it without the department around and the consensus, always at the end of the day, was to go forward.

**Q674 Dr Taylor:** Thank you. That has cleared that up. To clear up one other point, last week Professor Black said, “When the Douglas review was doing its work the chairman of that body asked the academy and BMA together to produce a letter which would be supportive of that review and would also correct some of the inaccuracies already in the press about it. It was a genuine attempt to see whether two bodies which perhaps are quite separate could come together to support the CMO.” Is that your recollection?

*Professor Douglas:* I absolutely suggested that the two individuals concerned wrote a letter to the media because I did not feel I could do that in my independent role as Chair. They had offered to support if they could. I was keen that they established the difference between MTAS, which, as you say, was in very deep problems, and MMC, the principles of which many of us supported then and still do now. That is what I asked them to do. She is right that I requested them to write a letter.

**Q675 Dr Taylor:** Right. It did not actually help, did it?

*Professor Douglas:* I did not write the letter.

*Dr Taylor:* Okay. Thank you.

**Q676 Dr Stoate:** Let us stick with the Douglas Review and the competition ratios. You wrote to the *Times* last week to complain at competition ratios of up to 20:1, and yet the MMC board has currently endorsed the 2008 arrangements and NHS Employers have gone so far as to welcome high competition ratios. Is it not true, therefore, that the profession’s leaders are in fact being taken for granted around this issue and, in fact, it is trainees who are receiving the lowest priority if it is acceptable to have ratios of that level?

*Professor Douglas:* I joined in writing to the media, having made considerable thought as to whether I should do that. I had not contacted the media at all over the last year about MTAS or MMC. Peter was at the meeting of the English Programme Board in December when we were first shown the figures for next year for England. You will recall that one of the big problems, as Peter said earlier on, for the 2007 process, was that the numbers of posts were too low and were not known until *post hoc* basically. When we were shown the numbers in December it became immediately apparent to me
that there were too many jobs at the lower levels. There were 1,200 excess jobs at ST1 compared to the feed-in from foundation. 1,300 too many jobs in ST2 compared to the feed-in from ST1 and FT/STA1. That was going to result in sucking in international graduates—with the moral issues that gives rise to—with the expectation that they will have that they might train further, and problems for the 2009 process as they compete again. Even more concerning to me was the fact that there were going to be many hundred too few jobs at ST3— exactly the same issues we had last year. I took this to ministers that day. We wrote to all the appropriate channels and made full recommendations as to what I suggested they could do to try to rebalance the situation just a little bit to try to help the situation, and, despite others taking the papers that I had written to ministers, I was getting the impression that there was just no movement on this. It was out of a feeling of intense frustration for these senior trainees, many of whom had been in medicine training towards their career for the last ten years and the only thing they had done wrong was to graduate at the wrong time, that I wrote a letter to the Times.

Q677 Dr Stoate: That is fair enough, I can see exactly what you mean by that, but postgraduate deans last week told us “so far, so good” with the 2008 process, and yet obviously the colleges took a rather different view that they were very worried indeed about these very high competition levels—particularly in surgery, where it did go up as high as 20. Why do you think the deans are so much at odds with the colleges over this issue?

Professor Douglas: I think I have made the colleges’ view quite plain. You would have to ask the deans why they have their position.

Q678 Dr Stoate: Fair enough. If three applicants for every training post appears to be too many but competition is desirable, what level of competition do you think there ought to be? What do you think would be a reasonable level? What should we be aiming for in terms of numbers of applicants for each post?

Professor Douglas: I do not think you can say anything from this year’s competition ratios because people are allowed an infinite number of applications. We just do not know.

Q679 Dr Stoate: I am asking you what would be desirable.

Professor Douglas: There is no way of knowing what desirable is.

Q680 Dr Stoate: I am asking you for your opinion of what you think is a reasonable level of over-demand for posts compared with supply.

Professor Douglas: My basic stance would be that people who have trained in the UK, who are highly competent, should have a reasonable chance of getting a job. That does not translate into a competition ratio.
Q685 Dr Naysmith: I know it was just an example but it is amazing how often it comes up, and yet, if one third of the population need treatment for mental disorders, should we not be providing more doctors in this area and better training?

Professor Sir Nick Wright: Let me give you two examples from the last round of MTAS where there were two candidates for psychiatry positions who both had MB PhD degrees from the University of Cambridge who were not short-listed for any psychiatry jobs in the country.

Q686 Dr Naysmith: That in itself is a bad thing. I am just pointing out that it could well be that the country needs more psychiatrists, highly qualified, well trained ones, than brain surgeons at the moment.

Professor Sir Nick Wright: Absolutely; as I would want try to make sure that the people who want to do psychiatry are able to do psychiatry.

Professor Douglas: It is one of the findings of our review group that there were very few UK graduates who wanted to go into psychiatry, obs and gynae and paeds, and we need to rectify that.

Q687 Mr Bone: This is not a party political point because I am well out of tune with my own party on this issue, but is it not strange that this unique state-run health system that we have cannot match the number of people it puts in with the number of people it wants? If you are like me and think that the people who want to do psychiatry are able to do psychiatry.

Professor Sir Nick Wright: Absolutely, as I would want try to make sure that the people who want to do psychiatry are able to do psychiatry.

Professor Douglas: It varies from country to country. In the USA, for example, they take a very pragmatic approach, in that they under-produce doctors and then buy them in. You can argue about the ethics of that very seriously, but that is how they do it. It comes back to having to have a serious, mature debate at the national level of what sort of health service we are looking for and how many doctors do we need in this country and, having decided that, are we going to produce them all ourselves or are we going to have a mixture of home-produced and abroad. We need absolutely clarity and honesty about that.

Dr Stoate: Could I just say that there is a massive imbalance across Europe. For example, Spain, Italy and Germany produce quite a lot more doctors than they need, who often have to come to this country for further training because they cannot get posts abroad. It is not an issue that just is facing us.

Q688 Chairman: From the evidence session of the postgraduate deans last week, I am going to leave you with a couple of quotes I would like you to comment on. David Sowden said, “There are elements of success in the sense that DGHs, which historically outside the South East in particular have had real difficulty in recruiting good quality staff, are singing the praises of the people they have recently appointed. Speaking to my specialty training committees, many say that this is the best cohort of trainees they have ever had in postgraduate training . . .” Professor Thomas, from my area of the UK, said, “In particular, Hull has said it has the best doctors that it has ever seen and many others have said the same, particularly DGHs across Yorkshire and the Humber which have had difficulties in recruiting doctors. This year they have had much better recruits.” Would you agree with those comments or do you have any knowledge of that?

Professor Douglas: I think those are perfectly reasonable comments. Some places have benefited from people looking beyond their normal horizons as to where they should be applying. My understanding for this current year is that there are going to be areas where there are relatively few applicants, still, and areas where there will be a vast surplus, so we have not solved the balance, but I am sure there are other areas that will benefit.

Professor Rubin: I am not surprised to hear this. A personal view with regard to MTAS is that just because it was implemented badly this time does not mean that MTAS is bad in principle. UCAS works well and has been respected for many years. UCAS results in good applicants, through clearing or whatever, going to universities they may not otherwise have gone to, but if MTAS is properly implemented then there is no reason why it could not work as well as UCAS with the benefits to which you are alluding, which is that very able doctors go where they might not want to go.

Professor Sir Nick Wright: I would agree with that. UCAS, as far as medical school admissions goes, is extremely well implemented. Most medical schools will, after short-listing from UCAS, form interviews for themselves. We know a structured interview is just about the only thing that does correlate with success in medicine, so it is a well-trodden path. If MTAS was implemented correctly, with CVs and appropriate interviews, then we would have much more confidence in it.

Q689 Chairman: The picture we have painted about what happened last year is one of complete disaster. I am saying that my constituents are benefiting by what happened last year, in so far as, when they go to Rotherham District General Hospital, the doctors they have there now are a better cohort of doctors than they have had in years gone by.

Professor Sir Nick Wright: That may well be true. At the same time, if you have individuals who are going into specialties they did not want to get into and they are having to do a speciality which they had no plans to do . . . Of course they will do it to the best of their ability but then we have stories of people stuck in specialist training without the ability to change because of lack of flexibility. I am sure that this is a success story so far as DGHs in the provinces are saying but, if you think about the personal aspirations of those doctors, then we have to consider this, because of successive generations of students who may find that their ambitions are not going to be realised.

Q690 Chairman: My personal aspirations are a bit clouded with the needs of my constituents in relation to healthcare, Professor Wright.
**Chairman:** Could I thank you all very much indeed for coming along here this morning and giving us evidence.

**Professor Sir Nick Wright:** I am speaking as head of a medical school.

**Ms Thomas:** We believe that evidence from our inquiry into MMC. I wonder if, for the record, I could ask you to introduce yourselves and give the position that you hold. Can I start with you, Anne?

**Ms Rainsberry:** Anne Rainsberry, Director of Workforce, NHS, London. Dr Moira Livingston, Strategic Head of Workforce and Deputy Medical Director, NHS North East. and Ms Sian Thomas, Deputy Director, NHS Employers, gave evidence.

Q691 Chairman: Good morning. Could I welcome you to what is our fifth evidence session in relation to our inquiry into MMC. I wonder if, for the record, I could ask you to introduce yourselves and give the position that you hold. Can I start with you, Anne?

Ms Rainsberry: Anne Rainsberry, Director of People Organisation and Development, NHS and I am a Member of the new MMC England Programme Board.

Dr Livingston: Moira Livingston, Head of Workforce, NHS North East and Deputy Medical Director; previously a Member of the Modernising Medical Careers team on the staff grade area of work.

Ms Thomas: I am Sian Thomas and I am here representing NHS employers. We are the employers organisation for the NHS supporting and helping employers implement best practice around employment.

Q692 Chairman: Thank you and welcome. A question to all of you. Do you accept that the 2007 MTAS process was a disastrous experiment in workforce planning?

Ms Rainsberry: I do not think it was absolutely disastrous in workforce planning, no. I would agree, actually, with the evidence that the CMO gave to the Committee. I think there was one particular variable, which was the late decision on IMGs, which changed the projections quite substantially. If that had not been the case, in effect, the projections, in terms of demand and supply, would have been pretty much aligned.

Dr Livingston: I would agree with Anne. I think the issue was the difficulty in predicting the number of doctors who would apply for the posts available. In terms of workforce planning, looking at the number of training posts and how that fits with future service delivery, that was well in place. I think with the increased number in specialty training posts, there was no budget cuts to the deanery. We receive a deanery investment plan every year and we met the requirements of the deanery. If we look at the increase in training numbers, since the standard at that point.

Ms Thomas: We believe that evidence from employers shows there were many good things about MMC, and we welcome the opportunity in this session to tell the panel about that. There are two issues that we think did affect the failures around MMC. One was the high volume of applicants, which has already been commented on, and the second was the failure to take into account a transition period and a big bang approach to, effectively, a large cohort of doctors, and that led to a sense for them of a last chance attempt to get into specialty training. So, it was those two factors: the high volume of applicants and no transition.

Q693 Chairman: You were a member of the Douglas Review.

Ms Thomas: I was.

Q694 Chairman: Which recommended a single interview for English candidates last year. Did the NHS Employers put pressure on the professional members to ensure the jobs were filled by the 1 August deadline and do you accept some responsibility for the way that many of your employees were treated during the subsequent months?

Ms Thomas: I endorse many of the things that you have heard Professor Douglas say this morning. In fact, his transcript would pretty much reflect our view. The review group, at the beginning, was in a very difficult situation, but all partners agreed that to carry on was the best thing. The 1 August date was critical because we only had weeks to go to ensure the service had these doctors in place to deliver Save Patient Care, which the service was relying on, so employers fully supported those decisions; and behind every representative’s evidence that I gave, we had over 150 employer views backing that. Increasingly, we based our decisions on evidence. It is always easy in hindsight to go over those decisions, but I think, on the whole, the review group did the right thing and tried to base its proportionate decisions to make a good outcome for the August service delivery pressure.

Q695 Chairman: Could I ask Anne and the Moira: by how much were medical education budgets cut in your areas in the lead up to the implementation in 2007. Do you accept that budget cuts were a major cause of the failure of the MTAS system?

Dr Livingston: I think in the north east there were, in fact, no budget cuts to the deanery. We receive a deanery investment plan every year and we met the requirements of the deanery. If we look at the increase in training numbers, since 2005, 2006, when the deaneries became the responsibility of the SHA in the North East, there has been an increase in training numbers, overall 58%, and if we look at the specialty training, training numbers, they went up by 71%, with general practice being less, at 22%. So that commitment to training, in terms of the number of trainees in the system, I think, is evident. At no point have we had any sense from the deanery that they were under-resourced. If we look at this year and our
commitment to delivering the MTAS process as efficiently and effectively as we could, then I think that we can demonstrate from the SHAs perspective that we invested a further £1.6 million in the delivery of the MTAS process, which included additional posts as part of transition as well as meeting the Secretary of State's commitment to on-going employment from 1 August and the transition arrangements for doctors to help them become more competitive for next year.

Q696 Chairman: So no cuts as far as you are concerned?

Dr Livingston: No.

Q697 Chairman: Anne?

Ms Rainsberry: It is a similar picture to the North East. There were cuts in 2006-07, and I gave evidence to this Committee last time we talked about workforce planning. The majority of those cuts came from non-medical education. Because of the nature of the way the contracts are set up with medical education, it makes it very difficult to do that. In London, since 2005, the numbers of specialty training posts have increased by 65% and, therefore, we have had to invest in the infrastructure to support that. I think it needs more investment, and we have just gone through a process with our own deanery of looking at their three-year strategy to look at how we would tailor that investment, but certainly, in relation to your question, I do not think there was a relationship between the problems that were experienced in the recruitment to specialty training in the last year and the degree of investment, and, indeed, as Moira has alluded to, SHAs used their flexibility quite substantially in order to smooth the bulge of trainees in their unit of application to help transition. That was funded by SHAs.

Q698 Dr Naysmith: Before I go on to ask the question I was going to ask, can I ask Anne and Moira: you have both said there were no cuts in postgraduate training, but are you not just talking about the salaries, paying the salaries? Is there not a separate little budget that is supposed to be used for courses and that sort of thing? Lots of people tell us that the budget was cut.

Ms Rainsberry: Let me clarify my answer. I said the majority that came from non-medical education. The financial position in London last year was really quite serious, and as an SHA we had to create the right platform in order to take the service forward, like other parts of the country, and therefore there were some reductions, temporary reductions.

Q699 Dr Naysmith: For that year?

Ms Rainsberry: For that year, which have been restored.

Q700 Dr Naysmith: Which impinged on some people who were training that year?

Ms Rainsberry: That is correct, but it was not to training numbers, it was around the infrastructure, and that has now been restored.

Q701 Dr Naysmith: Let me get this absolutely right. It was not to do with reducing training numbers?

Ms Rainsberry: No.

Q702 Dr Naysmith: But it may well have influenced the quality of the training process that took place that year.

Ms Rainsberry: Yes.

Q703 Dr Naysmith: By spending training money on something else.

Ms Rainsberry: Things like CPD were affected, so study leave budgets would have been affected, but not the core infrastructure.

Q704 Dr Naysmith: I will go on to the question I was going to ask you. During our workforce planning inquiry you told us that the strategic health authorities had little influence on the development of MMC. Do you think that is the reason why the disastrous transition took place in the new system in 2006? If you had had more influence, would it have gone better?

Ms Rainsberry: Yes. I think hindsight is a wonderful thing, but in terms of development of policy, as you get nearer and nearer to implementation, it is extremely important to gauge those people who are interacting on a daily basis with the service, because one of the complexities (and that played out last summer) is when you get into difficulties you have got difficulties around doctors’ careers, their aspirations and training, but also very real service risks around that and, therefore, all of those competing risks and priorities need to be properly looked at and balanced, and I think that going forward it is important to have that service view. I, together with an SHA chief executive, sit now on the MMC England Programme Board that has been planning a round for 2008, and I think that that view has been heard and has been balanced against the medical profession, and we have certainly, I think, as a board produced a framework that, to date, is working well for 2008.

Q705 Dr Naysmith: Is that the same in your area, Dr Livingston?

Dr Livingston: Yes. If I can address your previous question in terms of cuts to training, just to clarify for the North East that no such cuts were made in terms of access to training and study leave and that the way in which we managed the reduction in the allocation was through working very closely with the service through a bundling of funding approach and a quality monitoring of delivery to ensure that no such cuts were made. I would also add that, at times when phrases such as “raided the budget” are used and “cuts were made to training”, it is important to understand that, as part of effective workforce planning, there will be changes made to the commissions that we make with higher education and we have a contract which allows flexibilities within that. When we did reduce the contract for the number of diploma nurses, for example, in the North East, that was done through full consultation and also was done as a result of effective workforce
planning. I think sometimes that is misunderstood and is taken as evidence that budgets were raided. In fact, it was exactly what we think we should be doing, which is effective workforce planning and collaboration with higher education and the service.

**Q706 Dr Naysmith:** Thank you for clarifying that. In the north-east we had some evidence, clearly in my own area, where cuts were made by the Strategic Health Authority which had really disastrous effects on the local university which was training nurses, and it happened virtually overnight. Not everywhere is the same. Thank you for that clarification. What do you think about the involvement of strategic health authorities in this whole area going forward, given that you commission the trainees?

**Dr Livingston:** Going back in time, and certainly my knowledge is within the North East and particularly within the area of MMC that I worked in, I would say that there were attempts made at engagement, and I think when you look back it could always have been improved. There was a responsibility on us—at that time I was working in the deanery—to engage with strategic health authorities, so early on in the process of MMC development we were involved in the Workforce Planning Committee set up by the Strategic Health Authority so they could fully understand the implications of MMC at a local level. At a national level the SHA Chief Executive representative was on the MMC Programme Board throughout the process. For me, where I’d like to get to is, I think, full integration of education, training and service delivery. I do not think that they can be separated out. I think it is a core function of the NHS. I think it is essential that we see it as the core purpose of all our service delivery organisations, and in that sense understanding the needs of employers as we move forward is essential to get to the structure right for training. I do think that the structures now in place are going to be very effective. The evidence that we have seen so far, in terms of the signing up to agreements and the workforce planning embedded within the training thinking, is a really positive step.

**Q707 Mr Scott:** This is a question for Mrs Rainsberry and Dr Livingston. Is it correct that only three of the ten strategic health authorities have non-executive directors from a higher education background and, if so, is this not short-sighted, given your responsibilities for commissioning education?

**Ms Rainsberry:** I cannot comment. I have not done a survey of strategic health authorities.

**Q708 Mr Scott:** I am told it is correct.

**Ms Rainsberry:** Okay. Certainly in London we then would be one of the ones that does have an academic representative as a non-executive director on our Board. We also have a Workforce Strategy Board, which is a formal sub-committee of our Board, so I think you can take from that that we would obviously take the view that it is important to have that reflected on your book, but, there again, it is important to understand that of the 4.4 billion that is spent on training and education in England over a billion of that is spent in London. So, clearly, we have a very large responsibility in that regard.

**Dr Livingston:** Within the North East we have two non-exec directors who are both from higher education and a third who is a non-exec director on a Higher Education Organisation Board. We do see it as very important, and I think it reflects the priority that we give to workforce development. It is important that we do not see that as a solution to the engagement of higher education, which I think needs to be there throughout the system. I think, as Anne was mentioning in terms of her workforce board and engagement with higher education, we need to ensure that a proper debate happens at all levels within the decision-making process at a regional level with higher education, and the board membership signifies that interest and commitment, but the work has to be done throughout the system within the region.

**Q709 Mr Scott:** Do you think one answer to it in areas which do not have people is if postgraduate deans were co-opted onto local strategic health authority boards?

**Dr Livingston:** I think the structure at the moment is that the postgraduate dean is accountable to me and, in that sense, therefore, the deanery is fully represented through to the board. I think that the postgraduate dean needs to sit on the decision-making committees about workforce development and workforce planning, but their presence on the board I am not sure would be the right way forward.

**Ms Rainsberry:** I would agree with that. What is the problem we are trying to fix? If the problem we are trying to fix is to make sure that there is proper advocacy of education training issues, then I think it is legitimate to say: where on the board is somebody who has that in their brief and to ensure that there is a proper alignment with the dean. I suppose a strategic health authority could appoint their dean director as their director of workforce in some areas, but I think the principle is a good one, that you should have somebody on the board who is advocating, particularly when a large part— Normally, in most strategic health authorities, the largest part of their budget is their education training budget.

**Mr Scott:** Thank you.

**Q710 Charlotte Atkins:** Sian, do you feel that your organisation and employers in general had too little influence during the development of the MMC, and, if that is the case, what sort of problems did that cause?

**Ms Thomas:** I think we gave written evidence to you and in that evidence made it very clear that our views were that we had very little influence at the beginning. We were a fairly new organisation when MMC commenced, and it is very difficult to cohere the view of 500 separate employers, but increasingly we are, and were, doing that. I would see our role in three phases. Before February 2007 we had a very peripheral role. We were probably regarded as a peripheral stakeholder in the process and, therefore,
our influence was limited. We had no role on governance and had very limited engagement in implementation and design. In fact, I would say a great majority of the design decisions were made without employer input. One of the lessons learnt, I think, is that a great deal of expertise across the NHS in medical staffing departments and HR department was not, in fact, taken into account by the people designing the process, so we would agree with you. The second phase, which was during the latter part of 2006, we began to have engagement with the department because we were anxious about the lack of communication to the service and, indeed, became aware that the potential of mismatch between applicants and posts was greater than we had probably anticipated. We never knew what the numbers were, those numbers were not shared with us until the spring 2007, so we began road shows with employers and tried to engage with employers more during that time. Then, as has been alluded to today, at the beginning of March we realised there were grave problems, and that was when our active and full participation began through membership of the review group, and I would have to say since that date we are more engaged. I still do believe actually that employers need to be more centrally involved in this policy area and more employer views need to be taken into account in the design especially of the recruitment processes, because at the end of the day these are our employees who we will be employing for 30, 40 years and the end product of this process is important to employers on the ground.

Q711 Charlotte Atkins: The new MMC Programme Board has got two large employers on it, I think. Is that adequate?
Ms Thomas: It is adequate at the moment. We are giving a balanced view, and both of the people who attend the Programme Board are backed up by a system which means that over 100 employers' views are fed into that debate, but that is the only engagement we have on MMC at the moment.

Q712 Charlotte Atkins: In parallel with that, do you think that the department recognises the need for more employer input into medical education.
Ms Thomas: I think it has been acknowledged by the department and also by the Tooke Report that that is needed to be developed further.

Q713 Charlotte Atkins: Do you think at the moment things are improving?
Ms Thomas: They are improving.

Q714 Dr Taylor: We are moving on to NHS Medical Education England. If you were here for the first part, you would have heard all our three witnesses give a ringing endorsement to this. One of them actually said that he thought that recommendation 47 was the most important in the whole of Tooke. Would you agree with this or do you see alternatives or disadvantages?
Ms Rainsberry: I agree it is the most important recommendation, but I do not agree with it.

Q715 Dr Taylor: Let us have the counter view then. Ms Rainsberry: I was here for that evidence, and you were talking to those witnesses about the 87% level of support and, just as a point of clarification, that was a new recommendation that has not actually been consulted on, so there is no benchmark, if you like, as to whether 87% of people who responded agreed.

Q716 Dr Taylor: Let me be absolutely clear. To those last two recommendations that were added, there was no comment, so the 87% support did not apply to those?
Ms Rainsberry: That is my understanding.

Q717 Dr Taylor: What you were saying is you would have been one of the large per cent who disagreed?
Ms Rainsberry: Yes, that is right.

Q718 Dr Taylor: Why do you disagree?
Ms Rainsberry: First of all, I think that it fractures the relationship between service and education. At the end of the day, we are in the business of training doctors to deliver care to patients and at the moment strategic health authorities are the only part in the system where the balancing of service, long-term strategic planning and education align, and I think, by taking medical education off-line in that way, it would fracture that relationship. I think it adds another layer of bureaucracy by setting up an independent body and I think it would make SHAs in how they discharge their accountabilities in terms of the strategic development of health services and maintaining the integrity of the system, the health system, particularly as we move more towards foundation trusts, more challenging: because you have to have some body that has an oversight of a particular health system that is looking at where the service is developing and whether there are proper workforce plans in place to deliver that. So, I would be quite strongly against it.

Q719 Dr Taylor: You may remember that our workforce planning inquiry actually recommended that planning functions should be given to SHAs?
Ms Rainsberry: Yes; so I see it as being contrary to that recommendation.

Q720 Dr Taylor: Your views, Moira? Dr Livingston: I fully support everything that Anne has said. I do want to note a point about the 87% response rate to the Tooke Inquiry, because it is my understanding that where an organisation responded, such as an SHA, it was given the same weighting as a single trainee, and it would be very interesting to see that in some way managed, through perhaps a further request for some data on the actual pattern of responses, once we look at organisations with an appropriate weighting. Moving on to NHS Medical Education England, if you think about the policy direction, we have Our NHS Our Future, which is all about developing local services for local people: how do we develop local services for local people. That is running through the commissioner at the moment in PCTs. In
developing local services, we then train people in order to be able to deliver those services. In training people we need to therefore understand what those local services are going to be and, if we genuinely want to deliver care closer to home, deliver care which is exactly what the local public have asked for, we need to be able to flex and develop training according to local needs. Thinking about separating the medical profession off, I think there are certain elements which we need to consider. In the Terms of Reference for the Tooke Inquiry, it was very important that engagement of the medical profession was achieved, and I think there is evidence that engagement was sought and has been achieved, but the devil is in the detail and I think the challenge now is how do you maintain that. I think that much of MMC has been a challenge because of the difficulty in getting a consensus view from the medical profession and a consistent view from different bodies within the medical profession. I think that understanding how we can achieve that is an essential part of us moving forward and having a fully integrated and effective workforce development plan locally and nationally. If we then think about the Warwick Report, which was an evidence-based consultation which the Workforce Review Team carried out, the evidence is that workforce planning actually is not done very well anywhere inside health and outside of health, it is an extremely challenging area, but the thing that is much more likely to lead to success is when you integrate service planning with funding and with education and training, and that is very difficult to do from a distance. The other element is around quality assurance. I think that it is essential that we have a system of continuous improvement and drive forward the quality of education. At present within SHAs we are all required, through a service-level agreement with the Department of Health, to have a learning development agreement and that has provided us with a tremendous lever. In the North East we have all bar one trust as a foundation trust in terms of acute secondary care providers, and having a lever such as that allows to us to go in and discuss funding, directing the funding and driving up the quality of training. I have concerns that if we no longer have that lever that we cannot work through a dialogue with organisations delivering training to ensure across the board that the quality of training is continuously improving to benefit patient care.

Q721 Dr Taylor: One of the things you said was that it was difficult to take a consensus view from the medical profession, which we all realise. Was not the point of NHS:MEE, or one of them, to have a medical director in charge of that who would speak for the whole of the profession on training issues? Dr Livingston: My question back, I think, is: is that the solution? If we go back a few years, deans were accountable to universities. Did we see an integration of medical education in that point? We have royal colleges, we have an academy, we have specialist societies, we have the GMC, we now have the PMETB, and I think that, despite augment bodies doing an extremely good job and working hard and delivering what is required of them individually, we cannot seem to get a consistent consensus view. If we then think about the proposal of NHS Medical Education England, there is not enough detail in the Tooke Report that would enable us to analyse: “What exactly is this? Who is around the table? Why would it be different?” and when we think about the engagement that we have had, which has been extensive throughout the consultation period of “unfinished business” and through Modernising Medical Careers, of all those bodies that I have described, despite that engagement, we have what we have, why would it be different? I think I would like to understand that more, and I have not seen anything in Tooke that helps me understand that more at the moment.

Q722 Dr Taylor: Sian, do you want to add anything? Ms Thomas: Yes, one of the things I would say is that you are quite right, this was a new recommendation and we have only seen it for two weeks and we have not had a chance to discuss this recommendation with employers, but we are doing so on 6 February and I should think we will spend the majority of the meeting talking about this point, and so we are very happy to give you a note after the sixth on the views of the employers we talk to. I would say three things about it. First of all, there is definitely a need for strategic oversight—we cannot have a situation where there is not a strategic view about medical education, so we do need that—and, as has been alluded to today, there are wider government issues to consider, not just Department of Health issues, wider policy issues. You can only do that at a strategic level. The second is that that needs to be balanced against a demand-led, employer-led service focus, and so the challenge is how do you bring those things together? Finally, just about clarity of roles, we have already had major structural change in the NHS and we would always say further structural change needs to be very carefully considered before we go ahead and implement.

Ms Rainsberry: Can I make one further comment. I am not sure that just getting consensus is a good objective, because it is a very important area we are talking about. Actually, my experience over the last few months sitting on the MMC England Programme Board is that, whilst we have come up with what, I think, is working for the service, it has not always been through a process of consensus, and we have had some very frank, robust and important discussions through the different perspectives, and so I think if that board can continue it is a very valuable contribution. The other thing I think the Tooke Report is saying is that there is a need for greater co-ordination and, you touched on it with the previous witnesses, I think the model that the SHAs have around the Foundation Programme Office, which is commissioned by the SHAs and works on behalf of it but is a co-ordinating body, could be something that you could look at for specialty training which could provide that co-ordination across England. The last point, I would say, is one of size. It does work well in Scotland, I
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Dr Livingston: Were the reductions fairly true that you are reasonably well-off up there compared with some of us elsewhere in the country? I think Doug implied that there were drastic cuts, particularly in budgets for continuous professional development for nurses particularly.

Dr Livingston: I think we reduced the numbers of some of the nursing and physios as a result of continuous professional development, things that would agree with that, but the number of their trainees is similar to one of our medium-size deaneries and so I think it is a massive job.

Dr Livingston: I think the last point is very important. We have embarked on a consultation in the North East and, again, we would be very happy to submit the outcome of that consultation to this Committee, if you would like to receive it, on NHS Education North East. We are looking how we can integrate the whole work force, be employee-driven, and look at the whole quality issue and process as well as an understanding of the learning environment in which education needs to take place within NHS delivery organisations. I think the interim report is due at the end of this month and we are quite interested in some of the models that the consultancy organisation is coming up with for the future.

Q723 Dr Taylor: I am sure we would be very grateful for any further thoughts. Can I go briefly back to education budgets. I think it is right to say that Tooke recommends that the funding for NHS:MEE would be ring fenced, but what you have implied is that really there have not been cuts in actual medical education training budgets, the cuts have been borne largely by continuous professional development for nurses and people like that. Is that right across the country or is that just you? I think you said you had not had to make any cuts at all.

Dr Livingston: I think we reduced the numbers of some of the nursing and physios as a result of continuous professional development, things that have a much shorter lead time which you can then put money into the system the following year. It is damaged limitation.

Q724 Dr Taylor: What about last year when there were the reductions?

Dr Livingston: Last year we had a 15% increase, and it was a much higher increase this year.

Q725 Dr Taylor: Not coming from the north-east and being very envious of the north-east, is it not fairly true that you are reasonably well-off up there compared with some of us elsewhere in the country? I think Doug implied that there were drastic cuts, particularly in budgets for continuous professional development for nurses particularly.

Ms Rainsberry: I think the reality of the situation is that I am sure that SHAs would have made reductions in junior doctors’ salaries and the numbers of those?

Ms Rainsberry: No.

Q726 Dr Taylor: So there could not have been reductions in junior doctors’ salaries and the numbers of those?

Ms Rainsberry: No.

Q727 Mr Bone: Can I direct my question, first of all, to Ms Thomas. Supply and demand. Am I right in thinking you said it is good that there is plenty of competition for training posts. We are told that, on average, there are three people applying for every training post and that is good for patients. Is that your view?

Ms Thomas: Yes, we said to this Committee, I think 18 months ago, on the question of supply generally, that one might expect most employers in any sector to say that a modest over supply is a good thing because it improves quality. One expects that competition leads to improved choice for employers around candidates, so, as a general point, that is what we would say. I think it is a good thing that we have grown the supply of UK graduates, because it certainly is not a sustainable labour market strategy to rely on overseas recruits, and it is certainly true that in some parts of the country people have recruited doctors they would never previously have been able to recruit. In fact, as a result of some of the media attention on 1 August, I had an email from a chief executive at Ipswich—this is another little case study for your geography, and I do not get many emails from chief execs—directly to say for the first time Ipswich General Hospital has filled all of its junior doctor training posts with good doctors, and that is exactly, as a patient, what you want to hear if you are in Ipswich. Similarly, in Barnstaple, they recruited all of their orthopaedic training posts, a very high competitive specialty but they had not traditionally been able to fill all their surgical posts. Even in the high competition specialties, not every location in the country was able to find doctors, so, yes, on the one hand employers would always say in any sector (and it is particularly true in health care where safety is an issue) one wants more in the pool for better quality. However, we are different in health.

Q728 Mr Bone: Can I stop you there. That is very refreshing, Chairman, and that really is encouraging, because you are putting, effectively, the patients first, but we are not in a normal organisation, we are into this state planning, state-controlled unique organisation, and it is difficult for me to get into that organisation and I am not in favour of it, but having got there, you would think the one advantage you would have in state planning is that because you ration the amount of health care you are not subject to market forces for demand, you actually set it—you say, “This is how many doctors and nurses we are going to have”—and the one advantage of that system is that, if you know that, surely you can work out what number of people you need to put in at the beginning to supply those...
That is a dilemma around the cost; so I completely agree that a large pool of people is adequate. The final point is about legislation and recruitment. It would be something I would bring to the Committee's attention, because a lot has been said about entry to foundation. We have a legal framework in the Medical Act which requires medical schools to guarantee employment. That could be inconsistent with employment law, where guaranteeing employment to anybody might actually be unlawful. At the moment we have a situation in the foundation programme that needs urgent review around the recruitment processes for those individuals, because at the end of the day it may be called a foundation programme of training, but it is employment those people have, and therefore, the route to those posts needs to be through fairly robust employment law processes.

Q730 Mr Bone: Finally, I think you touched on it in your answer there, very briefly. Cost. There is a suggestion that if you flood the market with supply you keep costs down. It is a sort of cheap and cheerful model, if you like. Do you think there is any credence in that?

Ms Thomas: I think what I would say—it goes back to the first point I made—certainly one would expect in any sector, if you do flood the market and leave it to the market, then you do potentially apply some pressure around cost, but it is at what point in the career pathway you do that, and, arguably, you can achieve far more doing that at the end of the process when people have completed their training. Certainly the cost to the UK taxpayer of displaced trainees is significant, so that has to be a factor in making the decision about where the competition should be early on.

Q731 Dr Stoate: Can I clarify one point? I think you just said that you would like to see priority given to UK and EEA graduates in the selection process. Is that right?

Ms Thomas: We support the general recommendations in the Tooke Inquiry. We generally do support the first four-year broad-based concept of core training. As Neil Douglas pointed out, we can debate the finer points of where the cut-off point between F1 and core are and this issue of basing the decision of entry to core on evidence, which, after only five months training in F1 as employers, we are not quite sure how we are going to do that, but on the point about exactly how people are selected, I think we need more discussion, certainly.

Q732 Dr Stoate: How would you suggest doing it?

Ms Thomas: If legally there is a way in which entry to foundation programme and core should initially close off recruitment for EU and UK graduates and you set the bar at the appropriate level, then that might be a way, if you could then say this is the first four-year programme, that you, if you like, give as much chance. What we want to do is give
opportunity to those graduates to show excellence at the right point and to be competitive at the right point, which might be at the end of core.

Q733 Dr Stoate: We heard earlier on, though, that there did not seem to be a problem with the junior levels. If anything there was an over supply of posts. It was when you got up to the higher specialist training grades that there was massive over application with competition ratios of 20 to one. So your idea of sorting it out after core training, I do not think, would address it.

Ms Thomas: One way that could address it is better career advice during core. There is a world of difference between choosing four themed specialties and being asked to choose from 57 specialties, so taking that decision a bit later on for the trainee might actually give people better information about where the competition ratios were and potentially ease that problem.

Q734 Dr Stoate: But it would not stop a huge number of graduates coming in from outside the EEA, which the Court of Appeal ruled we could not do anything about.

Ms Thomas: It certainly would not unless the immigration rules change.

Q735 Dr Stoate: Our understanding is that the guidance given to the NHS, which was ruled unlawful, was in fact drafted by NHS Employers. Is that right?

Ms Thomas: It was certainly not drafted by us, no.

Q736 Dr Stoate: Certainly our information is that it was, but you are saying otherwise.

Ms Thomas: Our role is to implement the policy decisions of the Department of Health, and that is what we do.

Q737 Dr Stoate: What would you do then to restrict immigration rules? How would you see that happening?

Ms Thomas: It is not for me to comment. I am not an expert on the immigration arrangements. I think I have just said, the position employers are telling us at the moment, and it is not a consensus, is that we probably ought to try and priorities EU and UK graduates, and we should do that legally, through, if possible, a change to the immigration rules.

Q738 Dr Stoate: What do you think?

Dr Livingston: I think it is a really important issue that needs resolution. Sitting in SHAs with responsibility for delivering an effective recruitment process this year, we would like to know what success is going to look like for us. I think that if we have similar competition ratios, there will be a lot of noise, but that will not necessarily mean that the process has not been well implemented. I think it is essential at a national level that a decision is made. I think there are two other issues in terms of competition, I think the first is: do we have the eligibility criteria right for specialty training? Do we believe in an excellence model? In which case, is the barrier high enough in terms of eligibility. The second question is: are we confident that if we are producing a home-grown cohort, our future medical workforce, that that will be a highly competitive workforce in an open market if we cannot influence that? So what do we need to do to ensure that future medical graduates from the UK are highly competitive, and we should be in a very good position to influence that through working closely with higher education to ensure the curricula is mapped into the service changes. We should not forget that, as we move forward and look forward, Lord Darzi’s NHS next stage review is going to really help us understand the future picture of services, and that in turn should then greatly influence the content of curricula and the commissioning of education, and that may play some part, but working with higher education to ensure that we are confident that the money that we have invested in training medical students puts them in a very good position to be competitive.

Ms Rainsberry: I just wanted to say, I do not think it was hopeless. If you look at the high level numbers, and this is with no disrespect to IMGs because they have actually produced and given a lot of service to the NHS, but the ongoing hypothesis at the beginning of this whole process was that they would not be included, and that was the basis on which the additional medical school commissions came through. If you take that as a hypothesis and you look at that running through, broadly, the numbers were right. I think that is an important point. The other point is that there is a real challenge for us around the managing doctors’ training expectations—it is the point you were talking about earlier—in terms of which specialties they wish to train in, because a lot of the mismatch we are talking about that occurs and a lot of the noise, quite frankly, is about people who cannot get into surgical specialties or cannot continue to pursue their career in surgical specialties. There is a lot of evidence this year that SHAs funded transition packages, creating new training posts in specialties where we needed more doctors, provided career supports, counselling to doctors who did not get posts in round two to help them think about moving from, say, a general surgical specialty to maybe obstetrics and gynaecology.

Q739 Dr Stoate: That is all true, but that is not going to solve the problem of a very large number of non EEA graduates applying for posts. That is the issue I am trying to get to. What would you do to address that specific issue?

Ms Rainsberry: I am not an expert on this, but going back to when I was an HR director in a trust, I think the work permit rules we had there, both in terms of the work and the study, seemed to work very well. Where you had specialties that you found it hard to recruit and you had evidence that you could not get trainees, and that worked for Europe as well as it did for the UK, then you would make an application and someone would either come through on a training permit or a work permit. I wonder whether we have got the system to manage it, because in the
short-term (and this was the link I was trying to make) we do have a mismatch between what people want to train in and what we need for the service, and, therefore, we are reliant on doctors from overseas for some specialties.

**Q740 Dr Naysmith:** Even if we managed to restrict the entry of non EU applicants, there is still an increasing number of EU applicants coming in. Do you think that is going to increase in the future?

**Ms Rainsberry:** The evidence is that it is. You heard evidence last week from our Dean, Lis Paice, in London, and I would agree with her that some kind of examination would be a way of starting to manage that, thinking very carefully about what the bar should be in that. I think that would be one way of trying to manage that issue.

**Q741 Dr Naysmith:** We are going to have the first graduates from the new the British Medical Schools coming out in the next two or three years. They are going to be adding to the competition, so we really have to do something about that as well, do not we, fairly soon?

**Ms Rainsberry:** Yes.

**Q742 Dr Naysmith:** Even if we did restrict non EU applicants, we are still going to have a problem in a few years time.

**Ms Rainsberry:** Yes, and I think, as Sir John Tooke identifies, key in that will be the debate about what is the role of a doctor and are we having a consultant-delivered or a consultant-led service, because if you are sitting in an SHA the answer to that question makes an awful lot of difference to what you then commission.

**Dr Livingston:** I think the other aspect of Tooke, it is a question that remains unanswered but it is highlighted as an area, is this issue of excellence and understanding what excellence might be. If excellence is that a doctor who is in the country will train to become a specialist, then, of course, that means we continue to have a very broad programme, but it will be highly competitive and will be of interest to Europe because the salary is good and the training is paid for. If we then think about ensuring those who have the ability to move swiftly through a training programme achieve the competences, then you need a different type of structure to support that to ensure you have your workforce output at the end. I do not think we have a clear view on what excellence is, but if we knew what that was, then we would get the eligibility right. We would then be able to understand just how high is this bar and then actually consider, through proper modelling, what the competition ratios may well be in truth, not in terms of number of applications but in terms of eligibility to the post.

**Q743 Dr Naysmith:** Anne, you talked about managing expectations amongst those who wanted to get into the really competitive areas finding that they did not get a job. Actually, medical training is a very general training which trains you for all sorts of different specialties, so it is not unreasonable to say that we should be helping people who do not get their first jobs to do other things. Is that something that is happening fairly widely? Is it coming from recommendations from the department, or is it just some areas where there was a lot of expectations that were unmanaged coming up with ideas how to do it?

**Ms Rainsberry:** Yes. There is certainly evidence from the royal colleges in terms of the curricular and looking at core medical training and themed training in surgery. It is starting to look at that and, obviously, one of the issues that have been raised with run-through training was this issue that you were just nailing your colours to the mast. If you did not get in, it was seen that all was lost.

**Q744 Dr Naysmith:** Do you know of any good schemes that we might recommend?

**Ms Rainsberry:** Certainly in the London Deanery there are a number of programmes that are looking at generalising, if we can use that phrase, before you actually give people a broad base. There are challenges in that in terms of the design. The issue for us (and Sian mentioned transition) is just managing through people who have been training in a specialty for a large number of years who suddenly find that they cannot get into the higher levels. That is a particular challenge we are having to deal with.

**Q745 Dr Naysmith:** The other thing was something which Sian said, about controlling entry to the hospitals from the overseas doctors. Should not hospitals have the right to choose whether they want overseas doctors or not?

**Ms Thomas:** Some hospitals are saying that to us, and I think that just signifies the dilemma. Going back to the point about competition, it is where you want to put the pinch point of competition. Where do you want to have, as Moira said, the analysis of high skill? If we have got hard to recruit posts, it is absolutely entirely appropriate that we recruit from overseas but we must try and drive over supply into previously unpopular specialties by giving better advice to doctors and channelling good doctors into parts of the country that previously they may not have gone to.

**Q746 Chairman:** What level of competition is desirable? If we have got three people eyeing one post, what percentage of competition should there be?

**Ms Thomas:** When we were giving advice at the department last summer around the recruitment process, one of the first questions I asked as an HR professional, which is characterised in all high volume recruitment situations which are apparent in lots of different sectors—the IT sector has huge high volume recruitment processes—you need better hard measures to shortfall, but I asked a question about the ratio of interviews to posts. Because in the profession for high skill that is generally between a two-to-one or a three-to-one
Dr Livingston: I think the reduction in training hours across Modernising Medical Careers was driven to address that to ensure there was a competence structure and an assessment process in place and that we could then demonstrate that the curriculum had been delivered and that the doctor was fit for purpose as a specialist. I think all of that is an issue. I think that MMC is part of the solution to the original Working Time Directive issue. If we then think about how service reconfigures, certainly if we go back a couple of years, the service reconfigured by increasing the number of very junior doctors in order to cope with the Working Time Directive and they have subsequently been amalgamated into some of the new training posts and also the FTSTA, because there is concern that doctors at that level providing a service to patients are not as experienced as patients deserve their doctors to be. If we look forward, the discussions that we are having with the service are actually about new and different ways of delivering the service, I think that when we compare the UK NHS to other models of healthcare, we need to bear in mind that employers have a very different view on how they wish their service to be delivered and that they may choose multi-professional approaches, that they may have different team structures, and so I think the priority for services, certainly in the North East, is to actually look at the workforce in a different way, and they are not necessarily looking to increase the number of doctors. I think there are some striking examples where that will need to be the case, such as looking at obs and gynae, paediatrics and, I think, anaesthetics may well be another critical area, but I think in general the plans seem to relate to a change in the make up of the workforce rather than necessarily having more junior doctors in the system or more senior doctors delivering.

Q750 Chairman: Do you agree with that?

Ms Thomas: Yes, I think I agree broadly with that. One of the big risks, of course, of increasing numbers of people to cope with shift patterns where there were gaps for the European Working Time Directive results is the situation we have got around the SHAs bulge, which is that we have got lots of people who have done training programmes who now cannot find posts in their specialty. We have to be responsible when we do that and not lead people to believing that there may be posts for them in the future; so we are back to we need to be clear about what it is that the service wants in terms of the doctor for the future.

Q751 Chairman: If consultants and trainees are working fewer hours, when do they train or when do they have the opportunity to train people? The logic is that there are less opportunities in that sense.

Ms Thomas: One of the really welcome points in John Tooke’s report is bringing in the aspect of the Working Time Directive. I am not sure his recommendation—we have only just seen it, the new recommendation, in the last two weeks, and
we are carefully analysing it—is necessarily the solution, but he has raised again this issue of the tension between reducing hours, because it is certainly true that many doctors do not have exposure to procedures in the hours available, and if that is the case, then you either increase the number of years that people are doing their training or you change the role that they do when they finish their training, because they will not have had that experience. I think the fact that he has written it in his report means that we now need to go back to that, because certainly that was something that had become lost in the MMC debate.

Ms Rainsberry: I think that was one of the reasons why MMC was competency based, in the sense of trying to get away from this idea of time served, and is basically saying, “You will move on to the next stage when you are deemed to be competent.” So, I think that is an important principle that needs to be taken into account. I would also like to agree two points really. One is that there is a challenge about allowing employers to create additional training posts just to support rotas, and certainly in surgical specialties that is a big contribution to the bulge that we talk about. Equally, there is an awful lot of work going on which is looking at alternative solutions to meeting the European Working Time Directive which does not rely on doctors and training to do that, because they are a very expensive resource, and a lot of the evidence is that the way the old House Officer grade used to get used in hospitals really did not add a lot to patients and a lot to the training and, actually, by providing different models, certainly at night, you can get more training done during the day, more concentrated training, and provide different service models at night; so I do not think it necessarily follows you need more training posts because we have got to reduce hours.

Q752 Dr Taylor: We are nearly at the last lap. Moira, starting off with you, because as a committee we probably have not looked into the position of doctors in staff grade jobs and things like this and as you were responsible, we believe, for implementing the policies of Choice and Opportunity, we would like to know how you have got on. We know that the department estimated, because they did not know how many there were, that there were 12,500, no career structure, variation in the type of work and the stigma and the fact that it is a professional cul de sac. How do you think you see the career of these people going and how can you implement the suggestions?

Dr Livingston: I think that if we go back to unfinished business, where it was highlighted that there was an urgent need to review the staff doctor grade, which is the non-consultant career grade and the associate specialist. The choice and opportunity was consulted upon, and in January 2004 Choice and Opportunity was launched and was seen as a key part of Modernising Medical Careers. It is fair to say that a lot of the energy and focus of the work went into modernising medical training, and I think that that emphasis on training was very necessary and within the limited resources available at the time. I was asked to look at the implementation of Choice and Opportunity and the recommendations within that and worked very closely with NHS employers who were tasked with implementing the recommendations around the new contract, so the work that we did, which involved a very wide consultation with the service as a key focus because of the importance of the employer role in supporting this grade of doctor, did progress and the work was completed by December 2006. What then happened is that the work, which is a best practice guide for employers, is sitting with NHS employers and NHS employers will be responsible for publishing that guide and it is to be published at the time that the new contract goes out to vote and has been accepted. So there has been a delay in that we felt that the new contact was an essential component of Choice and Opportunity, and whilst waiting for that to be agreed there has been a hold on the publication of the work that we did within the MMC team. As we move forward, there was some work to be completed on a best practice guide for the doctors themselves who are currently in the posts but, more importantly, for doctors who then enter the new career post, as it was called under MMC, and that has been on hold because we were unable to find an organisation that would actually take responsibility for that. I think that that is a piece of the jigsaw that was missed. In terms of what we achieved, I think there are some things that we did manage to achieve. One was to bring together a body of evidence for the employer to understand how to ensure that doctors in these roles could fully reach their potential, how they could be supported in achieving their aspirations and how employers could view them differently in terms of their contribution as clinical leaders within organisations, so their role as managers, teachers, their role in research. Where we were unable to gain any momentum was around the issue of credentialing. The original aspiration had been that doctors in the new career post would be able to get the credentialing as they progressed within their job, learning as they go for new competences that they have gained, and there just is not a regulatory structure in place to support that. Because the doctors in the career posts are not part of the training structure and there was a lot of tension about using the term “training” with respect to these doctors who were in employment, they fell out with the remit of PMETB and, although we did work with skills for health to look at a structured framework for their development, again it was something that could not sit with the GMC in its remit and could not sit with PMETB. Whereas all the organisations were interested in this, and I know that PMETB were concerned that their framework did not allow them to do work on this grade—it is something that they would have in their sites for the future should the situation arise that they were able to address it, and their priority was going to address a kind of credentialing system post CCT initially for Consultants—I think that remains one of the recommendations that we were
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unable to successfully move forward. When we talk about MMC, I think there are three elements that are confused. I think Modernising Medical Careers was about modernising medical training, it was about choice and opportunity, and then there was MTAS, and I think sometimes that is confused and lost. I do feel concerned because I think you need to champion this area of development and, looking at the new MMC website, I think the non-consultant career grade does not feature and I think the reaffirmation of the principles of the MMC Programme Board, which were deemed MMC principles, actually are MMT principles, actually modernising medical training principles because they do not take account of Choice and Opportunity, which was a key part of the whole programme.

Q753 Dr Taylor: Because these doctors provide the backbone of a tremendous amount of service.
Dr Livingston: Absolutely.

Q754 Dr Taylor: Am I right to take encouragement from Tooke’s diagram, because his diagram of the inquiry recommendations puts the staff grade in the same sort of block as the specialist registrars and there is an arrow, if you follow it very carefully, that allows them to go towards CCT?
Dr Livingston: This is part of Choice and Opportunity. It allows them to enter the specialist register through PMETB, through something called the CESR route, through article 14 or article 11 in primary care. I think that certainly the ambition is there to support these doctors to progress, and I think that as a new doctor entering that career structure, if we get sign-up from employers, then gathering evidence of their performance will result in them having an effective portfolio, which will give them a better chance. For doctors who are currently in the system, actually going back five years and looking for evidence of achievement of competences that demonstrate their equivalent to a specialist is quite a challenge. I think that Tooke does ask for an urgent review, an urgent need to implement the new contract. I think that debate sits within the overall debate of what is an excellence model. We have talked a lot about the difficulty in workforce planning and how do you look at a 10-year programme with all the changes in technology, the change in service. How do you know that what comes out at the end from the start is what we are going to need? I do think we should take another look at a potential model which is slightly different to the model that we might be running with, whereby we can see doctors working in the service learning and developing all the right skills but actually they provide a drip-feed into the senior end and, because they are more senior and more experienced, actually provide us with a shorter run-through to delivering a fully trained workforce, if we mean by "fully trained" a specialist. I think at the moment everybody goes on the very long path. We do not have a fast-track path and, looking at other professional groups, the model we have in medicine is quite unusual in terms of other professions outside of medicine. The expectation that everybody is automatically on the excellence path is very high, and I think, as part of the debate, I am not sure that we are questioning that and I am not sure that we are looking at other models that would provide us with a workforce planning model that offers us a drip-feed from the service with doctors who have been fully supported, allowed to develop appropriately, with competence akin to what will be required in terms of service, but, therefore, better prepared to enter specialty training at a higher level.

Q755 Dr Taylor: You have mentioned the best practice guide and the new contract. Can Sian tell us when the contract is coming and why it has been delayed?
Ms Thomas: NHS Employers have been negotiating the new contract for SAS doctors, as you know, for some time and we concluded those negotiations in November 2006 and agreed with the Department of Health and the BMA the overall framework of that contract, and we are ready, through the BMA, to ballot SAS doctors. Before we could do that, or the BMA could do that, this needed to be sent to the Government for ratification, and that has taken a year, and in December 2007 we received the decision from the Government that we could implement the contract and the BMA are now balloting their members. So, we will know by the end of March if their members have supported the contract recommendations and then it will be implemented by employers from 1 April.

Q756 Dr Taylor: So the delay was not your fault.
Ms Thomas: It is not for me to say.

Q757 Dr Taylor: You have said it very clearly. Finally, do you have any suggestions about what they should be called, because staff grades, trust grades, associate specialist, non-consultant career grade—it is absolutely ridiculous, is it not? What is a complementary title for them that implies it is not a cul de sac?
Ms Thomas: There are two pieces of work in NHS Employers we are doing with employers. The first is to determine what we want doctors to do in the future: what is their role in the healthcare team and what will the career structure look like? Employers will determine that, and they may actually not all determine the same thing and may want to do different things, which is obviously, in an autonomous employer situation, what they are entirely able to do. What we will try to do is determine what the overall structure will look like. The second piece of work is on looking at what the individual career pathways for doctors look like to make them attractive in a world where 70% of students at the moment are women and their potential medical pathway might look very different for a workforce that might look very different in the future from what it does now.
Q758 Dr Taylor: It has got up to 70% now, has it?  
Ms Thomas: 70% of undergraduates are female.

Q759 Dr Taylor: Very good.  
Dr Livingston: If I can just add to that. Creating an alternative to specialty training is essential to improve the morale of the medical workforce, a real alternative which is valued. It has been one of the issues for doctors in the system, the importance of them getting on specialty training, because the choice was not there for an alternative route. Even where there is a work/life balance issue it is a very difficult decision for the doctor to make because we have not made it attractive enough. This work is essential to reduce some of the heat within the system around that.

Q760 Dr Taylor: These sorts of posts could be a long-term worthwhile alternative if they are organised correctly?  
Dr Livingston: They need to be.

Q761 Chairman: Earlier I quoted from what was said to us in our session last week from a post-grad dean. He said that in some parts of the country outside of the Southeast these were the best cohorts of trainees they had ever had in post-grad trainee. Could I ask you, Moira, do you have a view about that?  
Dr Livingston: Yes. We have had regular meetings with employers across the patch throughout Round 1A, Round 1B and Round 2. After Round 1A the employers were absolutely certain that they were very positive about the recruitment they had made from Round 1A. Round 1B, for them, was felt to be an add-on which was not necessary to assure them of getting the highest calibre, but we understand nationally the need for it and support the decision that the Programme Board made. We have also seen improved recruitment in areas where that has been a challenge in the past and general satisfaction with the quality of the doctors who have been appointed.

Q762 Chairman: A marked difference from years gone by?  
Dr Livingston: I do not think I am able to say a marked difference but I would definitely say satisfaction with the quality of recruitment.  
Ms Thomas: I have already given some examples of the real case studies we have had. I will just make two points. I do agree broadly with that statement but we have also heard of very excellent doctors who have not got into their specialty. The recruitment process did generally give us high calibre people and generally some employers who have not been able to recruit are recruiting, but the real question is did we discriminate between good doctors and excellent doctors. We did get reports from consultants that they were unable to do that through some of the recruitment process. I think the general answer to that is “yes”, but it is a “yes, but we may not actually have the right doctors”.

One example of that I would give where there is real concern is on the clinical academic recruitment. We were unable to recruit posts to the clinical academic structure in some parts of the country and we are not quite sure if we have got the really excellent clinical academic doctors we need for the furthering of scientific research. In a year where new money was injected into that programme, where we really need to give emphasis on encouraging doctors not only into clinical medicine but academic medicine and research, that is absolutely critical to get right. Broadly, yes is the answer but I do not think that fits for every single situation. A final point I would want to make about recruitment issues is you have heard a lot of evidence as a Committee about the redesign needed of this huge change programme and time is getting on. We have a process for 2008 which we think will run smoothly but is a one year local fix, if you like. We have got increasing concern from employers that we should not repeat the mistakes we have made before, if you like. Huge change needs time, it needs testing and it needs stakeholder engagement. I really do not know if we are going to have all of those things in place for 2009. We talked to John Tooke and his team about this. We may even be talking about 2010 or 2011 before we have the actual solution for the longer term and we must be courageous and stick to our guns if we think that is the right thing to do and not rush headlong into something for even 2009 which is not the right solution.

Q763 Chairman: I was just going to give the last word on the question I asked to the Southeast.  
Ms Rainsberry: We bear out what has been said in that our fill rate in London was the lowest we have known it, so there obviously was a redistribution that was going on. The question of whether gold standard doctors, the stars, were not getting into training is probably right, but the reason for that was because they persisted in going for being a cardiothoracic surgeon and the reality is you have lots and lots of stars going for that. Despite giving lots of advice and lots of support, it is very difficult to dissuade people when they have set their heart on it. On 2009, the MMC England Programme Board has just started to consider that and will be considering it in more detail at the next meeting. Just to offer some reassurance, there are a lot of stakeholders around the table saying exactly that. We need to look at what is the change that is required and then how long it will take to implement that change properly, not to say we must do this by 2009. That is certainly the tenor of the discussion at the moment.

Q764 Dr Naysmith: I wanted to pick up what on what Sian said. Obviously we do not want discrimination, we need to eliminate discrimination, but I have been around medical schools most of my working life and there have always been some people who were disappointed at not getting into their preferred specialty. It seems to have been highly focused this year but it is...
something that has always happened. The other thing is, it has always been relatively difficult to recruit into academic medicine, particularly with GPs getting the salaries they are getting now, and some of the consultants. Being an academic and spending a lot of your time doing research as well as seeing patients is not as attractive and never was as attractive to some people, unless you are obsessed with becoming a medical scientist. Both of these problems have been in the system for a long time.

Ms Thomas: They have, absolutely.
Q765 Dr Naysmith: It is not true to blame them, despite—
Ms Thomas: No, but we should expect a change through MMC to deliver improvement, that would be the point to make.
Dr Naysmith: Yes, we can always make things better.
Chairman: Thank you for coming along and helping us with our inquiry.
Monday 18 February 2008

Members present

Mr Kevin Barron, in the Chair

Mr Peter Bone
Jim Dowd
Stephen Hesford
Dr Doug Naysmith
Mr Robert Syms
Dr Richard Taylor

Witnesses: Ms Lorraine Rogerson, Director of Policy, and Head of Profession at the Border and Immigration Agency, Home Office, and Ms Judith Macgregor, Director for Migration, Foreign & Commonwealth Office, gave evidence.

Q766 Chairman: Good afternoon. Can I welcome you to the sixth evidence session of our inquiry into Modernising Medical Careers. I wonder if I could ask you to give your name and the position you hold for the record, please.

Ms Macgregor: My name is Judith Macgregor and I am Director for Migration at the Foreign & Commonwealth Office.

Ms Rogerson: My name is Lorraine Rogerson and I am the Director of Policy and Head of Profession in the Border and Immigration Agency.

Q767 Chairman: Good afternoon and welcome. I was going to start with Liam Byrne but, given that he has not been able to get to us this afternoon, Ms Rogerson, the first question is for you. When did the Home Office become aware of the Department of Health's policy of making the UK more self-sufficient for its medical workforce?

Ms Rogerson: The Department of Health first approached the Home Office in 2005 about using the Immigration Rules to limit further competition for training posts from international medical graduates.

Q768 Chairman: So it was 2005?

Ms Rogerson: That was the first approach. Do you want me to tell you the first change to the Immigration Rules?

Ms Rogerson: We first made a change which took effect on 3 April 2006 which restricted the provisions of the postgraduate doctors and dentists category.

Q769 Chairman: Yes.

Ms Rogerson: We first made a change which took effect on 3 April 2006 which restricted the provisions of the postgraduate doctors and dentists category.

Q770 Chairman: I think we will be asking you a few questions about that as we go along. Given that the move towards self-sufficiency began in the year 2000, why has it taken so long to address the number of overseas doctors? Did it not seem obvious to anybody that the increase in home-grown doctors would need to coincide with a reduction in overseas doctors or did you not hear any of this at all until 2005?

Ms Rogerson: As far as I know we were not approached about this until 2005. Before that we were still requiring quite a lot of international doctors to fill vacancies in the Health Service.

Q771 Chairman: You will have seen the headlines in the media over the last 12 months about whether or not this situation we are currently in has cut short careers for graduates here in the UK. Do you think there has been a failure of the Home Office and the Department of Health and the Treasury to co-ordinate this type of policy?

Ms Rogerson: We have been reviewing the impact of the changes of 3 April 2006 and also working with the Department of Health and other government departments to identify the best way of addressing this. It was based on joined-up thinking and a total government approach that we change the rules now.

Q772 Chairman: It is when the thinking came into being that we are more interested in. It seems it was a long time the Department of Health was setting goals that you were not asked to respond to until much later.

Ms Rogerson: We changed the rules on 3 April 2006. In January 2006 we were writing the command paper about changing the Immigration Rules and creating the new points-based system, and at that point we were looking with the Department of Health at restrictions on the Highly Skilled Migrant Programme and changing it to the new points-based system. It is that policy change which we have just done now.

Q773 Chairman: You introduced that on 6 February, preventing non-EEA doctors from applying for UK training posts from 2009. The memo that we received states that you were asked to make this change as early as June 2006. Why did it take so long?

Ms Rogerson: The Department of Health is the driver of the policy and there are a number of steps which they are thinking of taking to address the problem. The immigration solution is one part of that and we wanted to check what the evidence was about the change that we made in April 2006 and we were also discussing this with other departments. We wanted to check how this fitted. The Highly Skilled Migrant Programme, which was the one which was the concern, is a programme which is meant to enable non-EEA nationals who want to come here and who meet a certain level of qualification and skills to have access to the labour market, and as part of that the principle is that we would not restrict what they would have access to, and we have been looking at other ways with the Department of Health at meeting this concern.
Q774 Chairman: Your submission acknowledges that the rule change goes against your Home Office policy of attracting the brightest and the best to the UK.
Ms Rogerson: Yes.

Q775 Chairman: Was this agreed by the Home Office?
Ms Rogerson: Yes.

Q776 Chairman: Was it ever debated in Cabinet?
Ms Rogerson: It was. It has been debated through the Domestic Affairs Committee of the Cabinet. I think the Department of Health will be able to tell you more when you see them about the other steps they are taking. We have made this change which restricts the access by highly skilled migrants and forthcoming Tier 1 people to have employment in training places as a short-term step. It is implementing government-wide policy. It is not quite in step with our overarching principle of the Highly Skilled Migrant Programme but it meets this need and seems an appropriate thing to do for a short time while other more sustainable policies are put in place by the Department of Health.

Q777 Chairman: I was going to ask you about that because the Department of Health has described these provisions as “temporary changes”. How long will they be in force and why would you now reverse them when UK medical school output is still increasing quite rapidly if you look at the figures? What is behind this temporary change?
Ms Rogerson: The intention is that the Department of Health should find and are working on other methods of making a sustainable change to being self-sufficient and that it would not necessarily need to be a restriction like this on an immigration route.

Q778 Chairman: We may pursue that a bit later this afternoon. Could I finally ask you about this? If the Department of Health’s guidance is declared lawful by the House of Lords will these rule changes become obsolete and, if so, will they be withdrawn?
Ms Rogerson: We need to review that at that time.

Q779 Jim Dowd: Before we go any further, Ms Rogerson, what is a Head of Profession?
Ms Rogerson: I am the Head of Profession for Policy in the agency.

Q780 Jim Dowd: Yes, I heard you say that before. I do not know what a Head of Profession is.
Ms Rogerson: I take care of the policy skills and ensuring that we are developing policy in line with good standards.

Q781 Jim Dowd: Assuming that the House of Lords does not uphold the department’s guidance, will the Home Office come under pressure to make further restrictions through the Immigration Rules?
Ms Rogerson: We will have to look at that at the time. No further suggestions have been made about further changes we might need to make.

Q782 Jim Dowd: So you are making no preparation for an adverse decision at all?
Ms Rogerson: The current restriction is meant to have the same effect regardless of the House of Lords decision. We have made a restriction so that people coming in under the Highly Skilled Migrant Programme will no longer be allowed to have access to these training places. That is the short-term solution. There has been no suggestion that we need to make any further change.

Q783 Jim Dowd: You are saying that the House of Lords decision will not affect that one way or the other?
Ms Rogerson: If the House of Lords upheld the guidance then we would not need to have a restriction in the Immigration Rules.

Q784 Jim Dowd: And if they do not do you do not need any other arrangement?
Ms Rogerson: No. At the moment the suggestion is that this change to the Immigration Rules that we have made would be enough in the short-term to relieve the pressure on the places.

Q785 Jim Dowd: The Appeal Court ruled in November that the department’s guidance was unlawful as it did not have the authority of Parliament. Why did you not just take the opportunity when amending the Immigration Rules to enforce the department’s guidance by law?
Ms Rogerson: The Department of Health guidance?

Q786 Jim Dowd: Yes.
Ms Rogerson: I am not sure that we are able to do that. What we are able to do in the Immigration Rules is give effect to the Secretary of State’s decision about the purposes for which people might be able to come here and the conditions and restrictions that might be placed on them when they are here, and that is what we have done in these rules.

Q787 Jim Dowd: Do you know whether the department have asked you to do this?
Ms Rogerson: I believe that what we are doing is in line with what the department have asked us to do, which is to make any immigration changes a short-term contribution to the solution but it does not affect the Department of Health guidance.

Q788 Jim Dowd: This question again was originally meant to be directed to the minister so if your reply is somewhat more guarded I fully understand. Is the Home Office frustrated by the Department of Health throwing a spanner in the works of your attempt to introduce a fairer and simpler immigration system?
Ms Rogerson: One of the Border and Immigration Agency’s jobs is to manage migration in the interests of the UK and the changes we have made are about short-term immigration restrictions to meet a government objective agreed by the whole of government.

Q789 Jim Dowd: Is that why you only agreed a temporary exemption for doctors?
Ms Rogerson: Because the Department of Health has a whole range of packages of things that they can do and they are working on a more sustainable solution, it was intended that this would be a short-term contribution rather than the whole answer. Immigration control can only play a part in meeting Department of Health Workforce objectives.

Dr Taylor: I am very sorry the minister is not here and you are having to bear our attacks.

Jim Dowd: No—inquiries, Richard, not attacks.

Q790 Dr Taylor: This seems to me to be about the best or the worst example of unjoined-up thinking across four government departments that we have ever come across because we have got the Department of Health, the Treasury, the Foreign & Commonwealth Office and the Home Office. You have told us that the Department of Health was the driver and that there was a Domestic Affairs Committee. My question is really to Judith. Was your department represented on the Domestic Affairs Committee, because the very full and very helpful paper that you have given us suggests that really your involvement was pretty limited. Is that fair?

Ms Macgregor: We certainly were involved in the DA Committee, absolutely. Yes, I suppose, if you like, we are neither the drivers of health policy nor the drivers of immigration policy, so our involvement in this had been primarily to put in the foreign policy implications of any particular course of action and help steer the discussion in that way, so limited in that sense but very full nevertheless, I can assure you, within that.

Q791 Dr Taylor: So with the new immigration restrictions have they taken your advice into account?

Ms Macgregor: I think that our concern, as Lorraine has said, was that an immigration restriction can be only one part of a broader policy, so to the extent that we have a situation where an immediate challenge has been assuaged by recourse to the immigration system while other more sustainable policies are sought, I think we would say that this was something which was in the national interest to do. I think also the way in which the restrictions have been brought in, which is essentially to be prospective so that people coming to apply for the scheme know the score before they apply, is very important. I think governments do understand that other governments have to regulate their workforce supply but clearly the aim of the immigration system is to be as clear as possible about what that is going to be and how it will a.

Ms Macgregor: Not prevented, that is right, from applying for these speciality training courses.

Q792 Dr Taylor: You say in your paper that you recognise the tension between the desire for self-sufficiency and the supply of doctors and an open-door policy. Is there a compromise? Do you think this is an acceptable compromise?

Ms Macgregor: Compromise is never a finite thing; I think it is dynamic, and I think compromise is perhaps necessarily imperfect, but if we can achieve through this a better understanding of longer term, more sustainable solutions, and this will in the immediate term obviously prevent a very serious displacement of UK-trained doctors, then I think it has the merits of that. Obviously, we will look to see how the situation develops. The points based system which is being introduced is an innovative system. We will see how that also goes through and how that works out. Our concern was that it should be as clear as possible at the time of its introduction, which I think in this way now we have perhaps achieved: it is clear what it will cover and what it will not cover.

Q793 Dr Taylor: I think you suggested that it makes doctors an exception and sets an unwelcome precedent.

Ms Macgregor: We were concerned that, if you like, a permanent restriction at the time of something beginning would in itself not be a very good signal. I think something which is inherently stated not to be a permanent solution and is something which can be looked at again meets those conflicting requirements.

Ms Macgregor: About these specific changes?

Q794 Dr Taylor: It is well known that we owe an awful lot over many years to lots of doctors from India. Do you think the new regulations will damage the relationship with India?

Ms Macgregor: It will be something that we will continue to handle very carefully and very sensitively. Again, I think that governments, including governments like the government of India, will understand and respect that we have to regulate our workforce and our labour supply. The important thing is to be clear and to be timely and not to affect and disadvantage people who have come in in good faith under another system.

Q795 Dr Taylor: So those who are already here, halfway through their training, are going to be saved, are they?

Ms Macgregor: Our understanding is that they are not prevented, that is right, from applying for these speciality training courses.

Q796 Chairman: Have the Foreign Office had discussions, to your knowledge, with the Indian government about these changes?

Ms Macgregor: About these specific changes?

Q797 Chairman: Yes.

Ms Macgregor: When Liam Byrne was in India two weeks ago he did mention that this was likely to happen, yes.

Q798 Chairman: And the outcome of it is not known at this stage, presumably?

Ms Macgregor: To be fair, he also mentioned it publicly because he was in India at the time of the changes being announced, so he also, of course, made that public at the time.
Q799 Chairman: Do you feel, when we have recruited from the Indian sub-continent in particular something like 25%–30% of doctors coming into the National Health system over many years, that these types of changes are acceptable or unacceptable?

Ms Macgregor: I think it is incumbent upon everybody to take it very seriously and to look very closely at what can be done, as I say, to be both in good faith but also nevertheless over a period of time make clear what the policy of the Government is. As you have said, the policy of self-sufficiency has been one which has been coming through and I think in discussions we have made that clear. If you like, our role has been to interpret to both sides that there is this policy of self-sufficiency and that it will obviously have knock-on effects, but at the same to bring into the domestic debate precisely the fact that we have had very good service over many years from Indian doctors and nurses and it is only fair to ensure that the greatest clarity is given to them and the situation has to change.

Q800 Mr Bone: I think you said in your answer that the Indian government would understand. If I were the Indian government I would not understand. I would see all these people from the European Union being let in all of a sudden and yet people from India, being let in all of a sudden and yet people from India, would see all these people from the European Union being let in. If I were the Indian government I would not understand. I think the Indian government would understand. If I were the Indian government I would not understand. If I were the Indian government I would not understand.

Ms Macgregor: I cannot answer for what the Indian government does or does not think.

Q801 Mr Bone: I think you said earlier on in your answer that the Indian government would understand.

Ms Macgregor: I think they would understand that each government has the right and the ability to regulate its own labour supply. This particular restriction, of course, does not stop Indian doctors from coming and working in a wider range of posts inside the National Health Service, nor other medical care people. It is very targeted at these specialty training posts. To that extent it is not seen as closing a door entirely and, obviously, were that the case there would be greater unhappiness.

Q802 Dr Taylor: “A wider range of posts”—how would they get in if they do not get in into these training posts?

Ms Macgregor: My understanding is that they could come to study in the United Kingdom in the medical profession. They could presumably come in also in some consultancy or ancillary way. It is access through this particular competition to the specialty training posts in my understanding that this restriction applies.

Q803 Dr Taylor: But is not the only reason they want to come to get the specialty training?

Ms Macgregor: I am sure a number are wanting to do that because that is why there has been a large number of applicants, but I think it is also the case that people are coming under other streams of activity.

Q804 Dr Naysmith: I would like to follow up one or two of these matters with Judith. You have said that the Immigration Rules changing should be temporary; that is the favoured solution, and that the department’s guidance is the preferred way of restricting non-EEA doctors. Why is the use of guidance preferable to any other system?

Ms Macgregor: There are two reasons. One was because, as we have said in the evidence, of the introduction of the new points-based system and Tier 1 in particular is, if you like, fairly untrammelled. You do not need to have a contract before you arrive. It is based on your qualifications and your background, and the feeling was that to, as it were, stop a particular category of people ran counter to the principle of that, which is that you are qualified in your profession and you are free to come and look for work in the United Kingdom. The guidance also, as I understand it, was guidance literally to the recruiting people that they should give preference to candidates from a UK training background but not exclusively, therefore, when other candidates could be found. The Immigration Rules therefore, if you like, cut off at source people coming in whereas the guidance gave more discretion, and I think that was our preference, therefore, but that was something we fed into the debate at an earlier stage, obviously.

Q805 Dr Naysmith: That is because it is speciality training that we are talking about; is that right?

Ms Macgregor: I was talking about speciality training.

Q806 Dr Naysmith: And that is the thing that makes guidance more applicable than just allowing people in to take work, no matter how qualified they are?

Ms Macgregor: That is right. In this context it was the guidance, yes.

Q807 Dr Naysmith: What happens if the House of Lords does not uphold the department’s guidance? Are you concerned that the changes to the Immigration Rules will have to be made permanent?

Ms Macgregor: As my colleague said, I think it is very hard to pre-judge exactly what would be the Department of Health’s decision in that case. It would be for them to decide, so I think we have to take that one step at a time. We would hope, obviously, that some solution could be found that would give a sustainable solution without a permanent restriction through the points-based system, but that is as yet to be discovered and taken forward.

Q808 Dr Naysmith: But you must be thinking about alternatives. When you introduced guidance, for instance, you must have thought about other ways of achieving the same result.

Ms Rogerson: At the same time as we made the rules change the Department of Health issued a consultation paper which is now consultation about the new guidance and the way in which this issue might be addressed, but I am not the person you need to talk to about that. It would need to be them.
Q809 Dr Naysmith: Can you talk about it?
Ms Rogerson: No. I think the Department of Health should talk about that.

Q810 Dr Naysmith: No, no. The Foreign & Commonwealth Office will have a view on the consultation that is taking place, will it not?
Ms Macgregor: I think we have not yet taken a formal view on that. To be fair, and I think we would really want to see where the consultation lay and the different expert views and then we would obviously take account of that in due course. At this stage it really would be very difficult for us to say that we had a preferred view. We do not.

Q811 Dr Naysmith: Finally, how many doctors do you predict will come to the United Kingdom from within the European Economic Area over the next ten years? Do you have any idea?
Ms Macgregor: Sorry, I do not with my background have an idea on that, I am afraid.

Q812 Dr Naysmith: And no-one has mentioned any figures? Presumably when you introduced this policy you had some idea of what effect it would have on the restrictions.
Ms Rogerson: In terms of the restrictions in the current rules the Department of Health estimate is that there will be, through this restriction to the Highly Skilled Migrant Programme, 3,000 to 5,000 fewer people applying for places. We do not have any immigration prediction of people coming from within the EEA.

Q813 Dr Naysmith: But you have not had any advice from the Foreign & Commonwealth Office? Are these your predictions or are they in conjunction with the Foreign & Commonwealth office?
Ms Rogerson: We do not have any predictions.

Q814 Dr Naysmith: So where did this figure come from?
Ms Rogerson: The Department of Health estimate.

Q815 Dr Naysmith: That is what I am saying. That is a prediction, is it not?
Ms Rogerson: No. Their estimate is that in 2009, just in 2009, the impact of this rules change would be that there would be 3,000 to 5,000 fewer.

Q816 Mr Bone: I am sorry the Minister is not here and that you are having to bat on a sticky wicket, but if you do not know the number coming from the European Union how can you match the supply? Somebody must have that figure, we hope.
Ms Rogerson: We are working on the basis of Department of Health Workforce planning. Because it is self-sufficiency they will know how many people they are expecting to come through the system.

Q817 Mr Bone: Should the Home Office not know that really, migration? Is that not the Home Office?
Rules the department estimates that around 71,100 UK doctors will be displaced and unable to secure a training place in 2009, 2010 and beyond, so even that figure you give us of 3,000 to 5,000 is not going to be enough to reduce the potential fall?

**Ms Rogerson:** The potential IMG exempt are the people who are here already and because the rule change we are making is prospective in order to not to destabilise that is why the Department of Health needs to be looking at ways of managing this. We have made a change which would have that estimated impact in 2009.

**Q827 Jim Dowd:** Right, so essentially you are saying you have done the best you can to help them with this position, there is still more work to be done but it is the Department of Health that has the lead on that?

**Ms Rogerson:** We will continue to discuss with them and review what happens in terms of migration changes but at the moment the migration change we have made has that predicted impact, yes.

**Q828 Mr Bone:** My questions are about joined-up government and who is talking to whom. I have to say I am a bit miffed at the moment. We have had to rearrange this meeting to get both ministers here and they do not seem to be able to co-ordinate their diaries and have left you to take the flak. It is not a really good start. I think your two departments probably come out better in this because the Tooke Review really said it was leadership from the Department of Health that was weak in the implementation of MMC, so that is probably helpful from your point of view. Do you think that is why the failure was, that there was not better communication between the departments, because of lack of leadership from the Department of Health, as Tooke suggested?

**Ms Rogerson:** Our part of this has been trying to see to what extent the immigration system which we manage can and should be used to help to solve a problem that is government-wide, which we do quite a lot, but our part in that is to advise and implement when agreed and to support, and that is the role we played.

**Q829 Mr Bone:** Now that this has happened and MMC has been a pretty miserable event for the Government, I wonder if within your departments something from on high has come down saying, “We really must not do this again. We have got to improve our communication between departments”. Has there been some sort of memo or seminar or have ministers been exploding? Has anything happened?

**Ms Rogerson:** We have been asked to continue to work closely together, yes.

**Q830 Mr Bone:** “Continue to work closely together” means no change really because clearly you were not working closely together; or do you think you were working closely together?

**Ms Rogerson:** We have been working closely in terms of advising and supporting the implementation of this as part of the overall package.

**Q831 Mr Bone:** Can I try a different way? What are the current mechanisms for communicating with the Department of Health? Do you have a meeting every Monday morning or do you just wait for the phone to ring?

**Ms Rogerson:** We have been working with them closely on this particular area of work, so that is phone calls and meetings, and supporting the Domestic Affairs Borders and Migration Committee. Officials will meet co-ordinated by the Cabinet Office.

**Q832 Mr Bone:** In some businesses where you have diverse departments they will meet once a week, say, on a Monday morning, to discuss anything that goes across their department. Does that happen? Do key officials meet regularly on a particular day to see how policy in one area is affecting policy in another department?

**Ms Macgregor:** The Border and Immigration Agency and the Foreign & Commonwealth Office obviously have very regular consultation across a range of immigration and migration issues. We have quite a few, including at ministerial level, where we have fortnightly meetings also to review progress, particularly on illegal migration, which is somewhere where we are particularly looking to foreign partners for assistance, but also across the board in legal migration as well. With the Department of Health I would say that our contacts have been, as Lorraine says, regular over this particular issue over the recent period.

**Q833 Mr Bone:** But more back office than formalised?

**Ms Macgregor:** They have not been formalised. Obviously, there have been ministerial exchanges as well by letter. On the figures point I wanted to say that we have worked very much on the basis of the figures that have been supplied to us by the Department of Health in terms of the numbers of applicants that they were expecting to have in this competition and in 2009, but we have not made any independent or separate estimates of figures beyond that.

**Q834 Chairman:** Obviously, the Domestic Affairs Committee involves the Treasury as well. What role does the Treasury play in any of this?

**Ms Rogerson:** They put in views and ideas and query proposals in the same way as anyone across government would.

**Q835 Chairman:** Have they been helpful in terms of getting the business sorted out from your perspective? Has it been a helpful situation?

**Ms Rogerson:** Yes, I think so. What we have been doing collectively is looking at what the issues are that need to be addressed, looking at the options for addressing the issues and trying to come up with proposals which would do that.

**Q836 Chairman:** Were the Treasury involved from very early on?
Mr Taylor: And the Tooke Review does suggest that staff grades probably have a route into higher training. Is that going to queer the pitch as well?

Ms Macgregor: I think it is probably a question that the Department of Health could advise on in terms of what course leads into the next. As I say, our understanding is that these particular slots are affected but other slots are not affected.

Q840 Dr Taylor: But it is not very attractive, I would have thought, to people from the Indian sub-continent to be coming to purely service jobs without any training. What do the Indian authorities feel about that? Has that been put to them?

Ms Macgregor: I certainly have not been aware of that particular point being made to the Indian authorities. As I say, the point that we were discussing in India two weeks ago was specifically this particular scheme, so I cannot really comment further on that.

Dr Taylor: It has long been felt that some of these people are brought in just as drudges to do the unpopular jobs, so it is very sad if that continues.

Chairman: Maybe we could take that up in the next session, Richard. Could I thank both of you for coming along this afternoon and helping us with our inquiry.

Witnesses: Rt Hon Alan Johnson MP, Secretary of State, Mr Hugh Taylor, Permanent Secretary, Sir Liam Donaldson KB, Chief Medical officer, and Ms Clare Chapman, Director General of Workforce, Department of Health, gave evidence.

Q841 Chairman: Could I first of all welcome you to our sixth meeting of taking evidence on our Modernising Medical Careers inquiry. I wonder if, for the sake of the record, I could ask you to introduce yourselves and the position that you hold.

Ms Chapman: Clare Chapman, Director General of Workforce.

Sir Liam Donaldson: Liam Donaldson, Chief Medical Officer.

Alan Johnson: Alan Johnson, Secretary of State.

Mr Taylor: Hugh Taylor, Permanent Secretary.

Q842 Chairman: Thank you. The first question is for the Secretary of State. Why was the project management of MMC and MTAS by the department so inept?

Alan Johnson: Probably because the accountability was spread so widely. When you look back at how this was all put together, you had four UK departments of health, you had all the educational bodies, you had the bodies that set standards, you had the regulatory organisations, and all of that put together led to a classic case. I think, of systems failure. For instance, you had the policy being set by something called the UK Strategy Group. You had the criteria being set by the Specialist Training Action Group. Implementation was the responsibility of the MMC Programme Delivery Board. The Strategic Health Authorities through the Deaneries were responsible for implementation in England, local implementation. You had another body dealing with the selection criteria, so it was very disparate and it was, as it has been explained to me, a difficulty of knowing who had the lines of accountability with all of that group trying to work together.

Q843 Chairman: We will move on to that in some detail in terms of leadership or perhaps a lack of it, but did ministers know about the situation? Were ministers kept informed about what was happening? I know it was before your time.

Alan Johnson: I was not there at the time, but yes, they were. Indeed, one of the other problems was that Lord Warner, who was very closely involved in this and took a very hands-on approach, went, for personal family reasons, in, I think, December 2006 but at a time when his knowledge and expertise we could have done with, so there was a problem there as well, but as far as I am aware, yes, ministers were fully aware of what was going on.

Q844 Chairman: What have you done to improve project management in the light of this last 12 months and the Tooke Review?
Alan Johnson: A far simpler structure for a start. The Douglas Review very early on made the point about ensuring that we had a simpler structure, so, for instance, we had a single senior responsible officer, a single chief reporting officer that we introduced, a chief operating officer, but I think the most important innovation was the establishment of a Programme Board which had the medical profession represented on it as well. Tooke has made an enormous contribution but from before that when the Douglas Review came out we sought to streamline what was a pretty unstreamlined management structure.

Q845 Dr Taylor: Secretary of State, I am going to continue on the same line because when Alan Crockard came to us, and I am quoting, he said, “There was a clear dichotomy between the education and training role overseen by the MMCB and Workforce needs overseen by the MMCB and Workforce Directorate which resulted in two separate senior officers in charge of MMC and MTAS without close working of their teams. Never should a project have two SROs overseeing two parts of the same project.” Therefore, Secretary of State, when you listed at the beginning all the bodies involved it is really no wonder if it fell down in tremendous chaos?

Alan Johnson: No, and there were two lines of accountability on the issue as well. There was the policy accountability through the Chief Medical Office and there was the implementation accountability through the Workforce Directorate. I think that was a major problem. Once that was clarified and rationalised we saw the system work much better, and again that was something that the Douglas Review helped us with and the Tooke Review has helped us with even more.

Q846 Dr Taylor: On a rather wider note, do you think we risk the same thing on an even wider basis, having the equivalent of three permanent secretaries?

Alan Johnson: No, I do not, but we have had a capability review of our department and one of the central features of that was the leadership in the Department of Health. The capability review said we were a very good department at delivering. There was an issue about leadership, but personally I would not want to go back, and I do not think anyone would, to a joint Permanent Secretary/Chief Executive of the NHS, the Nigel Crisp position, but how we manage that better is something we are looking at all the time. As far as I see that was not the problem in terms of MMC.

Q847 Dr Taylor: Okay. So you think there were problems and you are doing something about them? Are you doing something about them quickly enough?

Mr Taylor: In one sense it was far from ideal but the important point to make about that is that there was continuity of senior leadership because Nick Greenfield, who became the acting Director-General for Workforce during the interregnum while we were advertising and waiting for Clare to take up her appointment, had been closely involved with the MMC project, so from the point of view of continuity that was certainly maintained during that period.

Q849 Dr Naysmith: Mr Taylor, it has been suggested to us that the shortcomings in the governance and management of these two projects, MMC and MTAS, suggest that civil servants in your department are simply not up to the job. Do you think that is fair?

Mr Taylor: No. I think it is much too sweeping a generalisation. I think we could point to a number of examples of excellent collaborative policy making and excellent delivery, but I think we have to accept responsibility for the fact that the governance arrangements for this programme in retrospect were not adequate. We have done, not just connected with this but more generally, a lot of work in the department over the last 18 months to significantly up our game in terms of risk management, for example, and overall support for people on policy governance issues generally and on project and programme management. It would be idle to pretend there were not lessons to be learned from this episode and those are lessons which I am determined we will take to heart.

Q850 Dr Naysmith: So you think there were problems and you are doing something about them? Are you doing something about them quickly enough?

Mr Taylor: As the serious problems with the implementation of the programme began to unfold in 2007 the department did move pretty quickly to establish much clearer lines of accountability and put real operational management in, and with the support of the Douglas Review and the Programme Board which emerged from that began to get a grip on the issue, so in relation to handling the particular operational issues around MMC I think we took action very quickly. More generally, we have been working hard at improving governance processes across the department through the introduction of stronger and more effective risk management processes. When you look back on this what you see in a sense is project management disciplines being followed in relation to different components of this overall programme but I think in retrospect what we see is a problem with looking at the programme as a whole and the impact it was going to have on junior doctors and consultants out in the field. You can apply risk management to an individual project or good project management disciplines, but if you are not looking at the thing as a whole then you are running into a problem. I cannot ever say that we will never hit another problem again but I think we have learned some lessons about how to run these sorts of big projects.
Q851 Dr Naysmith: Can I ask what your opinion is of the situation that Richard Taylor touched on rather lightly a few minutes ago, the fact that you have three individuals of the status of permanent secretary in the department, Sir Liam, yourself and David Nicholson? All three of you are permanent secretaries and now you have Alan Johnson telling all three of you what to do. He cannot do that all the time; you have to co-ordinate. Is there a problem there?

Mr Taylor: We do not find that a problem on a day-to-day basis. It is pretty clear that my responsibility is to make sure that the department runs effectively. David has responsibility for the operational management of the NHS and for advising ministers in relation to that. Liam is the Chief Medical Officer with a defined set of responsibilities. It is our job to make the best of those three important parts, all having critical roles for the department, so in relation to MMC, the management board which David runs, which is the NHS Management Board, that will be overseeing the operational management and the implementation of MMC during 2008. In relation to the more strategic issues affecting the future direction of medical education workforce policy those sorts of issues would come initially to the departmental board which I chair, and in practice David, Liam and I have formed together a sub-committee of that board to oversee the co-ordination of thinking around medical education, training and workforce issues and MMC on a regular basis, so we are meeting frequently to make sure we stay absolutely together on this.

Q852 Dr Naysmith: Is not one of your roles to warn ministers when their plans for change are over-ambitious? One of the main functions of Sir Humphrey of television fame was to stop ministers walking into disasters and falling down elephant tracks. If that is the case and you agree why on earth did you or other civil servants not stop the MMC being implemented with such reckless speed? It must have seemed like that to you, having overseen a few policies in your time.

Mr Taylor: That was not the view that was being taken of the programme at the time. We were, I think, at senior levels in the department monitoring a number of the key risks associated with it. A lot of effort—and I think this is all pretty well documented in Tooke and other places—was going into some of the key risks which were identified about the number of training places, for example, the plans that were put in hand to restrict access of people on the Highly Skilled Migrant Programme to the first cut of offers of training places and in relation to the computerised project. Assurances on all those three things were sought specifically. What, I am afraid, collectively we and others across the system failed to do was to look at the risk right across the system as a whole and draw what might in retrospect have been the right conclusions.

Q853 Mr Bone: Just before we move on, you never said to the minister, “This is a courageous policy”?

Mr Taylor: No.

Q854 Dr Naysmith: Why were the red light risks highlighted by Tooke repeatedly ignored? You mentioned Tooke just now.

Mr Taylor: Specifically those things were not ignored, is my recollection. The two things that were highlighted were the risks around the computerisation programme and specific assurances were given in relation to those in relation to the—

Q855 Dr Naysmith: I am not sure it is a good idea to mention the computers.

Mr Taylor: I am just honestly answering your question, which was that those risks were highlighted and assurances were taken in relation to that. Whether it was then right in retrospect to proceed straight into the national implementation of an unpiloted, untested system, particularly one which I think to some extent people were not fully prepared for, is a separate question, but in terms of pure project management assurances were obtained about the operability of the system. The other red lighted issue was that of the whole question about the policy in relation to people on the Highly Skilled Migrant Programme and their active risk mitigation being in place and I think it has been pretty well rehearsed what the circumstances there were, having taken a decision to issue guidance which would have had the effect of excluding people on the HSMP from the first round of applications. There was a judicial review challenge and so on and we got into a difficult sequence of timing around that. It was not that those risks, in the jargon, were not being actively managed; they were. I think the bigger question was whether the totality of risks associated with the project were overseen and that is where I think in practice we probably fell down.

Q856 Dr Taylor: Going on to policy development, Unfinished Business seemed to have fairly general support but in the move from that towards Modernising Medical Careers a lot of the principles seemed to get lost. The BMA puts it that of the seven principles only two were realised during implementation. How did this happen? Obviously, we cannot blame ministers because ministers change fairly frequently, but this is exactly where one needs the involvement of all the different bodies in the principles, the phrase is that success has many parents and failure is an orphan, but from the start of these principles, from the time when Liam published Unfinished Business, there was a fair consensus around about the need for change. Indeed, most of the people I have spoken to are highly critical of how MMC was implemented but the actual principles behind it they support and I have not met anyone who would want to go back to the old system. It was unfair, it was opaque, it was
blue-eyed boys and girls, so the principles behind the change were absolutely right. In terms of the department’s capability to implement policy, I think you only have to look at the cancer strategy, what we have done with cardiovascular disease, heart disease and the stroke strategy just before Christmas. Developing policies is one of the strengths of the department and delivery of policies is one of the strengths as well. What happened here, I think, as Hugh has just alluded to, was that there were lots of things happening at the same time, lots of things that were the right thing to do but all being done at the same time and an assumption that we would not have the problem with international medical graduates that proved to be a false assumption. There were also the points I have made about the lack of accountability in all these different organisations together and no-one quite sure who was in the lead on it, and a computer system that was not piloted, MTAS, in advance. Put all that lot together and you get the disaster that was MMC. You have made the point very fairly about ministers changing, but Patricia Hewitt on several occasions apologised for the way this caused disquiet and huge problems for people in the medical profession, junior doctors in particular.

Dr Taylor: I do like your quote. Is it a proverb, “Failure is an orphan”?}

Jim Dowd: It is. It is Chinese.

Q857 Dr Taylor: Is that a proverb that I have not heard about?

Alan Johnson: I would like to say I made it up but I think it is a proverb of some description. It is a Hull proverb from my constituency.

Jim Dowd: Hull in China then, is it not?

Q858 Dr Taylor: I rather get the impression that you feel in retrospect that the big bang approach was misguided and wrong.

Alan Johnson: Liam might like to say a word about this but, as I understand it, the argument that we should have phased this in had a number of problems as well in terms of what that would mean. “Phasing” is an easy word to use but if you look at the practicalities of phasing in different aspects of this, there was a strong argument to say, “Look: if we are going to do this let us do it all at once because if you try and phase it you just lead to a long period of confusion, et cetera”, so that argument probably went on. If you are looking at the cause of the problems here, certainly it has been said to me by many clinicians that we tried to do too much at once, but no-one was really looking in any depth at what the alternative was because I am sure there were problems there as well.

Q859 Dr Taylor: But if there had been better in-depth planning perhaps a staged introduction could have been brought in.

Sir Liam Donaldson: I think it would depend how you staged it because let us say that you were to stage it geographically or by speciality, then doctors hoping to apply as their first choice for a speciality that was not phased in may have worried about their future and have been forced to go for a second choice option, so I think the option of phasing it in was not free of problems and risk either.

Q860 Dr Taylor: I always accept your comments about cancer and cardiac care, which obviously have improved, but in items like this what lessons have you learned for policy development?

Alan Johnson: The need to have a very clear accountability structure on this in particular. Because we did it with four countries in devolved administrations and a whole set of other people involved there were no clear lines of accountability, is my answer to that first question, and however complex the issue is we have to make sure that we do not repeat those mistakes, and indeed the lessons we have learned and the lessons that we are still learning from the final report from Sir John Tooke, who has done an excellent job at finding a way through this and making very clear where the errors were, as did the Douglas Review very early on.

Sir Liam Donaldson: Could I just add something on that? The other lesson to learn is that it is not always clear that implementation is free of the need for policy making. Before this crisis developed, if somebody had said, “The detailed design of an application form—is that policy or implementation?” I guess most people would have said it was implementation, but in fact it probably ended up being one of the biggest policy considerations in the whole thing. Realising that apparently minor aspects of implementation need a much wider participation of policy makers, particularly clinical policy makers, is one important lesson that maybe could not have been foreseen but is obvious whenever you look at the causation of the crisis.

Q861 Mr Bone: My questions are all to do with leadership. It seems to be accepted now that leadership was very weak during the implementation of MMC, both in the Department of Health and within the medical profession. Does everyone agree with that or am I being unfair?

Alan Johnson: I do not think you are being unfair because it is an obvious question. I think the governance structure was too complicated. I do not think the answer lay in the leadership of the department. I think it lay in that complication. Okay, you can say that we should have recognised the perils of that very early on. The fact is we did not, and certainly the issue about having a clear level of accountability, which we changed very early on when Douglas first raised it, but there was a problem in terms of the accountability for the policy being with Liam and the accountability for the implementation being with Clare’s predecessor, and I think at one stage there was absolute ambiguity about who was responsible for what.

Mr Taylor: I would certainly say in retrospect that leadership was diffused and that is an issue. That was on both sides and that is not meant to be a critical comment of my colleagues in the medical profession, but I think one of the catalytic effects in positive terms was bringing the key elements of leadership
and the medical profession together under Professor Douglas initially and then in the Programme Board, which provided a much better and stronger forum for issues to be thrashed out in a coalition than had been the case previously. I think it was the absence of that very strong policy-making forum for collective leadership, if you like, that was missing.

Q862 Mr Bone: Just following up on that point, most of the leaders who were involved in this are still leading whatever part of it they were before. At any one stage one of those leaders could have said, “This is going horribly wrong. Stop”, and none of them did, so what confidence do you have that leadership has improved now and that we could not have the same thing happen again when there was a group from the medical profession and the Department of Health embarking on a major project?

Alan Johnson: This was a complex issue. I do not believe it can be laid at the door of an individual. Indeed, I think Tooke said something very similar in terms of the whole history of MMC, that there was not one person that should be carrying the can for this. It was a collective failure right through the system. If there were lots of occasions of this happening in complex areas then there could be a criticism of the leaders involved, but I hope this is definitely going to be a one-off. There has been nothing like this before. No-one ever attempted to make all these changes to the curriculum, to the way that the system worked, to the whole structure of the medical education and training all at one time, and I really do not believe that there is any individual at whose door all of the blame can be laid.

Q863 Mr Bone: I would like to follow on from that and get some specific comments on it, but your answer sounded a bit to me like when Social Services report that some young child has been killed. They say it is a systematic failure of 30 people but no-one individually is to be blamed and it will not happen again. Unfortunately, in Social Services it happens time and time again, so do you think this is a one-off?

Alan Johnson: Yes. I think the analogy with Social Services is wrong, actually.

Sir Liam Donaldson: I do not think the analogy is fair. In some of those child protection cases that you referred to the evidence is revealed over and over again to different people. It is just that they choose not to act on it. If you look at what happened in the MMC, the biggest risk that was flagged up to ministers was the risk that there would not be sufficient training posts to fulfil the demands of the programme and Lord Warner acted immediately to counter that risk and announced the creation of more posts and guaranteed a level of posts. Secondly, as the permanent secretary said, there was a full discussion at the NHS Management Board, which is the most senior governance structure in the NHS, of the programme just before it went into the final stages of implementation and reassurances were given about the risks and therefore the board corporately decided to proceed. If you look at the point at which the crisis was in its early or mid stages Patricia Hewitt appointed Professor Douglas to chair a group to take further decisions and that group had the opportunity at that point to cancel the programme but they did not, and I think they were right not to because at that stage a large number of interviews had taken place and a lot of consultants had given their time to undertake the interviews. There was not a point at which the whole risks of this programme were revealed in an unambiguous way and no action was taken, and I do not think the analogy is fair.

Mr Taylor: One further point on this is that I do think it is very important to build into your corporate governance systems proper challenge as well as assurance. One of the things that we have sought to do as a department is use our strategic risk register, which we take now to our audit committee which is run by non-executives and expose that to them in a much more systematic way than, I have to say, we were doing at the time when some of this was under way. The risk with all that is that you are still not seeing the things coming round the corner to hit you. I do think we have better systems in place now to give not just the leadership authority that you are talking about but some of the challenges to that which you get in effectively by having corporate governance systems.

Q864 Mr Bone: This is just for the Secretary of State. I know, Secretary of State, you have more or less answered this, but because this is an evidential session I would like to get it on the record. Some people have said that the Chief Medical Officer is the architect of these failed reforms, and if that is the case do you think that the CMO is the best person to resolve the crisis? I know you have indicated what you think but perhaps you could give a formal response to that.

Alan Johnson: Yes, I do. I think the CMO has done a terrific job over ten years. On this particular aspect let me remind you of what John Tooke said. He said that MMC was an honest attempt to accelerate training and assure the fundamental abilities of the next generation of doctors. In fact, I think this began in 1988 under the previous Government. I am paying a tribute to the previous Government.

Q865 Mr Bone: Oh, sorry! Do carry on!

Alan Johnson: It happens very rarely. The previous Government recognised the need for change and reform to medical education and training. It was Liam’s report, Unfinished Business, that galvanised action and on those very important principles. See what comes out of your report but I do not think there is anybody hankering for the old system in the sense of all that unfairness and the opaque nature of that system. I think it was an honest attempt. It went wrong in the implementation. That is now being put right and, as I say, I do not think there are any scapegoats in this and as far as Liam is concerned I think he is absolutely the person to take through the implementation.
Q866 Mr Bone: Thank you. Can I just move to Sir Liam? One of the problems with reports, and the Tooke report is no exception, is that you can read them in several different ways. Sir Liam, I think you said that you would not resign because the Tooke report supported the principles of MMC which the Secretary of State just referred to, but Sir John told us that he could not even work out what these principles were. He and others have argued that MMC swapped one “lost tribe” for another. If that is the case thousands of careers have been lost, confidence in the profession has gone and some people would say you are more of a hindrance than a help now. Would that be totally unfair?

Sir Liam Donaldson: I do not think I ever said that. If I said anything along those lines it would be that Sir John had commended the principles of Unfinished Business, but essentially in the Modernising Medical Careers programme the part of that which has become controversial was the reform of specialist training. There were many other aspects of it that have not been part of the criticism and controversy of Modernising Medical Careers, so the Unfinished Business proposals led partly to a foundation programme, they did not recommend wholesale introduction of a specialist training run-through grade. They said yes, it should be looked at along with other factors, and the programme broadened out over time. If you look at the factors that precipitated the crisis, in my view there were three. One was the planning assumption of international medical graduates being excluded could not be adhered to. Secondly, the design of the application form proved to be faulty and led to difficulties with discriminating the right candidates for the right jobs, and, thirdly, wholesale run-through training was introduced, but that itself is a factor on which there are mixed views, some Royal Colleges strongly favouring it, others now having reservations, some having favoured it initially and now withdrawing their support. I was not responsible for the decision on international medical graduates and I was not responsible for the detailed design of the application form.

Q867 Mr Bone: I suppose one of the things that some people would find strange is that nobody is taking the rap for this disaster. Some people could unkindly say, Sir Liam, that you are more concerned about saving face than the future of medical teaching. That I think would be one way people could look at it but can I put it to you another way? If you really thought this was your fault would you have resigned? You mentioned that there were other areas, but if you thought that you were the driving force—and it has gone wrong; nobody argues with that—would you have gone?

Sir Liam Donaldson: As the Secretary of State said, it was a widely participative process with a lot of different stakeholders involved. Had I been the single person sitting in my office having these risks played to me repeatedly by different people and ignored that, then yes, obviously, that would not have been a competent performance, but that was not the way it was.

Q868 Mr Bone: the other thing that I have not got my head round is that Government is normally very cautious when it is bringing in major changes and lots of different things at the same time, you know, you have pilot schemes and so on, and in fact yesterday the Government announced a pilot scheme on a new Sarah’s Law, so why were so many decisions and changes taken at the same time? Who was responsible for the fact that it all happened at the same time?

Sir Liam Donaldson: In the end 57 or so specialities redesigned or reaffirmed their training programmes and those were all signed off by the main regulator, the Postgraduate Medical Education and Training Board, so there was a groundswell of view that because the SHO programme was being changed it therefore threw out the interface with the next level of training and the training needed to be redesigned, so each of those specialities looked afresh at their training programme above the level of what was the SHO and put in reforms to their training programmes, so 57 different groupings looked at it.

Q869 Mr Bone: Yes, so it is like if a committee decides something it finishes up with a camel; it is that sort of thing. In hindsight, and hindsight is a wonderful thing, would it have been better to have one person driving it through rather than almost having committee-like decisions on the MTAS?

Sir Liam Donaldson: I think it probably would but in the past we have been accused by stakeholders of being undemocratic for taking that approach.

Q870 Dr Naysmith: Secretary of State, the Tooke Review has been mentioned quite a lot this afternoon and it has usually been in a congratulatory way. One of the things it very clearly recommended was that the Department of Health needed a dedicated lead for medical education. Do you agree with that?

Alan Johnson: Yes, we have accepted that recommendation that was made. Indeed, we implemented that before the Tooke recommendation when we put Dr Martin Marshall in, who in effect became the dedicated lead. Now Martin has moved on and when he left we put David Sowden into the job, so yes, we do accept that recommendation.

Q871 Dr Naysmith: David Sowden, when he was here, told us that you cannot appoint a permanent head of medical education over the next six to nine months because of “some particular issues within the Department”, and he would not expand on that. What was he referring to?

Alan Johnson: I do not know. If he did not expand on it --- you should have pushed him a bit further because I cannot speak for him.

Q872 Dr Naysmith: Maybe I will just quote a little bit. What he said was, “For my sins, I said I would be prepared to do it”—that is, lead the MMC—“as a secondment for a short period . . . There are some particular issues within the department which would have made it difficult for them to make a permanent
appointment over the next six to nine months. It seemed important that there was somebody in place who could take forward the 2008 process and lead on the development for 2009”. You have no idea why he would say that?

Alan Johnson: I have not, no. I do not know whether Hugh has.

Mr Taylor: I am not sure. One point that it is just worth mentioning is that one of the things we wanted to do was to get somebody into the post and, to be blunt, to do that quickly we needed to make a temporary appointment. If we want to make a permanent appointment and it is a Civil Service appointment we have to go through a proper selection process involving the Civil Service Commissioners and so on. Because in effect we can put him in on a short-term basis it meant that we could make the appointment straightaway. He was on a temporary basis because that was the quickest way of getting somebody with his expertise and relevant qualifications into that role.

Dr Naysmith: Do you have any idea, Sir Liam, what he might have been referring to?

Sir Liam Donaldson: No, I do not, I am afraid.

Dr Naysmith: Can we move on then to the other actors in this drama? It has been suggested here as well that there have been tremendous weaknesses exposed in the Academy of Medical Royal Colleges in providing a coherent voice for the profession. Do you agree with that, that the academy could have been much better in giving a lead?

Alan Johnson: Yes. In a sense it is less important whether we agree with that. That was a specific recommendation in the Tooke report and I think it is a matter for the profession to respond to that. That is one of those recommendations that is not for us to act upon. Given the amount of analysis that Tooke’s people did, I think it would be very difficult to argue that that is not a sensible recommendation and a valid point to make about this lack of coherence.

Dr Naysmith: It is a good point to make, and it is probably right, but actually getting all of the Royal Colleges herded together and going in the same direction is quite a difficult thing to do, I suspect, but you think it is the right way to go, do you?

Alan Johnson: I do not think it is impossible to get better coherence from the different specialties. As far as I am aware, they have not acted with any hostility towards Tooke’s Report and I presume that they are looking, even as we speak, at how they can actually give that some substance.

Ms Chapman: Secretary of State, can I add one thing on to that, and that is when the difficulties first started to emerge it was Carol Black and the Academy that actually raised the point that the Academy wanted to be part of the solution, not the problem, and then that led to the recommendation for a review and obviously the Douglas Review ensued. The work that was done on that group and subsequently on the Programme Board has shown that when you bring the people together across the profession to a place where actually consensus can be reached so recommendations can go to ministers then a very productive role can be played. I would just point that out.

Dr Naysmith: It is interesting you say that because we put both to Carol Black and Bernie Ribeiro, the President of the Royal College of Surgeons, that they had been present at crucial meetings when they could have stopped things going ahead and they both admitted that they had been but had not done so without explaining why. I suspect it was to do with the fact that they were not quite sure what some of the people who were recommending that they be there would say if they did. That is why it is important to have some kind of coherent voice for the medical profession at this higher level of training.

Ms Chapman: On the Douglas Review and then subsequently on the Programme Board, that has actually been happening because they have been sitting around the table and are able to see the whole programme as opposed to individual component parts.

Sir Liam Donaldson: Could I just add, Chairman, that does beg the question again that when they were sitting there at the time in those meetings, what was it that was worrying them that they wanted to put their foot down on and say it should not go ahead? At that point, as I said before, the principal risk identified was that there would not be sufficient training posts. That was what we were lobbied about repeatedly and that was where Lord Warner stepped in and increased the number of posts. On the detailed aspect with the application form at that stage, I do not think people at that level would have appreciated that there could have been a problem with that. The international medical graduate situation, at that point it looked as if the planning assumption would be adhered to so there would not be an excess of numbers over applications.

Chairman: Can I ask, when will the Department respond to the final Tooke Report?

Alan Johnson: At the end of February. I have given an assurance that we will publish our response by the end of February. There will be some bits of our response that will be an immediate response because of the nature of the recommendations. Some, like MEE for instance, that only appeared in the final report upon which there has been no consultation might take a bit longer. We will issue a response to the Tooke Review by the end of February. I have to say, John Tooke was very pleased about that. His fear and worry was that it would gather dust on a shelf somewhere for months or even years.

Chairman: Obviously you are not going to respond to it in total by the end of February from what you just said, Secretary of State. Would you like to give us a percentage of what you are likely to respond to in terms of recommendations? Will it be 50% or more?
Alan Johnson: Most, I think, because we have had since last October from the interim report to look at 47 of the recommendations. There were two that came up in the final report that were not in the interim report. There is also the issue about the next stage review that Lord Ara Darzi is leading for us where some of these aspects relate to specific work streams that he is doing, so it would make more sense for him to look at that in the round and then report in the summer. The vast majority of the recommendations we will be able to give an early and a full response to.

Q879 Chairman: So it would be wrong of us to read into the situation that those which you did not respond to would be those you did not agree with?

Alan Johnson: No. The things we do not agree with we will say. I have already put it on record, and I have certainly said to John Tooke, that I think this is a really, really helpful report. He has done an excellent piece of work. The thrust of what he is putting forward I agree with, but some of the recommendations are for the professions, as we have just mentioned, not for us. Some have very clear structural problems that, having been through MMC and seen the results of perhaps acting too hastily, we want to take a bit more time about and so might the organisations that he is referring to. He suggests the GMC should merge with PMETB. We cannot give a full response on some of these without more consultation and a bit more time to think it through. You should read into the fact that we are going to publish a response by the end of February that we think this is a very good piece of work, the momentum for which needs to be maintained.

Q880 Jim Dowd: Having said that you will respond in general by the end of February I am now going to pursue a line of questioning where I will try and get out of you what it is you are going to say by the end of February. You mentioned MEE and I was going to start there actually. I quite understand you say we have got to wait a couple of weeks for this, but do you broadly accept the need for a centralised overseeing of medical education in England?

Alan Johnson: I am afraid you are going to get a straight bat on all of these because we are not going to respond until we respond with a full and detailed response. It is fair to say MEE is one of those recommendations which will take an awful lot of thought and consideration. I doubt very much whether we will be able to give a full response to that at the end of February and, indeed. I do not think John Tooke is expecting it. The fact that it appeared in the final report suggests that he too went through a long thought process to decide whether that was a sensible recommendation or not.

Q881 Jim Dowd: Putting MEE to one side for a moment, would I be overstating the case if I suggested that there is a recognition, whether it is a reorganisation of SHAs, and I know you spoke to this Committee immediately after you took up this appointment and said you were reluctant to look at structural change within the NHS, if there is no central body surely there is a case for reorganising the responsibilities of the SHAs, for instance in the way they commission education and training.

Alan Johnson: I am not going to be drawn on this. The other thing about MEE is this is a specific strand of work that 1,500 clinicians are working on at the moment with Lord Darzi, so for me to give an off-the-cuff response would not do you a proper service in terms of your inquiry and would not be fair to the amount of work that is going on out there at the moment looking into this subject in more depth.

Q882 Jim Dowd: Clearly I would not ask you for an off-the-cuff remark in response to this but it is not as if we just dragged you off the corridor and asked you to come and give evidence. This is our sixth session and you have had the Tooke Report for three months or more, so it is not quite off-the-cuff.

Alan Johnson: Not this particular recommendation we have not.

Q883 Jim Dowd: It is an informed response. What about the issues that he raises around compromise? Will you be seeking a compromise between Tooke’s suggestion and the current situation, for example by creating a small new national organisation to oversee the work of SHAs?

Alan Johnson: That is another straight bat.

Q884 Jim Dowd: So you are taking the Fifth?

Alan Johnson: What we are determined to do is to publish our response to the Tooke Report in one document at one time in one place and not to dribble out bits and pieces of it.

Jim Dowd: I stand rebuffed and rebuked, Chairman.

Q885 Mr Bone: I know we have rearranged this meeting once, Secretary of State, but it is pretty useless having a Secretary of State for Health coming here and taking the Fifth Amendment on something that he says he is going to announce in a few days’ time. If that is the case, why on earth did you not wait until after Tooke to come here? This is hopeless in terms of a select committee when a Secretary of State cannot answer the questions, it is horrid.

Alan Johnson: I came when I was asked to come. The question was when will you be responding to the Tooke Review and the answer was the end of February and that is very, very quick. Expecting me to give a response to the Tooke Review just in response to questions here is not the right way for government to proceed and it actually does a disservice to Tooke’s work. I do not accept that criticism and I do not accept that we have come along not to answer questions. On this specific issue the response will be at the end of February.

Q886 Chairman: MEE is about medical education, it is not about workforce planning, something this Committee has looked at in recent years and found wanting as far as the National Health Service is concerned. It is not necessarily about budgets, and we looked at the issue of overspend in the National Health Service in our deficits inquiry last year and
there were issues about the raiding of education budgets up and down the land, and some of it was anecdotal but we did find some evidence of it. Are all of these things going to be looked at when you look at the future outcome of the recommendations of Tooke?

Alan Johnson: Yes. Indeed, as I have mentioned, the work is going on at the moment in the next stage review and training and education is a specific strand of that. This thought of putting one organisation in charge of that has got its advocates and its detractors. Since Tooke’s Report was published I have had many people saying to me that they do not agree with that recommendation. The deaneries have put on record their concerns about that recommendation. Given that is the case, we need to consider it and we need to consult, which is why, as I say, even if you invite me back in early March it is not a case of not wanting to give a response on MEE, it is a case of wanting to consult properly before we give a response.

Q887 Chairman: In view of what I said and in view of why we are here looking at MMC as an inquiry, it is pretty crucial in terms of the outcome of the Tooke Review to know where medical education is going pretty quickly in view of the circumstances of last year, this year and future years as far as we can see at this stage. When do you think you could respond on a wider view on that particular recommendation? Not the end of February and not the end of March?

Alan Johnson: If it is in with the Darzi Review it will be July.

Q888 Chairman: It could be as late as that?

Alan Johnson: It could be, but it was not in the October report. It is in this report and there has been no consultation on that.

Q889 Chairman: I accept that.

Alan Johnson: Perhaps the outcome of this inquiry might, as it often does, decide the course of events. You would have an influence over this as well.

Chairman: We will move on.

Q890 Dr Naysmith: I count the Secretary of State as a friend of mine so I may be about to lose that friendship by pursuing the Tooke Report just a little bit further. I will have to rephrase the question I was going to ask. One of the things that are recommended by Tooke is the uncoupling of run-through training and particularly splitting the 2-year Foundation Programme. We have had a lot of evidence, and I know from my own area, that there are people who think that the 2-year initial F1 training Foundation is a good thing and has contributed a lot. Tooke recommends that disappears. Are you prepared to say anything about that? The reason I am asking that is before you give your initial response at the end of this month I hope you will take into account the fact that there has been a lot of evidence to this Committee that not everyone in the profession is united in getting rid of the 2-year Foundation.

Alan Johnson: You did rephrase it very skilfully, and our friendship will not be affected by this, but it is the same answer. Indeed, I do not know yet what our response is going to be on that, we are still thinking that through.

Q891 Dr Naysmith: That is all I wanted to hear, that you have not made up your mind yet.

Alan Johnson: Mr Bone said that we would be giving the response in a couple of days, but actually it is not a couple of days until the end of February. In terms of the way our thought process is going, we have not got an answer to give you at the moment. It deserves proper consideration. It was in the original report in October and we do expect to be able to give a definitive response in February rather than a watch this space response.

Q892 Dr Naysmith: Could I ask you, does the requirement of the Medical Act for medical schools to guarantee their graduates employment until they register fully with the GMC fall foul of EU employment laws? Is that why splitting the Foundation Programme is desirable, that you become qualified as a doctor after one year of postgraduate training rather than two years? Perhaps we could ask Sir Liam Donaldson.

Alan Johnson: It is back to us having to consider that as part of the work that we are doing on the Tooke recommendations. I cannot give you a response on that.

Q893 Jim Dowd: Just on that point, this is the final evidence session of this inquiry so do you think our final report would be better informed and save a lot of tedious repetition if we were to wait until the Department’s full response to the Tooke Review was available before we concluded this report?

Alan Johnson: That is a matter for you. All I can say is that it would be quite normal for governments of all political persuasions to spend more time considering a report like that before giving a response. The reason I said we will respond by the end of February, and the reason why John Tooke is absolutely delighted with that and people in the medical profession are delighted with that is they recognise that is the quickest that Government can go on a report of that nature. You would have to decide yourself when to bring your investigation to a close. All I can say is we are working as quickly as we possibly can on that Tooke Report.

Q894 Mr Bone: We are going to move on to self-sufficiency and competition and the EU and non-EU, so this is something you can get your teeth into, you will not need to take the Fifth Amendment on this one. The Home Office has introduced new immigration rules preventing non-EEA doctors from applying for UK training posts from 2009, and we heard some evidence about that in the previous session. What impact will this have and why was it not done earlier because did the Government not talk about self-sufficiency in 2000?
Alan Johnson: Well, in 2005 really the monitoring suggested we were going to have a problem in 2007 and as soon as we found that was the case we acted immediately on something called permit-free training and it stopped that year in 2006. Then the question was how to tackle this issue of international medical graduates because we cannot have, on the one hand, a policy of self-sufficiency and, on the other hand, an open door policy. The original way to tackle this and the preferred way to tackle this was not through the Highly Skilled Migrant Programme, it was through employment law guidance that we can issue ourselves in the Department of Health that will ensure not just those people who have not yet come to this country as IMGs but those who are already here would only take post-graduate places if UK trained students could not fill those places. So our preferred route was down the guidance route. As Liam referred to earlier, we were stopped from doing that because there was a legal challenge. We actually won the legal challenge but we won it too late in the day to actually allow us to implement it. That is our preferred route. The decision made by the Home Office on 6 February was very helpful. It will stop around 3,000 additional people applying for posts in 2009.

Q895 Mr Bone: I think the Secretary of State has been most helpful in his answers on this subject. I think what you are saying really, and I think most people will commend you for saying, is UK jobs for UK citizens as far as possible but you were not allowed to go down that route because of a legal challenge. We understand that 3,000 less people will come in because of that, but two things have come up. There are around 10,000 IMGs already here, so that is not really going to reduce it too much. The extraordinary thing we heard in the last session was nobody knew how many people would be coming from the EEA, the European Union. Is it right that nobody knew how many people would be coming? Ms Chapman: Our estimate is 5%.

Alan Johnson: Our estimate is 5%. Ms Chapman: The estimate would be 5%. One of the things that we did get as a result of last year was much better data because of the centralised system in terms of information to interrogate. I think the 5% is a pretty solid number to forecast against.

Q897 Mr Bone: So the Health Department is putting its head on the block saying it is 5%.

Alan Johnson: Our estimate is 5%.

Ms Chapman: I am saying that last year it was 5% and if the last year is a good predictor then that is a good basis for planning.

Q898 Mr Bone: What some people cannot seem to handle on this is, yes, you are taking historic data and saying if that is repeated again that is what will happen, but what some people say you should be doing is actually forecasting the numbers that are likely to come in, not saying that last year might be repeated again. Has the Health Department actually done a forecast?

Ms Chapman: There are two things on that. One is that as a result of the forecasts that were done in spring/summer of last year we actually forecast very accurately the number of applicants and also the likely success rates of all of the applicants, and it was our forecasting that really helped us to put together a very targeted support package for any doctor that was identified as having the potential to succeed in further specialist training, so there is plenty of evidence that our forecasting really helped to inform decision-making.

Alan Johnson: Two things on this. First of all, it is the international medical graduates that are the problem; it is not people coming here from other European Union countries. Secondly, for us to set up a system to accurately predict how many students will come from 27 Member States I would suggest is the way we sometimes respond to written questions and the cost of providing that information would be far in excess of the results that it would produce. Working on the basis of what the normal number is, which is around 5%, is pretty good. The second point is we did not know anything about these ratios, we did not know very much about these ratios at all until we introduced MMC which gives us a much better picture. All the problems that are going on in MMC were going on before, they just were not centralised in one place, they were happening all over the country, so one did not get the same volume of difficulties because, as I say, it was an opaque system. It has enabled us to predict much more clearly what the ratios are going to be, which is why we predict for this coming year we are going to have three applicants for every place and last year it was 2:1. You are right, as a responsible Government we have to try to tackle this in any way we can. We are not just stopping at the basis of the Home Office ruling, we are also pursuing an appeal on the guidance that will actually prevent IMGs who are already here to the House of Lords. The hearing begins on 28 February and it is possible we may have the result by the end of March.

Mr Bone: I am sure most people think self-sufficiency is a very good idea and would welcome what the Government is trying to do but it has got tangled up in the legal system. Just put it the other way round, if we were not in the European Union you would not have to take people from the European Union and you would be self-sufficient.

Jim Dow: It is not the EU, it is the EEA.

Q899 Mr Bone: I know, but I am just using that as an example.
Alan Johnson: It is the EEA. That is not the problem. It allows medical undergraduates in this country to go and train for post-graduate education in any other part of the European Union, that is not our problem.

Q900 Mr Bone: I understand the benefits of it, but if you are trying to say that it is only people outside the EEA that you can control then it would be easier if you could control the whole lot because you are running a state health system employing 1.3 million people. If the state could actually control it you would do better at it, but you cannot because whatever you say about estimates you really do not know how many people are going to come in from the EEA.

Alan Johnson: It is a question on the free movement of labour in the European Union and I believe that is a very good thing for the European Union.

Q901 Mr Bone: Does it make your job more difficult?

Alan Johnson: No, it does not make the job more difficult at all. The problem we have is international medical graduates and the fact that well over 50% of international medical graduates go back after 2–4 years of working in the NHS so you actually lose them as well.

Q902 Mr Bone: The other side issue is you have messed around with what I think the Foreign Office said was an “unwelcome precedent” in what you have done in changing the rules. For the Foreign Office that is pretty strong terms saying, “Butt out, you should not be doing this”.

Alan Johnson: That was a Government decision cleared through the whole of Government.

Q903 Mr Bone: The Foreign Office should not say those things?

Alan Johnson: I have not heard the Foreign Office saying those things, but this was a Government decision.

Q904 Chairman: Can I just ask you about what you are saying. This comes from many years of the NHS not meeting our own quotas, as it were, from medical graduates here in the UK. This change has taken place in the last 8–10 years. Prior to that, and even during the time that these changes were taking place, we were bringing in quite a large percentage of National Health Service doctors and other health workers from areas of the world like the Indian subcontinent. Do you feel that we have any moral obligation to countries like that which we have relied on for many, many years to run our National Health Service?

Alan Johnson: I think two things about this. First of all, the contribution of those international medical graduates has been immense, and you are quite right. Chairman, we would not have been able to run the Health Service effectively without their contribution. That is the first point to make. The second point is they themselves understand this. I saw a quote from the organisation representing doctors of Indian origin on 7 February after the Home Office decision which said that they agreed with that decision and it should have been done years ago. One aspect of that is we have denuded the world of medical graduates that their own countries were very keen to ensure they kept. I do not think the open door policy was the right policy for us but I also do not think it was the right policy for countries like India, Pakistan and other areas where we took their medical talent, if you like, and brought them over here. Now that we have built four new medical schools, now that we have increased the number of medical places, including, I am pleased to say, the fabulous Hull-York Medical School that we were arguing for for 25 years and we have finally established, the policy of self-sufficiency makes sense for us and certainly on the facts and on the basis of all the arguments no-one could suggest this is in any way failing to meet some moral obligation, it is actually the right way for us to go. Of course, for many of the people who have come through the system, they have gone back to their own countries and have really benefited from the UK expertise in medical education.

Q905 Chairman: Do you see a situation where this country could not be training international medical graduates to be able to go back into different parts of the developing work and work there and improve their health services?

Alan Johnson: There could be programmes, the kind of medical equivalent of Chevening or whatever that we could use for that, of course. There is no other country in the world that has this kind of open door policy and does not have a policy that says we will train up our graduates and if there are shortages then we will take people who are international medical graduates to fill up those shortages. That is the way America runs their system, Australia, Canada and it is the way now, because of the investment we have put in medical schools, we can run our system in the same way.

Q906 Chairman: I am going to ask the CMO, when I said about the situation of people coming here maybe for specialist training for different aspects and then returning to the developing world, that has happened and it does happen now, but will these regulations in any way, no matter what happens in the next few months, change that at all?

Sir Liam Donaldson: No. I think it is important that we continue to run fellowship programmes of the kind that the Royal Colleges have traditionally run to allow people to come here to gain experience, receive training and go back again, but as a strand of an overall programme of training.

Q907 Jim Dowd: You have referred to the judgment awaited from the Lords and I think they will be looking at it towards the end of this month, reporting sometime in late spring, early summer. If the guidance is upheld in the Lords, do you think any further measures will be required or would you consider that to be the end of the matter?
Alan Johnson: If it is upheld I doubt whether we will need any further requirements. We are looking at other ways to do this, like, for instance, a fees system, but I think the guidance should resolve the problem providing it is robust and we could be confident that it would remain in place.

Q908 Jim Dowd: Would you then honour any commitments given to non-EEA individuals in the meantime, any contracts?

Alan Johnson: We would need to look at how the ruling goes but we said last year, for instance, before the challenge that we would allow those who were already in the system to complete their training.

Q909 Jim Dowd: Already in the system up to what point?

Alan Johnson: Already applied, I think.

Ms Chapman: This year we are actually going to have more than one pulse of recruitment, so there will be the opportunity for ministers to make a decision on whether or not any guidance would apply to further recruitment rounds that would happen this year.

Q910 Jim Dowd: I think I understand that.

Mr Taylor: It does not take away people who are on the system. It does not take people out of positions.

Q911 Jim Dowd: I understand that, but what we are trying to get at with this particular line of questioning is if it is upheld ultimately by the Lords it is perfectly legitimate for them to say it was always legal and, therefore, anything that happened between the time it was first challenged and now you can go back and revisit, or are you going to take the position which the law understands that until it proves to be unlawful it remains lawful, or vice versa?

Alan Johnson: We would not apply it retrospectively.

Q912 Jim Dowd: The Home Office describe the new rules as a short-term solution to the current problems, but if your guidance is not upheld in the Lords, and I put this to anybody who may have an answer, will the changes not have to be made permanent?

Alan Johnson: If the guidance is not upheld then we will continue to look at other options rather than through the Highly Skilled Migrant Programme. We do not like using the Highly Skilled Migrant Programme, these people are highly skilled, and the Home Office were reluctant to take that route, as were we, but they accepted, as we did across Government, that we had to get in a position to ensure that as far as we can in 2009 we do not repeat the problems that we had last year. There are other things that we are looking at and other ways of doing this. There are not too many other options but we are exploring them all.

Q913 Chairman: Could you tell us what those other options are, Secretary of State?

Alan Johnson: I mentioned one, which is a fees regime. The other is to see whether we could pass into legislation from my Department something that would cover this rather than dealing with it through the Highly Skilled Migrant Programme. This is predicated on the fact that we lose the appeal. If we lose the appeal, how can we get that guidance into a much firmer setting. We would have to look at the reasons for losing the appeal, and I hope we will win it and we are quite confident that we have got a good case to put to the appeal, but we need to ensure we have got a mechanism in place to ensure that we have a self-sufficiency policy, not a self-sufficiency and an open door policy.

Q914 Dr Naysmith: Following that up, Secretary of State, do you think that the current capacity of our medical schools in the United Kingdom is about right at the moment or are there any plans to increase or even decrease the numbers in the future?

Alan Johnson: I think it is about right. The number of medical school places has gone up from something like 3,500 to just over 6,000. We monitor this all the time and we did create more places, as Liam referred to, at the time of Lord Warner. I think we have got it about right.

Q915 Dr Naysmith: Given that we are looking at training places in six years’ time it is pretty difficult to predict exactly what the situation is going to be. Maybe Ms Chapman might have an idea about that. Do you think it is possible to do that?

Ms Chapman: I think that the Select Committee’s report on workforce planning and also the work that we have done as part of the Lord Darzi next stage review has shown that we are very good at planning supply, but we are far less articulate at planning demand. One of the things that are being looked at as a result of the clinical vision being looked at for the service is making sure that we build two things into that. One is the workforce implications of the service redesign and, secondly, the financial implications of the service redesign so that you are bringing service design, finance and workforce planning in line. Do I think that is possible? Usually when there are changes, about 80% stays fairly static and about 20% has got the discontinuities, so the challenge is spotting where the discontinuities are so you can plan for them.

Q916 Dr Naysmith: You will accept that in this situation that we are talking about this afternoon we have got major changes taking place, like cutting off largely the supply from outside the European Economic Area, plus admitting you do not know what is going to happen. If there is some sort of vacuum in this country of medical graduates then what will happen in the EEA is that more graduates will apply.

Ms Chapman: I think two things have happened as, again, was made clear in the Select Committee’s report. Since 1997 there have been over 250,000 more people brought into the service as capacity was built and over 35,000 more doctors. I think what we have seen during that period of time is a big increase
in the capacity of doctors and also some adjustments in terms of the service that is being delivered, so looking forward I do not expect there to be such a massive increase in capacity and, therefore, the predictions we have currently got with the medical schools looks adequate. I do think it is going to be critical, as was mentioned before, that we look at what are the service design implications coming out of the Lord Darzi work.

Q917 Dr Naysmith: Do you have an optimum level of competition for training places? Do you have an optimum that you are aiming for? For instance, should we aim to produce 5% more medical graduates than training posts? Does that figure in your calculations?

Ms Chapman: The devil is in the detail. When you start to look at the detail by specialty there are some very hard to fill specialty areas and that is where you would want very different resourcing strategies from those specialties which are very popular and in very popular parts of the country. My reaction is yes, you would want some principles but they would need to be specialty specific.

Q918 Mr Bone: Can I just come in on that because that is an interesting point. If there is a hard to fill area would we be turning down graduates who might be qualified in that area from outside the EEA?

Ms Chapman: No. Firstly, there would be the opportunity for graduates from English medical schools to fill the vacancies and where that is not possible we would be bringing in talent and expertise from outside.

Q919 Mr Bone: This ban in 2009 would not apply to that?

Ms Chapman: We would still be able to do that.

Q920 Jim Dowd: How do we square the circle of maintaining quality practitioners against the obvious expectation that anybody who gets a place at medical school will ultimately get a job working within the NHS?

Ms Chapman: Say that again.

Q921 Jim Dowd: Is there an expectation that anybody at medical school will ultimately become a practising doctor within the NHS and if there is then how on earth can we ensure that we are actually getting the best?

Alan Johnson: That is a very good point actually because we are just getting to the level of self-sufficiency. Previously it was a case of trying to get doctors from wherever we could but now we are coming through to self-sufficiency. There is a view that says why should the medical profession be different from any other profession. Nobody who trains to be a lawyer is guaranteed a lawyer’s job at the end of it and no-one who trains to be a plumber is guaranteed a plumber’s job at the end of it, why should you have a guarantee that there is a job at the end of medical training. I think it is quite important to get the balance right, not least of all because we are spending about a quarter of a million pounds on training undergraduates to be doctors. I really think we have to try and get it just about right. I would not personally go for an over-supply issue, but there are many people out there who would say that if you do that you get better quality. I think our quality can be guaranteed through other means rather than by a market forces way but, nevertheless, that is an interesting argument and we are only just having it because we are only just talking about self-sufficiency.

Q922 Jim Dowd: Good. As a variation on that as well, there are recent figures from the Department of whatever it is called these days that looks after universities and the rest about the numbers of applicants to universities generally, they are going up, but there is still this perennial problem of those from “non-traditional” backgrounds. I saw a release from the BMA not long ago saying that the most socially exclusive higher education course in the country is actually veterinary medicine, not human medicine, but it is closely followed by human medicine. It is still very much a preserve of those from more prosperous backgrounds, certainly those from traditional backgrounds, sons and daughters of doctors who become doctors, et cetera. What is being done to address that?

Alan Johnson: I am glad you have raised this as the former Higher Education Minister who introduced tuition fees and you alluded to the statistics which show not just a big increase in those applying to university but a big increase in the lower social classes, so this argument that fees was going to work contrary to that is not the case. This is the key profession in terms of attracting people from poorer backgrounds. There is no profession worse than the medical profession. You have just pointed out veterinary medicine, which I was unaware of, but when I was Higher Education Minister all of our efforts were to get poor kids, bright kids, to go into medicine because it was not seen as anything that they would be comfortable with. It was not just a problem of getting them to university, it was a problem of once they were at university of saying, “Why not go into medicine?” As Liam just pointed out to me, getting a medical school in a city like Hull, for instance, jointly with York and having medical schools in places like that does at least signal to youngsters in some of the deprived areas that there is a place nearby where they can train to be a doctor if they get the required qualifications. I think it does help the education system, which is key to all this of course, to build up the aspirations of youngsters to go into medicine.

Q923 Jim Dowd: What about the length of some of the courses to go into medicine? Does this not militate against those who do not have quite sufficient independent financial means?

Alan Johnson: That is true, but there are bursaries and grants. The new system introduces a bursary of £3,000 from the Government matched on many occasions by another £3,000 from the university itself. It is a long course in medicine as it is in
Disciplines like architecture, et cetera, but there is help available. The premium on that investment in education is huge in medicine more than many other professions.

Q924 Chairman: Could I just say on that basis, Secretary of State, I know you live quite close to my constituency and one of my secondary schools is visited annually by Sheffield Medical School to look at the brightest people there to talk to them and their families about whether or not they would like to go into medicine. Would you like to see something like that throughout places like Hull and South Yorkshire?

Alan Johnson: There is a lot going on out there and I think one of the problems is we have not brought this together. Perhaps we could do a piece of work with John Denham’s Department to actually look at this. I was in Birmingham when I was at Education where they take kids from primary school and introduce them to things like first aid and take them to a hospital and gradually as they go to secondary school they become more and more interested. Some of them go on to be paramedics, some go on to be nurses, but the message to them is they can go wherever they want to go if they are interested in medicine, and they have got structures in place to help that. I am really interested in the initiative in your constituency and perhaps we ought to look at this, and perhaps they are doing this work, together with the Royal Colleges and everyone involved in this as a specific piece of work to see how we can learn from that best practice and introduce it much more widely.

Q925 Dr Taylor: Can I go back to the question of the number of applicants per place. Overall it is three applicants per place. Professor Douglas, when he came to us about a fortnight ago, said very clearly that there were 1,200 excess jobs at ST1, 1,300 too many jobs at ST2 but a huge deficiency of jobs at ST3. Is there not a tremendous danger that we are sucking in non-EEA ones at ST1 and ST2 and making the problem even worse at ST3?

Ms Chapman: That is one view. It is certainly something that we should keep under consideration, but we do know how many people are coming out of Foundation and how many people are coming out of ST1 and, therefore, it is important that we provide the right number of opportunities to keep the doctors progressing.

Q926 Dr Taylor: Is it possible to actually look at what it was before and what it is now?

Ms Chapman: We will not be able to look with as much accuracy at what it has been over previous years because obviously we do not have the quality of data that we have now got through last year. I am sure that we could produce something to show that the toughest competition has always been at ST3. The other point is there is no point in creating false expectations by putting a lot more roles in at ST3 than we need because what you end up doing is creating a dead end for people. It is a case of balancing it. At ST1 and ST2 what is very important is that we are creating the right number of roles to reflect the number of people coming out of Foundation Programmes, et cetera, so it has been carefully balanced. Because we have got multiple pulses of recruitment that will go on, if we do find that we have significantly under-represented one of the levels we do get the opportunity to come back and recommend to ministers that we adjust it.

Q927 Dr Taylor: Do you agree that there is a risk of sucking in non-EEA ones at ST1 and ST2 and making the problem even worse at ST3?

Ms Chapman: That is one view. It is certainly something that we should keep under consideration, but we do know how many people are coming out of Foundation and how many people are coming out of ST1 and, therefore, it is important that we provide the right number of opportunities to keep the doctors progressing.

Q928 Dr Taylor: Professor Douglas really felt extremely strongly about this and in our evidence he said: “I took this problem to ministers that day. We wrote to all the appropriate channels and made full recommendations as to what I suggested they could do to try to rebalance the situation just a little bit. Despite taking the papers I had written to ministers I was getting the impression that there was just no room for movement on this.”

Ms Chapman: I think there are two things. Since then the Programme Board have discussed this issue and we have put, I cannot remember the exact numbers, about 156 new ST3 posts in place, so there was a recognition that we needed to take some action and we have taken some action. This was discussed at the last Programme Board and our conclusion was that what we needed to do was to recognise it as a risk and make sure that as we get the results from this next round of recruitment we look to see whether it is an issue. What we will do is continue to talk with Professor Douglas and the Programme Board about the facts that we are finding.

Q929 Dr Taylor: Those 150 extra are not going to overload the potential consultant posts?

Ms Chapman: A good question. There is sufficient capacity within the service to provide both the training for those extra roles and also we believe, because we have worked with the Royal Colleges, we have actually put the extra roles in places where we know the service has got need.

Q930 Dr Taylor: Just to follow on from that, we were rather distressed in the first session with the Immigration Departments to hear that there are still doctors coming from abroad not going on to actual

1 Note by witness: The actual figure is 165
training programmes, presumably filling in pure service, possibly dead-end jobs. Do you see an end to that?

**Ms Chapman:** I am sure the CMO would want to comment, but I do not think that doing service jobs are dead-end jobs on the basis that these are trained doctors and trained doctors doing very important roles within the service. We will continue to have overseas doctors coming in to fill—

**Q931 Dr Taylor:** They are trained to a certain degree but their training in some of these jobs will actually stop. Tooke suggests that Staff Grades could have access to continued development and continued training.

**Ms Chapman:** Indeed, and that is being looked at.

**Sir Liam Donaldson:** If you look at the figures from last year, quite a substantial number, albeit the minority, of doctors in those sorts of posts did get on to the full-blown training schemes which in my view, although we have not got data from the past, was less common in the past.

**Q932 Dr Taylor:** So you would try and find us figures to show that the competition was pretty well as tough before as it is now?

**Ms Chapman:** No, my point was different from that, which was we should recognise that competition has always been toughest at ST3. Whether the percentage of competition ratios has increased, I am sure it has bearing in mind that what we have had is a transition year.

**Q933 Jim Dowd:** Ms Chapman, this is for you. Immediately before we undertook this inquiry we concluded one into workforce planning in the Health Service and also during the course of this inquiry many of the witnesses we have had have criticised the lack of planning for the overall medical workforce. Do you accept that planning has been poor? Whilst obviously the focus, certainly of this inquiry, is on the medical frontline, if you like, the National Health Service has a wide variety of specialties and disciplines and although doctors have an unerring ability to generate the most attention and get the most attention devoted to them, they are just one significant part of an overall pattern that we need to address. Do you think that we are actually addressing it adequately now?

**Ms Chapman:** I think I am probably going to repeat the evidence I gave last time. An increase in a pattern that we need to address. Do you think that there has been a distraction because they are to where the people are needed. I do not think that there has been a distraction because they are done differently and done at different places within the service.

**Jim Dowd:** Do you think we need to break the link between training places and consultant posts? Do you think that is misleading us? We can wait for the Tooke Report and you can put it in there if you want.

**Q935 Mr Bone:** Take the Fifth!

**Ms Chapman:** It does get covered as part of that. What is very important is there is a connection between the number of training places and the supply and demand assessments that go on as part of the service planning. That is the key bit of analysis that needs to get done.

**Q936 Jim Dowd:** Sure, but my question was do you think we need to break that link? The purpose of training places is to keep consultant numbers at the levels they are at.

**Ms Chapman:** And GPs. To be honest, I am not sure I entirely follow your logic, which is why I am not sure that I am giving you a correct answer.

**Jim Dowd:** That is okay. I do not follow my own logic very often myself.

**Chairman:** Quite a few of us have problems with Jim’s logic at times!

**Q937 Dr Naysmith:** Do you agree that the plight of Staff Grade and Associate Specialist doctors has been overlooked during this crisis about MMC and the other ramifications? If so, do you have any plans to reform this forgotten part of the medical workforce?

**Alan Johnson:** Not only have we plans, we are actually implementing them at the moment. They are forgotten no longer. That was a very important question in the past.

**Q938 Dr Naysmith:** But they have been neglected in the last few years.

**Alan Johnson:** Where are we with the deal, Clare?

**Ms Chapman:** The Government has agreed the new contract terms and has offered to implement them over two years which would be an increase of about 10% for Staff Grades and 4% for Associate Specialists. That is going to ballot in March.
Alan Johnson: the new contract, did it not?

NHS over the last ten years.

changes and improvements that have gone on in the

that they are not forgotten or left out of the huge

can get a fair deal with their representatives which means

to be clear for both. That has been one of the benefits

of MMC. There is more work that needs to be done

that makes that reality and to take forward the choice

opportunity agenda that was laid out by the

Alan Johnson: This group was not part of Agenda

for Change so all the discussions that were aimed at

lifting the pay of GPs, for instance, consultants, all

the stuff around nurses and paramedics, those huge

changes in Agenda for Change which dealt with lots

of longstanding grievances, this group of around a

bit more than 5,000 were left out of all of that. The

deal has got to go to ballot and I am not suggesting

that everything now is coming up smelling of Chanel

for this particular group but I do say that we have

paid some attention to their concerns and sought to

get a fair deal with their representatives which means

that they are not forgotten or left out of the huge

changes and improvements that have gone on in the

NHS over the last ten years.

Dr Naysmith: It took just over a year to ratify

the new contract, did it not?

Alan Johnson: I know.

What were you doing in that

year? That was before you even started consulting.

Alan Johnson: I wish I could tell you a blow-by-blow

account of it. Basically it was the kind of difficulties

that go on in government where you have to get

clearance. Do not forget, this was a year when we

had a public sector pay ceiling of 2% for everyone

except the Armed Forces and it happened to be the

year when we came to a conclusion on this group of

doctors and it had to be related back—

Dr Naysmith: If you had come to it a little bit

quicker then you would not have got into that.

Alan Johnson: Sure.

You could have done it outside

of that year.

Alan Johnson: Sure, that is a fair point.

Three very broad questions to

finish with, Secretary of State. I think it was the

CMO who told us that we need more doctors

because we are only 22nd in the world rating of
doctors per head of population. Where would you

like to see the UK as doctors per head?

Alan Johnson: As the CMO made the comment

perhaps he would like to say where he thinks we

ought to be.

Liam Donaldson: The expansion of medical

schools will start to move us up the league table. The

position is quite complex. As your colleague said, we

need to look at the whole of workforce together and

look at changing roles in healthcare and Sir John’s

recommendation that we have to look specifically at

the role of the doctor vis-à-vis other professions. It

is now a wider question than just picking a number

but I am very pleased to have been associated with

the medical school expansion several years ago and

it is starting to put us on track.

Dr Taylor: Thank you. The European

Working Time Directive: obviously this is making

life and training very difficult, and we have already

heard that you cannot create more training posts just

to answer that, so do you have up your sleeve any

answers to the European Working Time Directive?

Alan Johnson: What we want to do is divorce

SiMAP and Jaeger away from the issue of the opt-

out. SiMAP and Jaeger is something that is affecting

every European Union country. It is this incredible

decision where if somebody is on-call but not

disturbed and sleeping for 12 hours at night they

have to another 12 hours to recover from their 12

hours’ sleep. The problem with resolving that is it

has become tied up with an argument in the

European Union about whether we should continue

to have our opt-out from the 48 hour limit, which we

are very determined to protect. We have been

arguing to separate the two things away and I hope

we can make some progress on that under this

Presidency or the next Presidency. Aside from that,

one of the two new recommendations in the Tooke

Review was about the European Union Working

Time Directive and splitting out training and

classifying it as non-work. We are looking at that but

I dealt with this Working Time Directive in a

previous life and it is quite clear it is a health and

safety directive, it is about the time you spend on

duty, if you like, and does not differentiate between

the time you spend on duty being trained and the

time you spend on duty working, you are still

attended. We will look at that but I do not think the

cavalry is coming over the hill on that one.

Dr Taylor: Is there any timescale on SiMAP

and Jaeger?

Alan Johnson: No. We live in hope that we will get an

agreement to the whole issue about Working Time in

Europe or we will get an agreement to separate away

SiMAP and Jaeger. If we separate away SiMAP and

Jaeger every European Union country will sign up to

the resolution because everyone is in the same place

over that. Not everyone is in the same place about

the opt-out, which has been the confusion of tying it

in with an issue that is not related to it but, if you

like, is a negotiating trick by the European

Commission.

Dr Taylor: When one is talking about medical

workforce planning one needs to know details of

what sort of doctors you want. Could we just have a

brief idea of your view of a consultant-led service as

opposed to a consultant-delivered service?
Alan Johnson: Forgive me if I hesitate. This is all tied up with the Darzi Review and in terms of whether we have a Health Service that is clinically-led locally-driven and that is very much what we are looking at at the moment.

Q948 Dr Taylor: Let me try and explain what I mean by the difference. Consultant-led is a consultant who has a team of juniors who are doing a lot of the work whereas consultant-delivered is the consultant who is doing most of the work and the juniors are specifically just in training. Without spilling the beans on the Darzi Report, and I was not aware that came to any real pointer in that direction, I was just trying to get your views about whether you thought that consultants should be on-call 24 hours a day doing all the work?

Alan Johnson: We do have a Working Time Directive! I think that the old system where people who were not properly trained carried out a large tranche of the medical care was not a safe, secure system. I am a big supporter of the Working Time Directive, incidentally. I always found it amazing 20 years ago when we heard these stories of junior doctors working 120/130 hours a week, you probably did it yourself, almost as if it was something we should be proud of, and doctors on-call being called out at three o’clock in the morning and having to be bright and breezy at nine o’clock at their surgery. I think that is all wrong and it is absolutely right to tackle that as we have tried to do. I think it should be consultant-led on the basis that people who are in training by and large should not be put in a position where the healthcare system relies on them to provide medical care as if they were fully trained.

Dr Taylor: Okay. So we will wait to see what Darzi says and you say to Darzi about it.

Q949 Mr Bone: Secretary of State, I did not quite understand one of the answers you gave to Dr Taylor. He asked specifically about the number of doctors per head of population and the fact that we are very poor in the league table on that. I know you said earlier in your evidence you had full confidence in your Chief Medical Officer and the Chief Medical Officer wants us to go up the table. Is it Government policy that we are going to have significantly more doctors per head of population to move up the league table?

Alan Johnson: We are going to have more doctors, and have had 36,000 more doctors, but I am not looking at it, and I think Liam said as well, as where we are on the league table but as how many doctors do we need to provide a proper service.

Q950 Mr Bone: How many more would that be?

Alan Johnson: I think that depends on a lot of things, for instance, in terms of tackling un-doctored areas, what happens there and what comes out of the Darzi Review. We are going to need more and we are actually planning for more at the moment. There is no magic position that we want to be in. These league tables could be very misleading. Number of doctors per head of population is a bit crude.

Q951 Mr Bone: Do we need to double the number per head of population? I am just trying to get a feel for how you think we should go on that.

Alan Johnson: You can see where we want to go by the number of medical school places we are making available.

Q952 Chairman: Last question. One thing that has come up during this inquiry is that some parts of the country have got probably the best cohorts of junior doctors going into their district general hospitals than ever before. Yorkshire and Humberside, which has my constituency in it, is one of them. The district general hospital in Rotherham has a better cohort of junior doctors in there than ever before, but that is not right throughout through the land. I look at Sir Liam who has an historical link with the town.

Sir Liam Donaldson: Yes, I do, I was brought up there. Despite the distress and anxiety caused to the junior doctors in 2007, which we all very deeply regret and I said so the last time I came before the Committee, I have anecdotally heard many senior doctors around the country saying they are very pleased with the quality of doctors they have had appointed. I think the problem is everybody is too frightened to say that because the minute you say anything positive about MMC you would be attacked.

Q953 Chairman: This was not part of the plan, was it?

Sir Liam Donaldson: It was part of the plan to try and get the best quality doctors we could into our training posts and to some extent the anecdotal feedback is that has been accomplished in some parts of the country. That does not take away from the anxiety and the damage that was caused to many junior doctors as part of the process.

Ms Chapman: In addition to the anecdotal feedback there is also clear evidence that some of the hard to fill specialties have had a much better fill-rate this year than in previous years as well.

Chairman: This just ends on a division, Secretary of State, not a fire alarm as was the case the last time you were here. Can I thank all of you very much indeed for coming along and helping us with this inquiry. Probably this will be our last session in relation to this and we will await the outcome of your points on Tooke at the end of this month. Thank you.
Written evidence

Supplementary memorandum by the Department of Health (MMC 01A)

HEALTH SELECT COMMITTEE INQUIRY INTO MMC

Thank you for the opportunity to give evidence to your enquiry. In response to a few of your questions we offered to give you more detail in writing.

MTAS capacity

The Invitation to Tender Documents for the MTAS IT system refers to multiple rounds of 10,000 leading to a capacity of 30,000 applicant users. The capacity ceiling was reviewed and increased to 40,000 in December 2006 (19 Dec). Methods Consulting was the supplier for this work.

At the time we procured the MTAS service, the expectation was that recruitment to ST1, ST2 and ST3 would be carried out in separate rounds, and that a maximum of 15,000 applications would be received in each of these rounds, for a maximum of about 10,000 posts. The MTAS supplier was consulted when the decision was made at a later date to combine the recruitment rounds.

There is a perception that problems arose with MTAS related to the capacity of the IT system: in fact there was sufficient capacity in the system. As we acknowledged in our evidence, the system did run slowly for a period of 11 hours and during this time some applicants had difficulty accessing the system. The reason the system ran slowly was not due to poor capacity planning but rather the way the load was distributed across the various computer servers. This was a technical problem that became apparent only when the system was fully loaded. The issue was fixed by Friday 2 February. We extended the deadline from 4 February to 5 February in mitigation. We very much regret the frustrations this created for some applicants, but by the deadline over 34,000 applicants had completed their applications and only 68 applicants appealed to be allowed a late entry application. Of these, 26 had substantial reasons to permit a late entry, mostly because of individual, personal circumstances.

Relevant excerpts from the tender documents are attached at Annex A.

There were several references in our oral evidence to WPP and 6,000 applicants. To clarify and correct any misunderstanding that may have resulted, the reference to 6,000 applicants in the Tooke Report (p.142) refers to the tender for designing the application form and selection procedure not the IT system MTAS. The reference to 6,000 refers to the initial tender assumption relating to ST1, that there would be approximately 6,000 posts available at ST1. This tender for the selection procedure was won by Work Psychology Partnership.

MTAS contract with Methods

When the security breaches occurred the contractor was required to undertake immediate security testing and to upgrade the security of the system to a much higher level than is generally required for an on-line recruitment service. This work was completed by the contractor at their own expense.

The contractor also undertook a number of additional, non-security related activities at their own cost. The following are some of the actions undertaken:

— While the system was blocked, as instructed by the Department, the contractor undertook additional work to ensure that there was minimum disruption to the service and that deaneries were supported.

— The contractor also produced additional reports and substantial documentation so that all deaneries could see which applicants were scheduled to attend interview events.

— Once deanery access was permitted by the Department, the contractor set up a process so that deanery access was only available to trusted IP addresses that were associated to a deanery. A manual process was created that allowed the Department to approve which deanery users were authorised to use the system and to approve the users’ access rights.

The Department is not considering terminating the contract while there is an ongoing need for this service. The supplier has cooperated fully with us in making appropriate changes to the security arrangements (at their own expense) to minimise the likelihood of further security incidents. The ongoing need for the service includes the fact that the system is currently in use for applications to the 2008 Foundation Programme. Although the system will not be used for recruitment in 2008 to Specialty Training, its adaptation is an option for use in 2009 for recruitment to Specialty Training.
Communication

The Department wrote in its evidence that one of the main issues this year was the high volume of applicants. High competition ratios, linked with four choices for applicants, meant that many would not get interviews in the first round. We said all along that Round 2 would be substantial. We also repeatedly warned that there would be high competition and that doctors should not take it for granted that they would get the interviews and offers they wanted, particularly in the popular specialties and locations.

As early as 4 September 2006 we indicated there would be two rounds (www.mmc.nhs.uk).

In February 2006 an article was written on the MMC website (published in June in BMJ Careers http://careerfocus.bmj.com/cgi/content/full/332/7553/221 ) by Shelley Heard which spelled out that competition would be high for some specialties.

On 18 December the results of a survey indicating applicants’ interest in various specialties was published. This should have helped applicants see that some specialties would have had higher competition rates than others.


It was made clear on numerous occasions and by different stakeholders that applicants should be aware they may not get their first choice specialty. For example a newsletter on 6 January advised:

... you should keep in mind that you may not get your first choice of specialty or location and that it might not be in a run-through programme. I’d definitely advise that you have a plan b and even a plan c when you apply.

In general terms MTAS communications were part of the wider MMC communications plan which involved Deaneries, NHS Employers and national stakeholders as well as direct MMC communication with applicants through MMC and MTAS websites.

There was a programme of co-ordinated MMC (Foundation, Specialty, recruitment proposals) and MTAS roadshows undertaken with deaneries between May and October 2006 at which the recruitment and selection processes were discussed and critical messages such as competition were considered.

All English deaneries were visited by the MMC team with the exception of Eastern Deanery, who instead, liaised with Sarah Thomas, Lead postgraduate Dean over the changes.

The deaneries were asked to invite to these roadshows stakeholders who they considered had a key role to play in implementing and cascading messages around recruitment and selection changes for specialty recruitment.

Typically, these roadshows were attended by representatives covering clinical and academic leads for specialties, recruitment personnel from Trusts and deaneries, some potential applicants (Foundation and Specialty), clinical tutors and medical staffing personnel.

Overall, there were approximately 550–600 people briefed directly through these roadshows specifically to cascade the information and advice to potential applicants and their managers.

As part of the roadshow programme, Deaneries were asked to nominate a key person in the deanery to undertake the role of “transition manager” who would have responsibility for co-ordinating local activity, including appropriate communications messages in their “patch”.

These roadshows covered the fact that there would be two Rounds.

One of the difficulties in preparing applicants for the new system was the lack of any national data from the pre-MMC recruitment process. As soon as we knew the number of applicants and the competition ratios this was provided (in March).

We accept that despite these efforts not all applicants were as aware of some critical factors about the recruitment as would have been desired. However, direct feedback from applicants during discussions about the revised arrangements for Round 1 indicated a clear understanding that there would be a substantial Round 2.

Nic Greenfield

December 2007
EXCERPT FROM MTAS ITT (WON BY METHODS CONSULTING)

The service must be able to deal with application peaks as each recruitment round nears its closing date.

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<tr>
<td>Number of employer users</td>
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<tr>
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<tr>
<td>Number of posts to be filled</td>
<td>10,000 per year</td>
</tr>
<tr>
<td>Number of national recruitment rounds per year</td>
<td>10 plus clearing rounds (maximum)</td>
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Supplementary memorandum by the Postgraduate Medical Education and Training Board (MMC 27A)

MMC Inquiry Report

Following the recent telephone conversation with the Committee Specialist I am writing to set out PMETB’s position regarding recommendation 30 of the MMC Inquiry report. As you know the report recommends that:

“PMETB should be assimilated in a regulatory structure within GMC that oversees the continuum of undergraduate and postgraduate medical education and training, continuing professional development, quality assurance and enhancement”.

As Professor Rubin indicated when giving oral evidence to the Committee on 24 January 2008 he has a conflict of interest given his chairmanship of both the GMC Education Committee and PMETB, he has therefore stood back from discussions on this topic.

PMETB’s Board has discussed the issue of merger on a number of occasions in the past 18 months and the Board is opposed to any change to the structure of the regulatory bodies at this time.

In coming to this position the Board has considered a number of key issues which I set out below.

Firstly, government has already considered this issue in the last year and concluded that a merger would not be appropriate at this time.

Sir Liam Donaldson’s report into the future of medical regulation *Good Doctors, Safer Patients* recommended that the education functions of the GMC should be merged with PMETB to provide a single regulator for the continuum of medical education. The government rejected this proposal, and the various alternatives suggested during the consultation on Sir Liam’s report.

In the subsequent White Paper, *Trust, Assurance and Safety—The Regulation of Health Professionals in the 21st Century?* published in February 2007, the government gave two principle reasons for this position:

— First the proposed wide-ranging reforms to the GMC will be a significant challenge for the regulator to manage while continuing to exercise its core functions.

— Second, PMETB is a relatively new organisation, which, after a difficult start, is beginning to consolidate its performance.

If anything, one year later PMETB believes these arguments are even more cogent and nothing in the past year has changed the rationale for this decision.

Secondly, PMETB is making strong progress and its work is now widely recognised as improving the quality and standards of medical education and training in the UK. During the passage of its work the MMC Inquiry made no suggestion that PMETB failed to meet its statutory responsibilities nor was the Board criticised by the Inquiry. The Inquiry highlighted the significant achievements of PMETB over the last two years and this progress has been highlighted by a number of witnesses before your Committee during the recent oral evidence sessions.

Thirdly, the coming years are likely to be a period of further uncertainty and change within postgraduate medical education and training, following the report of the MMC Inquiry and the government’s forthcoming response to that report. PMETB itself is currently putting in place a new framework for quality assurance which has wide support from those with an interest in postgraduate medical education and training. During this time it would seem appropriate that the regulators are focused not on structural change but on ensuring the impact of any changes is properly monitored to ensure that training standards are maintained. Indeed some of the changes suggested by the MMC Inquiry require the regulator to implement them.
Fourthly, as a relatively new regulator PMETB has been able to bring a new approach to the regulation of medical education. For example, in reviewing the content and outcomes of postgraduate medical education training, the Board has drawn on its statutory responsibilities to take into account a wide range of stakeholders. The new quality framework seeks to meet the principles of good regulation set out by the Cabinet Office, significantly reducing the burden of regulation whilst developing new tools to ensure ongoing pressure to improve quality.

Finally, some have suggested that PMETB is not independent of government and this is a key reason for placing the Board within the structure of the GMC. PMETB protects its independence strongly and we seek to balance all of the different Interests in postgraduate medical education and training. We are not aware of any evidence that our independence has been undermined. To ensure our autonomy in the longer term we are moving to a self-financing business model.

The government is committed to reviewing the structure of medical education regulation in 2011. This would be the right time to have a proper debate about continuum of regulation from undergraduate to continued professional development. To change the structure now would be an unwelcome distraction which will do nothing to tackle the current Issues facing the training of doctors within the UK.

Luke Bruce
Director, Policy & Communications
13 February 2008

Supplementary memorandum by the British Medical Association (MMC 35A)

MODERNISING MEDICAL CAREERS

Thank you for allowing us the opportunity last December to appear as witnesses for the Committee’s inquiry into Modernising Medical Careers. We are grateful to be able to use this opportunity to provide the Committee with further information following the evidence session.

INTERNATIONAL MEDICAL GRADUATES

A key part of our evidence session centred on discussion about international medical graduates (IMGs). We mentioned that the BMA believes that, despite competition for jobs in 2008 being extremely high, discriminating against overseas doctors, who have been encouraged to come to the UK to train and to whom a commitment has already been given, is wrong and is verging on being immoral. It is the view of the BMA that these doctors are being unfairly targeted as a consequence of the UK’s own failures of workforce planning, and that the position of these doctors should have been considered at the same time that the Government was increasing medical student places with the intention of rendering the UK self-sufficient in doctors.

We believe that the term International Medical Graduates (IMGs) is being used inconsistently by different organisations and will lead to misunderstandings. For example, the General Medical Council defines IMGs as “nationals from countries outside the UK/EEA” whereas the term should refer only to an individual’s place of qualification rather than reflecting their immigration status.

The BMA considers that a more appropriate term would be “doctors subject to the immigration rules”. Whilst a significant number of IMGs will be subject to the immigration rules, there are some who are not. It is wrong to suggest that an individual’s place of qualification should determine their right to work in the UK. Some IMGs are British/EEA nationals, hold indefinite leave to remain, or have permission to work without requiring a work permit, meaning that legally they must be considered on an equal footing with UK/EEA nationals who are UK medical graduates. The BMA has repeatedly requested the Government to accept their responsibility to highlight the vastly reduced training and employment opportunities available to international doctors, and to discourage future migration to the UK. For such doctors, the Government must ensure that information about the true situation of medical employment in the UK is disseminated as widely as possible.

At our oral evidence session, Stephen Hesford MP asked what proportion of the BMA’s membership was made up of IMGs. This data is not accurately collected in the form requested but we would estimate that nearly 20% of the BMA’s total membership might be considered within the very generalised grouping of IMGs. 1

1 The number of IMGs (doctors who qualified outside the EEA) who are in practice as a percentage of the total number of members who are in UK practice
The NHS owes an incalculable debt to international medical graduates. In the past, the UK has failed to train sufficient numbers of doctors and without medical immigration the health service would have failed years ago. Because of this, the Government has encouraged and even cajoled doctors to come to the UK from abroad on the understanding that they could expect to train and work here. The Government’s belated attempts to change the rules, effectively retrospectively, after these doctors have committed themselves to the NHS and the UK, is unacceptable.

NEW IMMIGRATION RULES

As you will be aware, the Home Office announced changes to the immigration rules on 6 February which were later discussed at your evidence session with ministers and officials on 18 February. Several questions were asked and it was stated that these changes would not affect those doctors currently in the UK who are subject to the immigration rules or applying for specialty training posts in this year’s recruitment drive. However, if the House of Lords decides that the original guidance released by the Department of Health was lawful, that would affect the rights of those currently holding an HSMP visa and would therefore impact on their chances of attaining a post by August 2008. This would make the introduction date for the immigration rule changes of 29 February irrelevant. Irrespective of the House of Lords’ decision, there are currently doctors going through this application process who were not aware of the rule change when applying for HSMP. These individuals may have intended to apply to specialty training in the future recruitment rounds taking place later in 2008 and will now face restrictions in doing so should the Department of Health’s guidance be introduced.

Furthermore, there may also be doctors who had not yet applied for HSMP before the immigration rule changes were announced in February but who intended to apply for the second round of recruitment for specialty training in 2008. These doctors will no longer be able to access training posts under the new immigration rules unless there is no suitable UK/EEA candidate for the post.

The BMA has received verbal assurances from the Department of Health that those doctors who are currently studying in UK universities with the expectation of continuing their studies and training in the UK will be exempt from the immigration rule restrictions and will be able to complete all of their postgraduate medical training in the UK. We would welcome further written clarification on how this will be achieved and the procedures that graduates of UK medical schools will need to go through to continue their postgraduate medical training in the UK. In addition, further guidance is sought from the Department of Health for those renewing their HSMP visas and those applying for HSMP prior to 6 February 2008.

The BMA’s policy on doctors subject to the immigration rules is already well established and consistent. All doctors who have entered the UK with a valid expectation to train or provide a service, and who do not require a work permit, should be eligible to apply for all posts on an equal footing with UK and EEA applicants. The BMA condemns the ongoing uncertainties for existing HSMP holders particularly the Department of Health’s policy of announcing that existing HSMP will not be restricted in their access to postgraduate medical training whilst continuing with their attempts to introduce further restrictions for existing HSMP holders subject to the House of Lords ruling. This is merely adding to the significant uncertainties already being felt by this group of doctors.

PENINSULA DEANERY MTAS EVALUATION

The Chief Medical Officer at his oral evidence with the Committee on 15 November 2007 referred to evaluation from Peninsula Deanery which appeared to support the view that the MTAS process was not flawed. We would disagree with Peninsula’s evaluation, as it only evaluated the internal consistency of how the questions and interviews were marked, not whether the best candidates were selected using appropriate questions. To give an illustration, the evaluation could have given the same findings if candidates had by accident been asked questions about their horticultural knowledge. The evaluation could then have found that horticultural scores distinguished candidates from one another, and the score at shortlisting was mildly predictive of how much you knew about plants at interview. But none of this would have selected the people who would be good doctors.

Technically, the sample size appears very small and may be unrepresentative of much larger Deaneries or more highly competitive specialties. The evaluation also simply says that candidates who scored well at shortlisting also scored well at interview. It does not tell you whether people who scored poorly at shortlisting (through unfair criteria) would have actually scored well at interview because they were unable to secure interviews.

Peninsula’s evaluation seems to be just a check of internal consistency, not that the right questions were asked and the evaluation does not answer the critical question of whether good candidates were missed.
KNOWLEDGE BASED TESTING

In the evidence session with COPMeD on 17 January 2008, the BMA’s opposition to knowledge based testing was cited as catalyst for problems with recruitment. The BMA’s policy is based on sound research and concerns were expressed simplistically at COPMeD’s evidence session. It is important to note that, with the exception of GP recruitment, which itself uses not a knowledge based test, but an aptitude test, no proposals or pilot studies of suitable knowledge based testing had been carried out. This was the reason the BMA’s Junior Doctors Committee refused to accept its introduction at this stage.

ATTEMPTS TO HALT INTERVIEWS TAKING PLACE

It was of great concern to hear at various sessions that a number of witnesses believed the medical profession had not raised awareness of its concerns. As mentioned at our own evidence, the BMA repeatedly called for delay both publicly and in private discussion with the Department of Health, the Royal Colleges and others. The BMA also wrote a number of occasions to the then Secretary of State, expressing serious concerns.

MMC PROGRAMME BOARD

We mentioned that we had some concerns about the MMC Programme Board and its direction of travel for 2008. The purpose of the Board is to advise ministers on changes needed both to medical training and the application process for training programmes in England for 2008 and beyond. Our experience since our evidence session has been that engagement between the BMA and other Board stakeholders has resulted in positive development of strategic thinking. There does remain a tendency for high level strategy to run away from initial thinking when it comes to practical implementation eg post CCT fellowships, which seem to have substantially increased without strategic or workforce planning.

The BMA has stressed that design for the future needs to be led by the profession but although the Programme Board’s membership draws together stakeholders from the Department of Health, the NHS and clinicians from the BMA and the royal colleges, we remain concerned that some of the pitfalls of last year’s recruitment process could be fallen into if the medical profession’s voice is not fully heard.

The Programme Board’s remit should focus on quality and standards, of which detailed, robust workforce planning is an important part. However, the Board’s efforts should not be subjugated entirely to crisis-management in workforce numbers decided externally and in isolation. Proper workforce planning is central to quality and standards and not only about numbers. Clinicians on the Board feel that their role is to build on the frameworks outlined by Sir John Tooke to develop excellence in training and education for the future, and not to simply to endorse decisions about numbers, crudely based upon what strategic health authorities are willing to afford.

FINAL TOOKE REPORT

The BMA views the recommendations contained in the report as an important package that the medical profession can move forward with but it is essential for the Government to play its part in light of the report. While there are some areas of detail in Sir John Tooke’s report that need further, careful consideration, speedy action on the key recommendations will deliver better education and training for doctors, and will be beneficial for the NHS and the public. In response to the report, the BMA is ready and willing to play a leading role in developing a mechanism for providing coherent advice on matters affecting the medical profession.

The Department of Health in England has agreed to implement many of Tooke’s recommendations but delayed making a decision on several others, including the key recommendation to create NHS: Medical Education England (NHS: MEE), to oversee training in England that effectively moves power from the Department of Health, and puts it back into the hands of the medical profession. The BMA strongly feels that all the stakeholders who have expertise to bring to these areas should be part of this body. The evidence has always shown that excluding any major stakeholders results in negative outcomes. NHS:MEE must be a body of all the talents.

The creation of NHS: MEE in this way would regain the faith of doctors and provide a better guarantee of quality and safety for patients. The medical profession also applauds Sir John Tooke’s recommendation to ring-fence the budget for medical education and training. The BMA, along with all the other medical bodies, believes that both of these changes are absolutely essential if we are to ensure high quality medical training in future. For several years now, trusts have been raiding funding set aside for professional education and training to meet deficits. This funding also pays for medical student placements in hospitals—an essential element of their education. Failing to protect it risks the standard of training for many doctors, and ultimately the future quality of patient care.
The BMA does understand why some of the changes cannot happen immediately, as it was the rushed implementation of earlier reforms that caused many of these problems in the first place. However, the BMA will be closely scrutinising the process of implementation to ensure that vital action is not delayed, or lost in bureaucracy. There appears to be a lot of reliance in the Government’s response on the results of the Next Stage Review of the NHS, the results of which are expected in July. Whilst the BMA accepts the need for some further consultation on the implementation of NHS:MEE, we must be assured that the Government will proceed with this vital development. Without this the whole confidence of the medical profession, only just being re-built, will be thrown away.

The Government needs to take action on NHS: MEE and the protection of funding for education and training. The BMA is committed to working with others to ensure the effective and timely delivery of these necessary improvements to medical training to continue to ensure the highest quality care patients deserve.

Dr Ian Wilson  
Deputy Chairman  
Central Consultants and Specialists Committee

Dr Jo Hilborne  
Past Chairman  
Junior Doctors Committee

13 March 2008

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Supplementary memorandum by NHS Employers (MMC 45A)

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 submitted written evidence to the HSC Inquiry into MMC on 16 October 2007 and Sian Thomas, Deputy Director of NHS Employers, provided oral evidence to the Inquiry on 24 January 2008.

During the Inquiry’s oral evidence session, Ms Thomas was asked to provide employers’ views on the final report of the independent inquiry into MMC, led by Professor Sir John Tooke, and in particular our views on Recommendation 47, the establishment of NHS Medical Education England.

Ms Thomas noted in her response that this was a new recommendation from the Inquiry and we had yet to complete our discussions with employers on their views about the proposal. Ms Thomas agreed to provide this supplementary written evidence setting out these views following consultation with employers.

TOOKE INQUIRY: RECOMMENDATION 47

The Panel recommends the formation of a new body, NHS Medical Education England (NHS:MEE). This body would fulfil the following functions:

- hold a ring-fenced budget for medical training;
- define the underpinning principles of postgraduate medical education and training (PGMET);
- act as the professional interface between policy development and implementation on PGMET;
- develop a national perspective on training numbers for medicine working with the revised medical workforce advisory machinery;
- ensure that policy and professional and service perspectives are integrated in the construct of PGMET curricula and advise the regulator on the resultant synthesis;
- coordinate coherent advice to Government on matters relating to medical education;
- promote national cohesion of Postgraduate Deenery activities;
- scrutinise SHA medical education and training commissioning functions, facilitating demand led solutions whilst ensuring maintenance of a national perspective is maintained;
- commission certain sub-specialty training;
- act as the governance body for MMC and future changes in PGMET; and
- work with equivalent bodies in the Devolved Administrations thereby promoting UK wide cohesion of PGMET whilst facilitating local interpretation consistent with the underlying principles.
It is proposed that NHS:MEE would be accountable to the Department of Health’s Senior Responsible Officer (SRO) for medical education and would be advised by an Advisory Board with professional, service, academic, BMA and trainee representation.

Employers views on the establishment and purpose of NHS:MEE

The NHS Employers Policy Board, comprising of senior managers from a range of NHS organisations across England, supported by members of the Medical Workforce Forum, an advisory group formed of senior clinical, HR and organisation managers and stakeholders with experience and interest in medical workforce issues, recognised the benefit of co-ordinating advice and support on medical education and training issues but expressed concerns about the proposal, including:

— the proposal appears to conflict with the desired intention outlined by the Next Steps review led by Lord Darzi to integrate the planning of workforce, finance and service issues;
— the creation of a new central national body does not seem to fit with the desired policy direction of local devolution of decision making;
— consideration of medical education and training issues in isolation from those for other staff in a multi-disciplinary NHS is not helpful;
— employers tended not to support the ring-fencing of specific budgets; and
— the proposal does not seem to support the desirable intention, set out clearly in the Tooke Report, of getting those involved in the policy and commissioning of education for doctors closer both to undergraduate medical schools and to the service.

Employers have expressed a clear view that if the proposal is accepted by Health Ministers there were several important principles which had to be met. These were:

— the need for substantive and genuine employer involvement;
— the need to ensure a co-ordinated approach with non-medical education and training; and
— the need for responsibility for funding for postgraduate medical education and training to continue to rest with postgraduate deaneries as part of the SHAs and with local organisations.

Employers have also recognised that, as this was a new recommendation, there had been no formal consultation on the proposal and felt there should be time for proper consideration of the issue by all stakeholders. Equally it is important that proposals arising from the Tooke report align closely with the findings of the Next Steps review.

14 February 2008

Memorandum by Work Psychology Partnership (MMC 52)

IN Volvement in Specialty Selection 2007

1. Specifically, our work in 2006–07 comprised of advising on selection methodology for; (1) Foundation Programmes in the UK; (2) the GP selection process (shortlisting tests and selection centres) and; (3) selection into all other specialities at ST1. The time scale for delivery was extremely tight and we expressed our concerns at the outset (June 2006). We were also concerned about the lack of piloting opportunity. The selection methodologies for both Foundation and GP have been shown to work well.

2. In relation to Specialty selection, The Work Psychology Partnership (WPP) responded to a DH Invitation to Tender in May 2006. The scope of work states; “The number of applicants expected to apply for entry into Specialty Training is approximately 6,000 and that applications will be via a single electronic national portal entry system (separate project) the working assumption for the closing date will be 5 January 2007”. We were informed that there would be 16 specialities and there were existing Person Specifications submitted by the AoMRC. Although there were 16 specialities in the original scope, in late autumn 2006, WPP were asked to deliver an additional 110 Person Specifications (signed-off by College representatives) to include those in transition at levels ST2, ST3, ST4 plus FTSTAs). At the outset we were asked to deliver a shortlisting process for ST1. We were not asked to deliver the selection methodology for doctors in “transition” via ST2, ST3, ST4 and FTSTAs. We were led to believe transition arrangements would be delivered via local processes.
3. In relation to shortlisting for ST1, WPP recommended to COPMeD the use of a national standardised test in 2007. However, we were informed that this was not the preferred option for 2007. By contrast, in collaboration with the GP National Recruitment Office, WPP designed the shortlisting test for GP, which has shown to work well.

4. Given the time scale (approximately 12–16 weeks) we had no option but to use existing application form materials. Our input into design of the application form for 2007 was directly based on existing application forms previously used for entry into specialty training (including those used by the London and Yorkshire Deaneries). WPP were sent the application form template by the Project Manager (then Ms Carole Mistry, latterly, Ms Janet Brown).

5. On reviewing existing application forms, “white space” questions were widely used. This is not an invention from WPP. “White space” questions were used in the past, and are used frequently for shortlisting purposes in medical selection. However, our advice was that if used, they would not be a long term solution given concerns regarding plagiarism (see GP experience where our advice and work has involved the development of other short listing solutions). We were clear that the use of these questions was an interim solution and that other short-listing procedures should be developed. Specifically, we highlighted all the risks to the COPMeD steering group (including need for training, standardised rating scales etc). In addition, we were led to believe that MTAS would comprise software to detect plagiarism.

6. Relevant experience, posts completed and other CV related information are clearly important indicators of competence and would normally be used to make selection decisions. However, we were told that there should be no weighting of previous relevant experience. This is unusual in a selection context. The decision not to score experience and previous posts was not ours, it was the brief given. This was guidance from COPMeD and MMC team regarding PMETB standards. This is not an interpretation or new development proposed by Work Psychology Partnership. Similarly, we were advised that gaining a College exam could not be “scored/used to rank individuals”, even though these are clearly robust indicators of competence. The shortlisting scoring framework received legal and HR approval from the Department of Health. WPP were not responsible for HR input at any stage. HR expertise was provided by the DH.

7. We were led to believe that there would be sufficient posts to applicants so that the vast majority of applicants would gain a training post. Interview capacity was determined locally. WPP were told that the competition ratios would not be too high and so short listing would be relatively “light touch”. The actual numbers of applicants was vastly underestimated by various stakeholders. In fact, the shortlisting system had to sift over 128,000 applications for approximately 20,000 posts. This inevitably meant that several thousand competent doctors would not be invited to interview, let alone offered a post. Our scope of work was for ST1 applicants only and we believed that the vast majority of applicants would be shortlisted.

8. All our work was signed off by the COPMeD steering group and the Department of Health (we have a full contact log for effect). WPP can provide a full log of all communications with all stakeholders on request. Both parties stated that they were happy with our work and that we had fulfilled our contract.

9. WPP were not involved in any way with the development of selection methodology for Academic posts. We were asked to provide advice in November 2006 but we declined because of our concerns regarding the lead time to develop appropriate scoring frames for the academic community. We were also concerned about the time scale for consultation. As a result, Professor Thomas (Chair, COPMeD steering Group) informed us that this was to be delivered by “Mark Walport’s group”. WPP had no involvement in academic recruitment.

10. At the outset, given that the original project manager left her post (Carole Mistry), there was no formal discussion about contracting arrangements and we worked at risk for several months. We tried to address this on several occasions as the team was working at risk for several months. There were gaps in project management and we were unclear about who was leading our contract management. I asked for an urgent meeting with DH staff in January 2007 as I had major concerns about how our contract was being managed and the work demands therein. As suppliers, throughout this project there was a lack of appropriate project management and as a result, reporting arrangements were very unclear. We were not presented with a contract to sign from the DH until 17 February 2007, which was nine months after we had commenced the work. We expressed our concerns throughout this time as the work plan shifted significantly out of scope.

11. In October 2004, Professor Patterson presented a list of all the risks of inadequate preparation and development of the selection methodology at a meeting with the MMC team (then Dominic Hurndall and Dr Andrew Havers and others). She recommended a selection methodology comprising selection centres that could be validated over two years with large scale stakeholder consultation. Following this meeting, Professor Patterson received no further correspondence from the MMC team regarding selection methodology, and no pilots were delivered.

12. On all counts, as suppliers, WPP delivered our original scope of work plus major and significant out of scope activities in an extremely tight timescale. The design brief was changed significantly and our early advice on selection methodology was not taken up. Within this time we made significant personal efforts to consult with all key stakeholders, including presentations to the AoMRC STC committee, and delivering an additional 19 workshops with stakeholders in an 8 week period. WPP cannot be held responsible for a reported lack of consultation. Our expertise and long-standing reputation has been questioned as a result.
of this process. We are particularly unhappy that detailed information regarding our involvement and our responsibilities has not yet been made clear by the various stakeholders involved, who were responsible for setting, managing and “signing-off” our scope of work.

November 2007

Memorandum by Dr Graham Winyard (MMC 53)

MEDICAL IMMIGRATION AND MODERNISING MEDICAL CAREERS

I am writing as a recently retired Postgraduate Dean to urge you and your committee to include full consideration of the issue of medical immigration in your deliberations on MMC. This year, for the first time ever, we face the likelihood of substantial unemployment among UK medical graduates, with a worse situation predicted for 2008. This is being widely attributed to the chaos around the MTAS/MMC collapse, as reflected in your Committee’s intended focus on:

“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.”

However the planning of the supply and demand of junior doctors and the management of medical immigration are important issues in their own right whose mis-management would have resulted in the current problems even if MTAS/MMC had not been introduced.

In essence what has happened is that ten years ago this Government decided to expand medical school output specifically so that the NHS would be less dependent on overseas doctors. It invested heavily including establishing four new medical schools, and those extra doctors are now ready to begin specialist training to become consultants or GPs. Until this year, providing they were willing to be flexible about their choice of specialty and geography, UK graduates could expect to access such training without too much difficulty. Now, as a direct result of the failure by Government to tailor its broad immigration policy to reflect its own intentions with regard to medicine, not only are 1,200 UK graduates unable to progress their careers this year, but next year, by the same Department of Health estimates, only one in three will obtain suitable NHS posts. This scale of loss completely negates the carefully planned medical school expansion.

I raised the issue in September in an article in the British Medical Journal\(^2\) but the basic facts are not in dispute being confirmed by the Tooke report and by the Department of Health’s own analysis in its recent consultation document on the eligibility of doctors from outside the EEA to compete for specialist training in 2008. However the impact that this will have on the careers of thousands of young doctors, and on the attractiveness of medicine as a career, seem to be going largely un-noticed. It makes no sense at all to train thousands of extra doctors simply to make many of them unemployed at a stage when they are still too junior to work usefully in the NHS. Nor can it be good for long term recruitment to medicine for it to become a career with a built-in cull after seven years of training and thousands of pounds worth of debt.

This seems to be a real case of the right hand not knowing what the left hand is doing across Government. The simple approach that could have prevented all the above problems would have been to modify the terms of the Home Office Highly Skilled Migrants Programme to exclude eligibility for postgraduate training in medicine. However I understand that it was not possible to reach agreement with the Treasury and the Home Office. Instead the Department of Health has had to attempt to introduce unilateral guidance to achieve the same ends. This has already been subject to prolonged legal challenge (not yet concluded) during which thousands of extra doctors from outside the EEA entered this year’s competition pool creating the unemployment levels highlighted above. But the fact that policy coherence seems to depend on the outcome of an Appeal Court hearing surely shows that something has gone seriously wrong here.

I do hope that your committee will be able to look into this. The pros and cons of detailed career structures and recruitment processes which will form much of your committee’s MMC deliberations become irrelevant if we cannot get the basics of managing supply and demand right.

I would of course be happy to amplify any of these arguments if that would help the committee.

Dr Graham Winyard CBE FRCP FFPM
Retired Postgraduate Dean

November 2007

\(^2\) BMJ/22 September 2007/Volume 335. 593
Memorandum by Dr Jack Dummer (MMC 54)

MMC—ORAL EVIDENCE PRESENTED BY PROF SIR LIAM DONALDSON ON 15/11/2007

I am a British citizen and a UK-trained medical doctor currently studying as a PhD student in New Zealand. I am also a member of RemedyUK.

I was prompted to write to you regarding Sir Liam Donaldson’s response to a very pertinent question: Sandra Gidley MP asked him if he thought he should have resigned as CMO given that he was the architect of MMC. Key to his answer was that, “ . . . the principles and policy [of MMC] were commended in the Tooke report . . .”

His answer is relevant to the first of your inquiry’s terms of reference (whether the principles underlying MMC are sound) as well as being critical to Sir Liam’s defence of his decision not to resign. I am concerned because, having searched the Tooke Report for any commendation of MMC principles and policy, I have found none. Rather, Sir John Tooke stated that they were unclear and had detrimental consequences:

“ . . . the precise policy objectives of MMC do not appear to have been definitively stated at any point nor agreed by key stakeholders.” (4.1.1, Page 38)

“The inquiry has revealed that the development and implementation of MMC has been hampered by a lack of clarity regarding the policy objectives and guiding principles . . .” (5.1, Page 84)

It is possible that I have missed the commendation to which Sir Liam Donaldson referred but I think it highly unlikely that Sir John Tooke would have commended any policy or principle that lacked clarity or was never definitively stated.

It appears to me that, at best, Sir Liam made a careless slip of the tongue. At worst, he deliberately misled the Health Select Committee in order to preserve his position as Chief Medical Officer for England. I hope you will carefully consider this part of his oral evidence.

Dr Jack Dummer
21 November 2007

Memorandum by the British Association of Physicians of Indian Origin (BAPIO) (MMC 55)

MODERNISING MEDICAL CAREERS

1. SUMMARY OF RECOMMENDATIONS

1.1 There is a need for urgent and comprehensive review of workforce estimates which are specific to specialities and regions.

1.2 Entry of international medical graduates (IMGs) in the future should be regulated by requirements dictated by workforce estimates.

1.3 All IMGs then working in the UK should be treated solely on merit for job appointments.

1.4 PLAB part 1 examinations overseas should be reconsidered.

1.5 Doctors on Highly Skilled Migrant Permit (HSMP) should be treated on par with UK and EU citizens for applications to postgraduate training posts.

2. INTRODUCTION

2.1 The British Association of Physicians of Indian Origin (BAPIO) is a voluntary organisation and represents the interests of medical doctors from the Indian sub-continent.

2.2 BAPIO is grateful to the Health Select Committee for giving us the opportunity to submit evidence to its inquiry into Modernising Medical Careers.

2.3 The Tooke enquiry into MMC has flagged up lack of recognition of rights of HSMP holders as one of the issues along with MTAS application process as problem areas. This evidence will concentrate mainly on the issue of IMGs including those on HSMP.
3. BACKGROUND

3.1 International Medical Graduates (IMGs), majority of who originate in the Indian subcontinent have historically played a significant role in the provision of healthcare of the British people. This has been especially so in specialties and regions traditionally under subscribed by UK graduates.

3.2 IMGs have contributed immensely to the success of the NHS. In 2005 27.8% of doctors on the GMC register had qualified outside the EEA. The magnitude of contribution from these doctors was amply highlighted by Professor Aneez Esmail as part of the 2005 William Pickles lecture in the Spring Conference of the Royal College of General Practitioners. The DH document also acknowledges this contribution in service provision as well as professional skills.

3.3 It is estimated that the cost of training a Medical Graduate in the UK is around £262,000. There are over 40,000 IMGs working for the NHS and this translates into a saving of £10 billion pounds for the British taxpayer. Further any references to the loss to the UK taxpayer if a IMG doctor is appointed to a post instead of a UK graduate are flawed as for every doctor the UK “loses” it gains another it did not pay to train.

3.4 In April 2006, immigration rules were changed abruptly, without warning and without consultation. These were rushed through Parliament. The rules were applied retrospectively so that all IMGs on permit free training (PFT) had to satisfy a residence labour test to be eligible for postgraduate training posts. The effect of this was a huge economic and emotional trauma to thousands of doctors who suddenly had no choice but to leave the country. We estimate that about 8,000 IMGs had to leave the UK in the aftermath of the new immigration rules.

3.5 The consequence of the new immigration rules is that the number of IMGs coming to the UK for postgraduate training has been significantly reduced.

3.6 BAPIO is grateful to all the medical fraternity, politicians and public who supported the IMGs against their obvious unfair treatment.

3.7 Doctors on Highly Skilled Migrant Permit (HSMP) are those who were already in employment at the time of the new immigration rules. Thus these doctors bring both much needed skills as well as experience of working in the NHS to the British people. They are committed to settle in the United Kingdom and are an important resource for the NHS.

3.8 The Tooke Report, an independent inquiry into modernising medical careers led by Professor Sir John Tooke, concluded that there must be clear shared principles for postgraduate medical training that emphasise flexibility and an aspiration to excellence. It has always been our contention that principles of merit should be applied and IMGs should be allowed to compete on equal footing for training. This will encourage excellence and the best doctors will be able to progress in their chosen careers. This can only be advantageous in the long run for the NHS and for UK.

4. COMPETITION FOR PLACES

4.1 There has been concern regarding the paucity of training places compared to the number of applicants and it has been implied that this is primarily due to IMG applicants on HSMP. We disagree with this assumption.

4.2 At the end of round 1 of MTAS 2007 process, HSMP doctors obtained 2,679 of 14,247 appointments (around 18% of all appointments). 10,856 of 14,247 appointments (76%) went to UK graduates, and UK and EU citizens. We expect that the appointment rates for UK/EEA nationals would be even higher at the end of Round 2. The majority of unsuccessful UK candidates would have applied to highly competitive specialties like Surgery and Orthopaedics. We do not have statistics regarding the appointments of HSMP doctors but believe that many of these would be in specialties and locations not preferred by UK graduates and a significant number may have been to FTSTA posts (described as the new lost tribe in the Tooke report as they do not lead to completion of training).

4.3 It is anticipated that there would be about 8,400 to 8,700 training posts in the coming years. We think it is correct to assume that the current slack of about 1,200 UK graduates and remaining 5,600 HSMP holders will be absorbed slowly into the system in a few years time, with some doctors gravitating towards service and career grade posts.

4.4 The competition from HSMP holders in the coming years will decrease dramatically. Many doctors on PFT visas and Work Permits (WP) were able to “switch” to HSMP as they had been in the UK at the time of announcement of the new immigration rules. This is no longer the case as PFT has been abolished, and issuance of a WP requires a Resident Market Labour (RLM) test. It is very difficult for a newly arrived IMG to accumulate enough points to apply for HSMP status.

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3 British Journal of General Practice: Asian doctors in the NHS: service and betrayal pp. 827–834(8) Author: Esmail, Aneez
4 MMC: Modernising Medical Careers (MMC) England Recruitment to foundation and specialty training—Proposals for managing applications from medical graduates from outside the European Economic Area, Dept of Health, 8 October 2007
5 Verbal communication from GMC—see Table 1
6 Aspiring to Excellence: Independent Inquiry into Modernising Medical Careers, Professor Sir John Tooke
4.5 The DH occasionally refers to the high attrition rates amongst IMGs but the statistics used are from a time frame when different immigration rules existed. These do not apply to doctors on HSMP.

4.6 DH suggests that it has reached self sufficiency in medical manpower. However Sir Liam Donaldson has said in his evidence that there is no over supply of doctors and UK will continue to need doctors from overseas. We are in agreement with this assumption.

4.7 UK continues to need IMGs in under subscribed specialties. Obstetrics & Gynaecology received only 0.5 UK applicants for every post in the current recruitment session. Similar situations exist in the specialties of Psychiatry, Anaesthesia and Paediatrics amongst others.7

4.8 There is however a need for urgent and comprehensive workforce estimations which are specific to specialties and regions. Entry of IMGs in the future may be regulated by requirements dictated by such workforce estimates. All IMGs who will then work in the UK should be treated solely on merit for job appointments. Conduct of PLAB part 1 examinations overseas may need to be reconsidered.

4.9 We believe there is no reason for British Graduates to fear competition as they are extremely well trained.

5. **Equality of Opportunity**

5.1 The Appeal Court has now declared that the DH guidance on excluding HSMP holders from training is illegal. Lord Justice Sedley said “The guidance, in my judgment, directly and intentionally affects immigration law and practice by imposing on the possibility of employment in the public sector a restriction beyond those contained in the Rules.”8

5.2 The House of Lords and House of Commons Joint Committee on Human Rights (JCHR) ruled recently against retrospective application of immigration rules as follows: “The Committee concludes that the changes to the HSMP are clearly not compatible with the right to respect for home and family life under Article 8 ECHR and contrary to basic notions of fairness. It recommends that the Immigration Rules should be amended so that the changes apply only prospectively, that is to future applicants to the HSMP, and that those already granted leave to remain under HSMP when the relevant changes took effect should be treated according to the rules which applied before those changes.”9

5.3 It further censured the government as follows: “The Committee recommends acceptance by the Government that it does not have unfettered power to make changes to the Immigration Rules which engage Convention rights and would interfere with a right, that such changes should be prospective only, and that changes to the Immigration Rules should always be accompanied by a statement as to their compatibility with the ECHR”.10

5.4 There is a strong argument that the Department of Health as one of the largest employers in the world should set a good example and show due regard to the principle of equality of opportunity in recruitment of its work force.

5.5 We would also like to point out that Mr Justice Stanley Burnton in his judgement on the Judicial Review Action brought by BAPIO commented that the Home Office had failed to undertake the Race Equality Impact assessment in line with the Requirement of the Race Relations legislation. It is unfortunate that a statutory body disregarded their own regulation.

5.6 We believe that had the DH undertaken expected adequate steps to consult all the stakeholders including IMG organisations prior to issuing guidance on PFT and HSMP, they would have gained the insight to the most likely impact of their proposals and some of the problems of MMC could have been avoided.

We would like to acknowledge the contribution of Dr Joydeep Grover, Dr Asha Reddy, Dr Vinay Shanthi, Dr Ashok Beckaya, Mr Buddhdev Pandya and Dr Raman Lakshman in the compilation of this document.

*Ramesh Mehta*  
President

*December 2007*

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7 Fourth Report from the Health Committee, Session 2006–07, Workforce Planning HC 171-II.
8 Bapio Action Ltd & Dr Imran Yousaf (on the application of) v Secretary of State for the Home Department & Secretary of State for Health.
9 Twentieth Report from the Joint Committee on Human Rights, Session 2006–07, Highly Skilled Migrants: Changes to the Immigration Rules, HL Paper 173/HC 993, paras 27–51
Table 1: Reduction in number of doctors taking the PLAB examinations subsequent to new immigration rules introduced in April 2006. Figures Based on verbal communication with GMC

PLAB PART 1—PRIMARY QUALIFICATION FROM INDIA

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of candidates who passed</th>
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<tbody>
<tr>
<td>2005</td>
<td>3,268</td>
</tr>
<tr>
<td>2006</td>
<td>902</td>
</tr>
<tr>
<td>2007</td>
<td>368</td>
</tr>
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</table>

PLAB—PART 2 ALL CANDIDATES

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of candidates who sat the examination</th>
<th>Number of Candidates who passed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>8,569</td>
<td>6,585</td>
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<td>2,936</td>
<td>2,166</td>
</tr>
<tr>
<td>2007</td>
<td>1,379</td>
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</tbody>
</table>

Memorandum by Professor Dame Carol Black (MMC 56)

MODERNISING MEDICAL CAREERS

INTRODUCTION

I have the advantage of having studied Aspiring to Excellence, Sir John Tooke’s interim report of the Independent Inquiry into Modernising Medical Careers, together with records of the proceedings of the Health Committee, and familiarity with developments in MMC following the events last year that led to this inquiry.

The interim report identifies eight major issues and proposes actions necessary to correct each of them. I am in agreement with the conclusions and the corrective actions and with the broad intention of the recommendations.

This short memorandum focuses on an understanding of the essential principles on which postgraduate medical education and training are based. It is ordered to match the focal points of the Committee’s Inquiry.

*To what extent the practical implementation of MMC has been consistent with the programme’s underlying principles*

1. As the Committee has learnt, the principles that we believed underlay MMC were defined by the Chief Medical Officer’s Report *Unfinished Business*. The chief principles to be observed in postgraduate medical education were that it should have broad-based beginnings, offer flexibility and be conducted within a structured programme.

2. *Unfinished Business* described flexibility as the ability to support and accommodate varying needs of trainees and to respond to changing and challenging service demands. It meant allowing for individually tailored or personal programmes, with arrangements to facilitate movement into and out of training and between training programmes. It recognised that for many doctors, though not all, career decisions could change during the early years of specialist training.

3. Approaches to training in the past produced doctors with deep and varied experience and was inherently flexible. But often it was incomplete. Numbers of junior doctors were trained through planned rotations of high quality, but for many more, probably most, training was less well structured and often those doctors were less well advised and supported than they should have been. Their training experience was patchy and uncertain, though they often had much clinical experience and indeed were vital to the service.
4. With the ever-increasing complexity of medicine and the need to ensure no significant aspects are overlooked in training, a more structured approach is necessary today. So among the profession’s purposes in supporting modernisation of medical careers was to ensure the provision of better-structured training for every doctor than had been available hitherto.

5. There was a further imperative. It was to ensure there would never again be a group of doctors, “a lost tribe”, with few further or, at best, uncertain career opportunities. Indeed if the “lost tribe” were simply replaced by another it would be seen as a new betrayal. To our shame, that is just what is happening today.

6. The precise policy aims of MMC, the name given to the Department of Health programme of training arrangements, have become obscure. Founding principles have been lost sight of, and there has been a palpable change in emphasis. The structured approach remains but it has become rigid, the arrangements allowing none of the flexibility, including the individual tailoring, that was promised. There has been a failure to observe fundamental principles that had earlier received such strong support. MMC is not really synonymous with training activities centres on curricula, educational programmes and assessment. It has more to do with central delivery of training programmes that are closely tied to the role of junior doctors in delivering service needs. The weakened focus on needs of trainees themselves became rather clear during the recent debacle.

7. The potential benefits of broad-based, themed training are on the one hand a fuller opportunity for making a mature career choice, and on the other a cadre of doctors whose sound core specialist training provides the surest foundations for subsequent specialised differentiation according to service need and technological and therapeutic progress.

8. A word about specialisation. I can think of no specialty that works in isolation. The interdependency of people in different specialties has long been a feature of secondary care. Now it is reaching seamlessly across and within both primary and secondary care. It is sensible to recognise this in training programmes.

9. Sir John Tooke’s interim report addressed the concern to restore flexibility by provision of a period of core training with diverse experiences, with the opportunity for individuals to reflect what their choice of subsequent specialist course should be. That said, for some doctors in particular specialties a run-through training programme might be more appropriate. Even then there is a potential loss; for example, removing the possibility of diversion to explore an unexpected research challenge.

10. The 45 recommendations of Sir John Tooke’s interim report embrace and reflect the original principles and the means for ensuring they are observed. They captured 87% agreement or strong agreement across the 45 recommendations. I believe that is a powerful affirmation of the soundness of the principles espoused in 2002.

11. Flexibility has come have another meaning, which has less to do with the sense of enabling doctors to shape their training pathway in ways that allow them to make adjustments according to their aptitudes, their early experience of different fields of medicine and their developing interests. Instead, MMC described itself as “a key enabler for other DH programmes”. It focused on the development of a flexible workforce of doctors; but in reality the approach it favoured denied the very flexibility or adaptability necessary in an evolving service.

12. MMC also stated that the skills and the absolute guarantee of standards from new methods of assessment are key to the success of modern workforce programmes like the Hospital at Night, and the Working Time Directive; and that most importantly it will deliver a modern training scheme and career structure that will allow clinical professionals to support real patient choice. Thus there was a shift of emphasis towards current service imperatives.

13. It is obvious that training and service are intertwined, that the experience of service is, and must be, part of learning; but we must ensure that service is not at the cost of learning. It is crucial that the long-term investment in training, including those who have training roles, is not put at risk by unbalanced pressures to meet service or financial needs and that secure arrangements are in place to ensure that is so.

14. There was a declaration that “streamlined training and explicit standards of assessed competence are also essential if doctors’ careers are to accommodate the pressures of a family and modern lifestyles. MMC aims to greatly improve the opportunities for those who wish to take a break in their careers and will promote fairness and equality of opportunity at all stages of a doctor’s career”. Such statements ring hollow today.

15. The experience of MTAS has made the primary claim open to question. Many believe that MMC appears to have been designed with the primary purpose of meeting NHS workforce needs linked to training opportunities. But it has become clear that for many doctors those opportunities have become seriously limited. Moreover the arrangements have shown little if any regard to the career and personal aspirations of trainee doctors.
The strengths and weaknesses of the MTAS process

16. Any process of selection must assess what is valid, must not ignore what is significant, measure what it claims to measure, and be capable of discerning between candidates fairly. It should be accepted by participants—candidates and assessors, and the public—that the process meets such criteria. There were demands that the MTAS process be so validated and evaluated before general introduction, but this was not done.

17. In the selection methodology we find a shift in the meaning of terms: in the terms competent and competency, for example. There was an untested belief that the methods of assessment were capable of recognising and discerning between the different qualities and attributes that doctors, at each level of responsibility, must bring to their practice.

18. The approach to competency adopted by the Department of Health has become reductionist in nature. In trying to reduce specialist knowledge and skills to a “list of parts”, it loses the sense of how a doctor—like other professionals who must take important decisions in the face of incomplete information and uncertainty—is shaped through education and experience to make the kinds of judgements that are the essence of maturing practice. It goes without saying that that they must be competent in the range of functions that are necessary for safe practice as they undertake training in service. But the demonstration of a range of competences alone is far from sufficient assurance of the knowledge, skills and attributes demanded by the service element that is an indivisible part of training. Indeed much emphasis was given to requirement that doctors should be “judgement safe” early in training, particularly given their part in acute work.

19. May I recall the statement made by Sir John Tooke in his evidence to the Committee:

“To be proficient and capable in one’s role requires considerable experience, depth of knowledge about one’s discipline, experience in exhibiting fine judgment—a lot of medicine requires that—and not just a capacity to undertake certain tasks under defined conditions. I think the idea of proficiency is a more embracing one that wraps up competence but accepts the need to embrace these other qualities that we and society would wish to see in a doctor”. It is view with which I wholly concur.

20. Whatever kind of medicine—I use the term generically—doctors come to practice, they build upon common educational foundations. Indeed the soundness of these foundations is critical to each specialty, from general practice to the most specialised and arcane sub-specialty. This commonality permeates the professional ethos; it is recognised and highly valued by patients; it is very important.

21. The subject of selection and assessment procedures is treated authoritatively at Appendix 4 of the interim report.

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

22. The interim report contains a great deal about the management of MMC, including a detailed forensic analysis of its proceedings, and I am not in position to add more.

23. Out this analysis emerges a clear need for a greatly strengthened mechanism for bringing together the diverse interdependent perspectives that bear on health policy, workforce requirements and postgraduate medical education and training, with high accountability.

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

24. The policy decided in 1997 to achieve medical self-sufficiency in the UK was made a reality by the expansion of medical schools. From the outset this investment had clear quantifiable implications for training and the provision of training posts for all doctors who achieve the required standard. And it had implications for the future immigration of medical graduates from outside the EEA, in relation both to postgraduate training and to employment in the NHS.

25. It is regrettable that failure to address the issues adequately and in good time has led to the calamitous position of many doctors in the UK today, not only of UK medical graduates but also international medical graduates who trained outside the EEA, including those who have already served the NHS. The resulting uncertainties facing many able young doctors today and in the near future call for the swiftest and fairest possible resolution.

26. The rigid training structure of MMC has brought other restrictions. The UK has a high international reputation for postgraduate medical education, fostered particularly through the links established by the Royal Colleges. It uses that standing to benefit countries with less developed training programmes. These links have long supported and enabled education and training, research, and quality improvement and they facilitate international exchanges. Appropriate overseas experience for young doctors during and at the end of training provides important mutual benefits.
27. We should also have proper regard to the reasonable expectations and claims of doctors from abroad, the contributions they make to medicine and the service in the UK, and the skills many are able to take back to their own countries.

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 roles and responsibilities of these bodies are intimately related, in respect of service needs, evolving service opportunities to exploit medical advances, trained workforce requirements and finance. Yet the linkages between them are often tenuous and fragile, and sadly, distrustful. I believe we could and should take steps to expand our alliances and relationships, to address these matters in new more open collaborative fora.

29. Experience of the development and implementation of Modernising Medical Careers has brought important lessons for us all—for the Department of Health, its internal structures, its relationships and its accountabilities internally and externally; for the professional institutions, collectively. The interim report has spelt them out clearly.

30. The experience has also reinforced the importance of strong medical leadership, its role in developing and presenting a coherent view of the principles and values that identify the profession, and the ways in which these must be grasped and handled in policy development and implementation. Leadership is a hallmark of professionalism. To warrant that hallmark it is quite clear that the institutions of medicine, in partnership with other stakeholders, must construct more effective mechanisms for safeguarding and advancing the principles they share.

January 2008

Supplementary memorandum by Professor Dame Carol Black (MMC 56A)

MODERNISING MEDICAL CAREERS

The position of international medical graduates eligible for training in the UK.

This submission draws closely on the response of the Academy of Medical Royal Colleges to the Department of Health Discussion Document on proposals for managing applications from medical graduates from outside the European Economic Area (October 2007).

INTRODUCTION

1. For many years the NHS has depended on international medical graduates to help provide its services. They have made essential contributions, particularly in general practice, obstetrics and gynaecology, paediatrics and psychiatry. Indeed there is no area of the NHS in which they have not had and continue to have a distinctive part in maintaining and enhancing the quality of practice and service. However, as a consequence of other changes our dependency on recruitment of doctors from abroad has lessened, and this must be recognised.

2. There are unacceptable tensions between the way in which the policy of greater self-sufficiency has been implemented alongside immigration policies that allow continuing open competition for entry into postgraduate and specialty medical training programmes.

3. Clearly there is a duty to support UK graduates from our medical schools. If the UK is to achieve self-sufficiency by continuing to attract able young UK nationals into UK medical schools and, in turn, the NHS, there must be good prospects of completing training after graduation. Significant denial of training opportunities for UK medical graduates, and subsequent unemployment, would be a waste of major investment in talented people who have already undergone highly competitive selection.

4. At the same time we should also have proper regard to the reasonable expectations and claims of doctors from abroad, the contributions they make to medicine and the service in the UK, and the skills many are able to take back to their own countries. Moreover, medical graduates from outside the European Economic Area include doctors from countries with whom UK medicine has forged strong and greatly valued bonds over many years. The Colleges are doing their utmost to maintain those bonds and urge government and the NHS to assist them in doing so.

5. It is scarcely necessary to say that steps towards restoring the reduced training prospects of UK graduates must include a way of defining candidature for training posts that ensures continuing high quality, is just, wise and proportionate to the problem, and is legal. The challenge is to find imaginative solutions that marry these responsibilities. Unsurprisingly, there is some divergence of views among the Colleges; but all see the need for compromise of some degree in finding solutions to this problem of the Government’s making.
6. The UK has a high international reputation for postgraduate medical education, using that standing to benefit countries with less developed training programmes. We have urged Government to take the necessary steps to safeguard that high reputation. For example, the Academy of Medical Royal Colleges has recommended that the Health Departments create a limited number of training places for young doctors from developing countries, with the requirement that they return home at the end of their training. This would demonstrate commitment to an ethical approach to international recruitment. The Academy would also like to see exchanges of doctors at the higher end of their training, where doctors on the threshold of their specialist careers are enabled both to give and receive new experiences and skills that can benefit the service in their home countries. We also believe it is important to develop medical training initiatives that will encourage and allow overseas doctors to come over for periods of focused training of high quality, and to take these skills back to their home countries.

7. We recall that most international medical graduates come to the UK in search of specific training needs and yet spend time in junior training posts providing service without having their educational needs met. In the Academy’s view the UK has a responsibility to continue to provide these doctors with training in specific specialised areas, enabling many to return home with improved clinical skills and the ability to improve health care in their own countries.

8. The Academy also feels that it is important that medical graduates from outside the European Economic Area should be able to come to the UK for defined periods of training, in College approved posts, perhaps in rotation with a UK trainee going abroad on a planned exchange scheme. This would have major benefits for both the doctors involved and the countries they serve.

**Impact of MMC**

9. It is also clear that the design and implementation of MMC have served to stifle career and service enhancing opportunities, both in the UK and abroad, and the Academy strongly supports the more flexible approach to specialist training and employment envisaged by the Tooke Inquiry. Overall the Academy believes there is a case for looking more widely, to providing new opportunities in specific training, individual career development and service needs in different countries.

**Shortage Specialties**

10. The Academy has drawn attention to the problems of specialties that have depended on recruitment of trainees from other countries to fill vacancies. Although it is to be expected that with current pressures the requirement to recruit from international medical graduates will lessen with time, the Academy recognises the challenges that a number of specialties face.

**Guidance for International Medical Graduates Wishing to Work in the UK**

11. There is a common view that guidance surrounding eligibility to work needs to be made substantially clearer. Several years ago the Colleges drew attention to the growing problems facing international medical graduates wishing to work in the UK. They were skilled practitioners, some with considerable experience from overseas, but they lacked full and current advice on the UK job market and therefore their decision to come to the UK was often uninformed. Even then the available number of UK junior posts (both training and non-training posts) was far below the number of international medical graduates applying for them, and consequently there was high unemployment.

12. Potential applicants for all posts need to be told of work permit restrictions at and prior to the point of application. It will require careful management of the expectations of international medical graduates, including those in the UK and in no post, or in a temporary post, and doctors outside the country. One problem with introduction of the previous policy was that doctors who had come in good faith to seek postgraduate medical training in the UK had no adequate forewarning. Recruitment drives overseas have also caused damage. The International Fellowship Programme, aimed at recruiting overseas qualified specialists into consultant posts in shortage specialties, led many medical graduates from outside the EEA to believe that there were widespread shortages in medicine in the UK, a mistaken belief that to some extent prevails.

13. The Highly Skilled Migrant Permit (HSMP) is a particular issue, providing a route for significant numbers from outside the EEA to compete for entry into postgraduate and specialty medical training programmes. Applicants for an HSMP need specific guidance about a wide range of matters including availability of training posts, professional registration and equivalence or not of qualifications. There are concerns, for instance, over doctors who have worked in service posts for two to three years to whom retrospective application of changed policy might be seen as unfair.
14. In view of the numbers, and the tensions referred to in points 2 and 3 above, it may be desirable to investigate tightening the criteria for award of an HSMP. This will require care and sensitivity, in view of the differences between specialties in the need for international medical graduates to provide service—an across-the-board redefinition of “highly skilled migrant” may be difficult to achieve.

15. A further point is that it might become necessary in future to make it clear at entry to UK medical school of non EEA people that there is no guaranteed specialist training.

January 2008

Memorandum by the Conference of Postgraduate Medical Deans (COPMeD) (MMC 57)

MODERNISING MEDICAL CAREERS

1. Introduction

1.1 COPMeD provides a forum in which Postgraduate Deans from the four nations meet to discuss current issues, share best practice and agree a consistent and equitable approach to postgraduate medical training in all deaneries across the UK. It acts as a focal point for contact between the Postgraduate Medical Deans and other organisations, eg the Academy of Medical Royal Colleges, Medical Schools Council, GMC, BMA, PMETB and Health Departments for postgraduate medical and dental education matters.

1.2 COPMeD is not an executive body, but it facilitates the deans taking corporate action. For example, in the last decade the postgraduate deans have successfully implemented wide-ranging reforms of pre-registration and specialist registrar training across the UK. The Committee of GP Education Directors (COGPED) developed and delivered a selection process for GP training over the past seven years administered through an online system in 2006.

2. Key Points: Executive Summary

2.1 COPMeD had significant input into the development of the principles of MMC and considers them to be sound.

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 these features.

2.3 Transition to the new MMC specialty training structure, in one step, required an unprecedented number of trainees to be recruited at one time. National electronic recruitment was intended to reduce the workload on consultants and deaneries, and hence the cost and service impact. In order to do this effectively, there needed to be a reliable means of ranking applicants electronically.

2.4 COPMeD supported the introduction of a national computer-marked test which all applicants would take if they wished to apply for specialty training, but other stakeholders—particularly trainee representatives—did not agree. Without this, or any other reliable metric to use for shortlisting purposes, the potential for an electronic process to cut down the workload for consultants was severely restricted. An invigilated computer-marked test was introduced in GP selection and proved an effective way of sifting out less able applicants.

National electronic recruitment processes are the way forward and should be re-introduced once structural reforms are in place, processes are bedded down, technology has been tested, and there is a reliable metric that can be used to sift applicants at the shortlisting phase and thereafter. As Sir John Tooke has recommended in his interim report, a national computer-adaptive test, to be taken by all applicants, should be developed without delay and piloted for this purpose.

2.5 Problems with MTAS have drawn attention away from the principles of MMC. There remains a continuing need to reform specialty training, so as to ensure an adequate supply of well-trained doctors competent to provide a modern, safe, high quality service to patients.

2.6 Failure to manage medical migration has brought into question the policy decision for the UK to become self-sufficient in the production of doctors. COPMeD believes these policies were well-founded and should not lightly be abandoned.

3. Background

3.1 COPMeD fully supported the MMC principles. Postgraduate deans and GP directors were engaged in all stages of planning this reform.
3.2 The senior house officer (SHO) grade was sandwiched between two reformed grades, and increasingly depended upon by the service to deliver front-line care out of hours. The grade burgeoned when controls on the numbers were lifted to help hospitals deliver the 58 hour week (European Working Time Directive-2004), and an identified expansion of non-training grade “trust doctor” posts. This expansion resulted in an influx of international medical graduates (IMGs) who came in expectation of entering higher specialist training at a later date.

3.3 While the Specialist registrar (SpR) grade also expanded this was not sufficient to accommodate all these SHOs and trust doctors, many of whom were employed in surgical specialties, where the demand for consultants is falling. Many doctors, at this level, either tried to progress in specialty after specialty or “queued” ie followed an increasingly demanding (but clearly understood) pathway to enter the specialty of their choice. The latter was typical in some of the surgical specialties, where it commonly took eight or nine years, from leaving medical school, to getting onto an SpR programme. Not all those who queued were ultimately successful, most of the remainder going into staff grade posts or leaving the country.

3.4 COPMeD opposed the introduction of a run through grade when it was first proposed by the BMA in 1998. Postgraduate deans felt it would force trainees to make their career decisions too early, and the workforce planning horizons would be too long. Improvement of the quality of training could be achieved in other ways. However, as time went on it became clear that the SHO/trust doctor grade was burgeoning, more IMGs were registering with the GMC each year than UK graduates, and fresh UK graduates were having difficulty competing with experienced IMGs for SHO training programmes. Something radical had to be done. The policy statement by the four CMOs, in response to the consultation on Unfinished Business, provided the blueprint.

3.5 The first step was to provide UK graduates with a firmer foundation from which to compete, and give them more exposure to different specialties, as well as career management support, to help them make their career decisions earlier. Following extensive piloting, the two-year Foundation programme was successfully introduced. Programmes were forged out of the previous pre-registration house officer year and posts that had hitherto been first year SHO posts, supplemented by a significant new investment in GP, academic and shortage specialty placements. An education management infrastructure for each Foundation School was fully funded. Formal evaluations of every aspect of the Foundation Programmes have been positive. COPMeD was disappointed that this evidence was not taken into account in the Tooke report, and would wish to see Foundation Programmes continue, at least until they have been fully evaluated.

3.6 COPMeD considered it important that the first full cohort of trainees to exit Foundation programme training should move into a modernised specialty training system.

3.7 The next tasks for postgraduate deans were:
   a) to deconstruct existing SHO rotations and use the posts to build the early years of specialty training;
   b) to increase training posts where appropriate by converting trust doctor posts into educationally approved ST1-4 posts; and
   c) to select trainees into each of four levels of entry to fill the posts.

3.8 There was concern about whether there were sufficient numbers to accommodate all existing trainees. It was estimated that there were 17,500 SHOs in approved posts in the UK in 2006 (data from PMETB). The census in England in 2005 had identified 21,000 doctors employed at “SHO level”, ie including Trust doctors. The number of specialty training posts available across the UK to accommodate these doctors was estimated at 22,000, once 1,000 trust doctor posts had been converted to training posts. These figures indicated more than sufficient posts for all those in the F2 and SHO training grades.

3.9 COPMeD was aware that there would be applicants from outwith the existing F2 and SHO grades eg Trust doctors; trainees who were engaged in research; those working abroad or taking time out eg for maternity. These were hard to quantify, but we were keen to ensure as many as possible could be accommodated.

3.10 The other factor that was hard to quantify was the number of applications that would come from European and international medical graduates. If interest was high, experience had shown that some UK graduates would be displaced, especially at the more junior levels of entry.

3.11 COPMeD strongly supported better management of medical migration. The health service depended too much on IMGs to provide a migrant SHO-level workforce, filling locum and trust doctor posts. This seemed a poor way of providing a service and treating these doctors. Increasingly, trusts were depending too much on IMGs to provide a migrant SHO-level workforce, filling locum and trust doctor posts. This seemed a poor way of providing a service and treating these doctors. Increasingly, trusts were depending too much on IMGs to provide a migrant SHO-level workforce, filling locum and trust doctor posts. This seemed a poor way of providing a service and treating these doctors. Increasingly, trusts were depending too much on IMGs to provide a migrant SHO-level workforce, filling locum and trust doctor posts. This seemed a poor way of providing a service and treating these doctors.

3.12 COPMeD recognised the reasons for the withdrawal of permit-free training in March 2006, and alerted the DH to the subsequent sharp rise in applicants on the highly-skilled migrant programmes (HSMP). The bar for entry to this programme was low, especially for medical graduates who unlike professionals in other fields achieved the required HSMP entry score without having completed the majority of their training. It was obvious that withdrawing permit free training was pointless if there was this
alternative route. The Chairs of COPMeD and English Deans went to see the Minister in July 2006 to express our concerns. In the event, because of the judicial review brought by BAPIO, and the permission given to appeal when the case was lost by them, no changes were made and those with HSMP status and their dependents were deemed eligible for the first round of application. This increased the numbers expected to be eligible for the first round of application by many thousands.

4. What are the principles underlying MMC and are they sound?

COPMeD fully supports the principles of MMC as set out in the MMC Policy Statement: http://www.dhsspsni.gov.uk/response_unfinished_business

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 In order to ensure the principles of MMC are reflected in implementation, COPMeD believes that there is now an urgent need to focus on modernising the content, delivery and assessment strategy of specialty training programmes. This work is already well underway, and the new, PMETB-approved curricula are being implemented, but the momentum must not be lost.

5.3 The postgraduate specialty schools that are being set up in each deanery/SHA in England, in partnership with the royal colleges, provide a structure in which this can occur. There is a need for reliable sustained funding for this important work. Clinical and educational supervisors, training programme directors and heads of specialty schools all need time, training and administrative support to carry out their roles effectively. Consultant and GP expansion is needed to support the service while time is freed for the intensified training that will be required to train the new generation of specialists within a 48 hour working week—as will be required by the WTD—by August 2009.

6. The strengths and weaknesses of the MTAS process

6.1 COPMeD accepts the analysis provided by Sir John Tooke in his Inquiry.

6.2 The previous system of SHO recruitment by application to individual hospitals for individual posts or rotations was inefficient and ripe for modernisation. National electronic recruitment had the potential to reduce the workload on consultants and deaneries, and hence the cost and service impact of recruitment.

6.3 In order to do this effectively, there needed to be a reliable means of sifting out ineligible applicants electronically. There also needed to be a way of electronically ranking applicants where the volumes and competitiveness were high, so that consultants did not have to score every application. Neither was available. COPMeD strongly supported the introduction of a national computer-marked test, as is used in GP selection, which all applicants would have to take in order to apply for specialty training. Without this, or any other reliable metric to use for shortlisting purposes, the potential for an electronic process to cut down the workload for consultants was severely restricted.

6.4 Lessons should be learned from the US National Residency Matching Programme, which requires all applicants to have taken the USMLE. This is an invigilated exam, covering basic sciences, clinical skills and knowledge. The scores from this are obtained directly from source, eliminating fraud. Applicants may apply for as many programmes as they wish. Local programmes use this metric to sift applicants, supplemented by local criteria, depending on the popularity and character of the programme. This approach allows trainees to "earn the right to choose". It rewards diligence, encourages learning and provides a level playing field for applicants whatever their place of qualification or experience.

6.5 COPMeD recommends the commissioning and piloting of a computer-marked selection test to be taken by UK medical students in their final year and by all external applicants seeking postgraduate training in the UK. Such a test must provide a means of electronically ranking applicants in a way that is valid, reliable, fair and transparent. Such a selection test could be designed to elicit the characteristics of patient-centredness, breadth as well as depth of knowledge and the ability to solve problems.

6.6 A national electronic recruitment process for specialty training should be re-introduced in the UK only when we have developed a reliable metric for ranking applicants electronically. Once that is available, we will be able to cope with high volume applications, and can proceed to a specialty specific selection centre approach for a manageable number of applicants. This is what COGPEd has successfully implemented over several years, and the same principles could be extended to cover all specialties.
7. The degree to which current plans for MMC will help to increase the flexibility of the medical workforce

7.1 In order to make the medical workforce more flexible, trainees need to experience working in a variety of settings, for a range of providers. They need to be actively engaged in service reform, and be exposed to medical role models who embrace and champion change. They should be educated to consider the patient holistically, to put the patient’s needs before their own and to balance the service as a whole against the needs of the individual patient. All of these are features of MMC training.

7.2 The current plans for MMC include modernised curricula that have been developed in consultation with the service; e-portfolios that capture experience and skills gained; work-place based assessments that ensure trainees are reliably and demonstrably competent in their specialty. Such documented acquisition of competencies should allow trainees to move more easily between specialties.

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 COPMeD had a co-ordinating role for the postgraduate deans across the UK in the design and implementation of MMC. Most postgraduate deans were involved in one aspect or another of the design and all were involved in the implementation.

8.2 The COPMeD Recruitment and Selection Steering Group was set up when, in March 2005, one of the postgraduate deans was commissioned by the UK Strategy Group to develop person specifications, selection criteria and the application form for the specialty selection and recruitment process. This group reported to COPMeD and JACSTAG among others and was accountable to the UK Strategy Group.

8.3 COPMeD and the Academy of Royal Colleges came together to agree the entry criteria, person specifications, selection criteria and the application form in the Joint Academy COPMeD Specialty Training Advisory Group, which advised the UK Strategy Group.

Prof Elisabeth Paice
Chair of COPMed
January 2008

Supplementary memorandum by Methods Consulting (MMC 58)

FURTHER INFORMATION REQUESTED DURING THE ORAL EVIDENCE SESSION OF 13 DECEMBER 2007

1. This document contains a written clarification of an answer provided to Sandra Gidley MP, as requested during the oral session. In the oral session I was asked to clarify our contact with the MMC team during the MTAS project (Q266).

Clarification

2. As explained in the oral session, the MTAS project’s role was to design, build and run a solution against a set of detailed requirements which were provided into the project from other groups.

3. Our contact with the MMC team during the design of the MTAS system came predominantly from our engagement with the “steering groups”, the membership of which included MMC team members.

4. There were two steering groups responsible for defining how recruitment of junior doctors should take place, one group looking at foundation recruitment, the other looking at specialty recruitment, both managed by the Conference of Postgraduate Medical Education Deans (COPMED) outside of the MTAS project.

5. Specifically, the steering groups were responsible for defining inputs to the MTAS project which included areas such as the overall business process for recruitment, application form structure, content and associated explanatory guidance for applicants, eligibility criteria for applicants, the number and type of the applications that each applicant could make, rules for scoring applicants, timetable for recruitment, etc. The steering groups were also responsible for liaising with the wider stakeholder community to ensure that what they were proposing was acceptable.

6. The specialty steering group included Shelley Heard, of MMC, and was supported by a full time project manager from the MMC team.

7. We held a series of formal workshops with the specialty steering group between September and December 2006 during which aspects of the rules and their implications for the design of the system were clarified. The outcomes of the workshops were recorded in structured notes, which then became embodied in changes to the prototype and a requirements catalogue. The prototype and requirements catalogue, along with the workshop notes from which they were derived, were published for stakeholders to view on a project
website, and members of the MMC team were involved in the QA and sign-off of the requirements along with the project board and other relevant stakeholder bodies (eg CoPMED steering group for specialty recruitment).

8. In addition to the workshops, MTAS team members and MMC team members were in attendance at various meetings on specific topics throughout the project, organised by others, eg DH and the COPMeD Steering Group.

9. User acceptance testing was managed jointly with the Department and undertaken by volunteer groups of doctors and deanery users. This included a MMC representative.

10. I trust this provides the clarification requested. We would be pleased to assist further if required.

Mark Johnston  
Managing Director  
11 January 2008

Memorandum by the Foreign and Commonwealth Office (MMC 59)

MODERNISING MEDICAL CAREERS—INTERNATIONAL MEDICAL GRADUATES

The FCO is grateful to have this opportunity to explain to the Committee its role in the formulation of Government policy affecting training opportunities available to non-EEA doctors in the NHS.

The FCO recognises that there is a tension between a desire for self-sufficiency in the supply of doctors and an open door policy for foreign doctors. Efforts to resolve this have been underway for about two years. Principally an issue for the Department of Health and the Home Office to resolve, FCO ministers and officials have always appreciated the difficulties with which these other Departments have faced. FCO involvement and interest has been confined to advising these Departments on the foreign policy implications of the various policy options under consideration.

For many years the NHS has relied on foreign doctors to fill vacancies and they made, and continue to make, a very valuable contribution to the NHS. Many of these doctors come from South Asia, in particular from India. The Government of India follows this issue closely. Announcements of the introduction of measures that limit access to training slots in the NHS for non-EEA doctors need, therefore, to be handled carefully and sensitively.

We have a strong bilateral relationship with India, exemplified by the recent UK-India Summit where discussion between the two Prime Ministers covered a wide range of issues and reinforced the depth of our strategic partnership. Migration is an issue that constantly features high on the Indian agenda. We have been keen to ensure therefore that details of any changes to the immigration rules are communicated clearly and in advance to the Governments of those countries concerned.

The FCO would also have a more general concern over any change to the Immigration Rules that excluded doctors from Tier 1 of the new Points-Based System (PBS) for managed migration (which will replace the Highly Skilled Migrant Programme). The PBS is the mechanism through which we will attract the migrants our economy needs. Tier 1, for highly skilled migrants, will uniquely allow all those whose qualifications meet certain standards to enter the UK without a job offer. It is aimed at the brightest and best. Measures that significantly limit one highly skilled sector would run counter to the essence of Tier 1 and could set an unwelcome precedent. However, the FCO recognises that, given the argument for self-sufficiency in the supply of doctors in the UK, some such changes may now be justified.

SPECIFIC QUESTIONS

Was the FCO consulted by the Department of Health (DH) or Home Office on the decision to end permit-free training in March 2006?

According to the records we have found, we were informed before the decision was implemented, but we were not consulted on the decision to end permit-free training.

Was the FCO involved in subsequent attempts to limit the entry of non-EEA doctors such as the use of the DH guidance?

Our involvement has been limited. Our role has been to inform the Government debate of the foreign policy implications of any proposed changes.

Of the various options considered, the use of the DH guidance would have been our preference because it would not have automatically blocked specialty training slots to all non-EEA doctors. It would also not have required a change to the Immigration Rules. We understand that the DH is appealing against the judgement of the courts that the use of the guidance was illegal.
Does the FCO have any arrangements with non-EEA countries (eg India) regarding access to UK medical training places for their citizens?

We understand that a number of non-EEA countries have arrangements with the Royal Colleges to provide medical training and there have been some preliminary discussions to consider how HMG might offer specialist medical training overseas, but the FCO has had no significant involvement in this.

Does the FCO know the number of non-EEA doctors who return to their country of origin after completing medical training in the UK?

Specialist training within the NHS is valued highly by many doctors, especially those from South Asia for whom comparable training opportunities do not exist. For these doctors, specialist training in the NHS is a vital part of their career and many do return to their country of origin after completing their training to use their new skills. We do not have details of the numbers involved.

Does the FCO have a view on what the Government should do in future to limit non-EEA applicants to UK medical training places, notably, once the cohort who came to the UK with an expectation of training have passed through the system?

We have accepted the need for temporary changes to the Immigration Rules to limit access by non-EEA applicants to UK medical training places, provided that they are prospective and not retrospective in application, and limited to addressing the immediate difficulties. It will be for the Department of Health to find a longer term solution to the workforce planning problems that it faces.

Does the FCO have a view on the best way of providing training for non-EEA doctors who wish to return to their country of origin?

As we have said above, training in the NHS is highly valued. In order to avoid disrupting relations with key emerging economies and to continue making a contribution to improving the quality of health services in the developing world we believe it will be important to retain some degree of access to specialty training in the UK. There is also a place for training in countries of origin. We should consider options to help finance these, but this would be outside FCO’s area of expertise.

What would be the consequence for UK/Indian relations of stopping non-EEA doctors from applying for medical training?

The implementation of measures to prevent access to specialist training by non-EEA doctors would not be welcomed by the Indian Government or medical bodies. As we have said above, in recent years this issue has been top of their agenda in discussions on migration and restrictions on access would be very likely to create difficulties for our wider bilateral relationship.

India is also a priority market for trade in pharmaceutical and medical devices. This trade could be affected if we prevent non-EEA doctors from applying for medical training slots in the UK.

February 2008

Memorandum by the Home Office (MMC 60)

MODERNISING MEDICAL CAREERS—INTERNATIONAL MEDICAL GRADUATES

SUMMARY

The Home Office welcomes this opportunity to explain to the Committee its role in implementing Government policy on ensuring self-sufficiency in the supply of doctors. We have provided advice on, and implemented, changes to the immigration rules to achieve Department of Health policy objectives. The two key sets of immigration rules changes were laid before Parliament in March 2006 and February 2008.

We believe that amending the immigration rules is the right short-term solution to NHS workforce planning problems. We know the Department of Health believes it urgently needs its own sustainable solutions to workforce planning problems and has acknowledged that a solution using immigration rules is only a stop gap.

The Department of Health first approached the Home Office in 2005 about using the immigration rules to close down competition for training posts from International Medical Graduates. We agreed to restrict the provisions of the Postgraduate Doctors and Dentists category so that it would be open only to those who had studied for their medical qualification in the UK and that it would enable them only to complete their Foundation Training. Those immigration rules took effect on 3 April 2006.
We were approached again in June 2006 with a request to impose restrictions on the Highly Skilled Migrant Programme (HSMP) and Tier 1 of the (then) forthcoming Points Based System for controlling migration. This proposal is, of course, an exception in the policy behind HSMP and Tier 1—to attract the brightest and best by offering free access to the labour market.

Domestic Affairs Committee cleared the policy in time for rules changes to be laid before Parliament on 6 February 2008. These changes will come into effect on 29 February in the UK and 1 April in India. The restrictions imposed by these changes will be extended to the rest of the world by the end of the summer in line with the roll-out of the Points Based System.

Specific Questions

1. When the Home Office and Department of Health ended permit-free training in March 2006, did the Home Office anticipate that this would lead to a major increase in the number of non-EEA doctors applying to the Highly Skilled Migrant Programme?

We made the rules change in 2006 to implement Department of Health policy. When the Department of Health first approached us in 2005, it identified that continuing to allow doctors to enter under the Highly Skilled Migrant Programme or Tier 1 of the Points-Based System might undermine the effects of restricting the Postgraduate Doctors and Dentists category. We agreed with its analysis.

2. Can figures be provided for the number of medical HSMP applicants from 2005–07?

It is hard to give precise numbers as HSMP migrants are not required to declare their profession or say what they intend to do when applying to enter or remain in the UK. We have estimated the following for 2006 from management information:

- Around 8,000 HSMP approval letters were granted to migrants applying from outside the UK, of which fewer than 1,000 were granted to applicants self-reporting their profession as doctors.
- Around 14,000 approval letters were granted to migrants already in the UK switching into HSMP from another category, of which around 7,500 were granted to applicants self-reporting their profession as doctors.
- Around 14,000 approval letters were granted to applicants seeking to extend their stay in the UK under HSMP, of which we estimate, from a limited survey of cases, that fewer than 8,000 were granted to doctors.

Source: Border and Immigration Agency local management information. These figures are not provided under national statistics protocols. All the figures are provisional and subject to change.

3. What options were considered for addressing the problems caused by the increase in HSMP applicants?

The Department of Health was concerned that the April 2006 changes had led to a displacement of migrants from the Post Graduate Doctors and Dentists category into HSMP. We provided advice on the immigration option of placing a condition on the leave of HSMP migrants to prevent them from taking junior doctor training posts.

4. Was the Home Office surprised that the appeal against the DH guidance was upheld and the guidance declared unlawful in November 2007?

The government’s position is that we believe the judgement was wrong, which is why the Department for Health has appealed to the House of Lords.

5. In the light of the Court of Appeal decision, is it clear how restrictions could be made legally?

Amendments to the immigration rules placing conditions on leave granted under particular immigration categories can be legally made under the power in section 3(1) of the Immigration Act 1971. The Court of Appeal decision was in respect of the Department of Health guidance. The Department of Health should be asked to comment on the legality or otherwise of other options it has under consideration.

6. Is it the case that the UK can restrict applications if it decides to?

The Home Secretary has the power to place conditions upon a migrant’s leave which restricts that person’s employment or occupation in the UK. It is for the Department of Health to comment on the legality of any levers they have to restrict applications to specified posts in the NHS.
7. Are there any other plans for future restrictions on the number of non-EEA doctor applicants from 2009 onwards? What immigration options are available to limit the number of applicants?

There are no plans for any further restrictions being placed via the immigration rules. It is for the Department of Health to comment on what they are doing to find a sustainable way to ensure self-sufficiency in the supply of doctors.

8. Since it is the Government’s long-standing policy to make the UK more self-sufficient for its medical workforce, do you agree it is necessary to restrict non-EEA applications?

This question should be addressed to the Department of Health.

13 February 2008

Memorandum by Professor Sir John Tooke (MMC 61)

MODERNISING MEDICAL CAREERS

I appreciate that the Committee has now completed its collection of oral evidence but hope that you will admit some summary written observations in the light of the published transcripts.

1. THE ROLE OF THE DOCTOR

Everyone accepts that contemporary healthcare depends upon a multi professional team approach, with different professionals bringing particular attributes to the team. Each professional “cluster” needs particular educational foundations (in the case of medicine a deep and challenging education with a strong science base to support the development of clinical reasoning skills, upon which diagnosis and the capacity to deal effectively with ambiguity and uncertainty rely).

Notwithstanding the need to develop shared understanding about roles with the other members of the healthcare team, for a variety of reasons, listed below, medicine does have to be treated differently:

— Medical education is much more expensive than that of other healthcare professionals, reflecting the key requirements of the role.
— The length of training cannot be determined locally—it is set in stone by EU directives.
— There cannot be wholesale revision of curricula to meet perceived local imperatives. The curricula apply across the UK and have to be approved by external regulators.
— Medical trainees subserve other key national interests being crucial, for example to the biomedical research that supports UK plc, and are not just NHS service personnel. The training content and structure needs to be sensitive to such issues. This aspect does not impinge on the other professions to anywhere near the same extent.

Whereas the Final Report proposed the creation of NHS:MEE (reflecting the fact that our remit was medicine) the Panel supports the concept of NHS Education England, embracing the needs of the various professional clusters. However the current crisis in PGMET needs to be urgently resolved, so important is such training for the future health needs of the population. The national significance of the medical professional contribution in a variety of domains makes it imperative that there is national oversight and scrutiny of PGMET.

2. FOUNDATION TRAINING

The Inquiry proposed splitting years one and two of Foundation, principally to ensure UK medical graduates achieve full registration with the GMC. Failure to guarantee such status would lead to legal challenge to Universities, would be a profound injustice to new graduates with tens of thousands of pounds of debt, and would deter the socio-economically disadvantaged from applying to study medicine just at the time when medical schools’ widening participation programmes are beginning to achieve traction.

The Inquiry Panel is yet to see convincing legal opinion that such protection can be afforded in ways other than splitting F1 and F2 in an employment sense. Persisting with a two year Foundation programme will shorten and impact negatively on core training. Three years of core training is key to flexibility and future workforce redesign—and is necessary to help provide trainees with adequate time to develop the relevant specialty experience and skills in the face of EWTD.

Thus from an education and flexible workforce perspective we strongly urge that a themed “F2” is incorporated into “core”, and split, in an employment sense, from F1. It is a fragile argument to say the current Foundation programme has not run long enough to change. All good curricula are responsive to the required outcomes (ie the health needs to be addressed) and should be subject to continued review and evolution.
We have already written to you with additional evidence of strong professional and organisational support for this move. The only voice of discord was heard from those directly involved in the current provision, keen to maintain the status quo.

3. Harnessing Academia

Our Interim Report pointed out the steady erosion of the Health:Education sector partnership in recent years. Such partnership was a founding principle of the NHS. Harnessing academia for the benefit of health is a mechanism adopted by most developed nations to drive up health care quality and innovation, and is crucial if the UK is to achieve its stated goal of being a strong knowledge-based economy.

We suggested a variety of ways in which better links can be fostered including:

- Incentivisation of Trusts to engage in education and research.
- Scrutiny of SHAs regarding the local academic relationships they have fostered, and the use of PGMET funds.
- Review of the relationship between Postgraduate Deaneries, Medical Schools and service including the trialling of graduate schools.
- Clear accountability at Trust Board level for PGMET.

4. NHS:MEE

The consultation response showed that a mere 12 people—1.3% of respondees—had any measure of disagreement with the suggestion that there should be a “National Institute for Health Education” (Recommendation 12).

Our belief that such a body is necessary stems from a fundamental lack of confidence by the medical profession in the Department of Health’s ability to manage the implementation of changes in PGMET, and the clear need to separate policy from implementation. Devolution of complete responsibility to SHA level engenders even less confidence, given the current lack of workforce planning and commissioning capacity, the lack of labour market intelligence and the very recent history of education and training budgets being raided to meet service pressures. The Panel believes that local ownership and demand led solutions, informed by service are key to success; nonetheless the national dimension must not be ignored and without a body such as NHS:MEE to provide scrutiny, the national interest is at severe risk. Such risk takes a number of forms:

- Lack of integration of the local with the overall requirement for medical workforce.
- Poor provision of subspecialty expertise, not required in every SHA.
- An erosion of an integrated approach to development of the clinical academic workforce, crucial to UK plc.
- Inequity of specialist service provision, striking at a fundamental principle of the NHS.

In addition NHS MEE would address the following deficiencies identified by the Inquiry:

- Provide coherent professional advice on PGMET to policy makers.
- Develop and act as the guardian of the principles underpinning PGMET and the evolving role of the doctor.
- Integrate curricula requirements (service and professional viewpoints) and interface with the Regulator.
- Scrutinise the allocation of PGMET resources both centrally and at SHA level.
- Act as the commissioning agent for certain small volume, highly specialised areas of medicine.
- Act as the point of reference in England to facilitate UK-wide collaboration on matters relating to PGMET.

In any complex system transition imposes risk. The Health Select Committee revealed deficient central workforce planning. We believe the transition to demand led, local input should be managed over a number of years during which time, adequate local labour market intelligence is developed, central agreement on professional roles is secured and new PGMET structures become embedded.

5. Support

We have recently sent evidence to the Committee regarding the degree of support for the Inquiry’s final recommendations. We should emphasise the overwhelming support for all our Recommendations from the medical profession. Even where some Postgraduate Deans and Foundation School Directors naturally feel unable to support us, the vast majority of the profession, including the trainees, wish to see full implementation. We owe it to tomorrow’s doctors—and to the nation—to harness their aspirations. It is
the profound expectation of the medical profession that the Inquiry’s recommendations will be adopted in full. Such a response would maximise engagement in resolving the difficult challenges ahead, which is in the best interest of patients.

Professor Sir John Tooke
Chair
MMC Inquiry
21 February 2008

Memorandum by NHS Education for Scotland (MMC 62)

MODERNISING MEDICAL EDUCATION

PURPOSE OF REQUEST FOR WRITTEN EVIDENCE

1. To provide comment on: the Tooke recommendation to establish an arm’s length body to oversee medical education in England, to be known as NHS Medical Education England (NHS MEE); and in particular the role of NHS Education for Scotland (NES), its role and work to date, its relationship with other bodies responsible for medicine in Scotland, its experience of MMC and its views, if any on whether such a body would be helpful in England.

EXECUTIVE SUMMARY

2. NHS Education for Scotland has developed a unique model for commissioning and delivering education and training for the health professions. While there are some similarities to the model proposed by Tooke for NHS MEE, there are significant differences. NES is an NHS Health Board with responsibilities for commissioning and delivering training and education across the NHS Scotland workforce and does so to standards set by external regulators. It does not undertake workforce planning nor determine major policy on postgraduate medical education. These latter functions fall to the Scottish Government to which NES may provide advice. A focus on its key functions and responsibilities for commissioning and providing education and training coupled with close relationships with key partners are at the heart of NES’s mission.

SUBMITTER

3. My name is Michael Watson. I am a physician and Medical Director of NHS Education for Scotland.

NHS EDUCATION FOR SCOTLAND

4. Here I set out what NES is and possible similarities with and differences from what Tooke has recommended for NHS MEE.

What is NHS Education for Scotland (NES)

5. NES is an NHS special health board accountable to the Scottish Government. It principal aim is to help provide better patient care by designing, commissioning, quality assuring and, where appropriate, providing education, training and life long learning for the NHS Scotland workforce. Its remit covers the allied health professions, dentistry, medicine, midwifery, nursing, pharmacy, psychology, audiology, as well as healthcare scientists and chaplains. It is intended that its remit will expand to include all staff groups in NHS Scotland.

6. Although much of the core work focuses on supporting individual disciplines there is a growing emphasis on taking a multi-disciplinary and multi-agency approach.

7. NES receives most of its funding from the Scottish Government. Currently the largest part of its total expenditure of £403 million is committed to supporting the salary costs of trainee health professionals (mainly doctors) and to the payment of Medical and Dental ACT (Additional Costs for undergraduate Teaching). About 12% provides for the educational infrastructure for the trainee groups described above and to provide specific training opportunities for certain other groups.

8. NES works closely with regional service and workforce planning groups established by the Scottish Government, to ensure that its commissioning arrangements meet workforce requirements and are compatible with effective service delivery. There are also close working relationships with relevant medical Royal Colleges and their representatives in Scotland. It was these close relationships that together made it possible to respond rapidly and effectively last year to the fallout from the failure of MTAS.
Interpreting the Tooke recommendations to establish NHS MEE in a Scottish context

9. Tooke made the following recommendation(s):

"The Panel recommends the formation of a new body, NHS Medical Education England (NHS.MEE). This body would fulfil the following functions [the relevant related recommendations are referred to in square brackets]

i. Hold the ring-fenced budget for medical education and training for England [recommendation 23]

Comment NES does not hold a direct and specific ring-fenced budget for medical education for Scotland. It is a multi professional Health Board with global funding provided to enable it to discharge agreed responsibilities across all health professions.

— postgraduate medical education. NES is responsible for funding the base salary of almost all trainees. (Rather less than 5% of the medical training workforce currently remains directly funded by the service and then only for a diminishing number of one year Fixed Term Training Appointments). The service through 14 employing health boards provides any “additional component” of trainees’ salaries—notationally the amount paid for additional duty hours. Again this element of trainees’ salaries is diminishing. The training establishment is determined by the Scottish Government on an annual basis and informed by that the Board of NES determines the proportion of its budget to meet trainees’ base salaries for the forthcoming year. Infrastructure costs eg for the operation of deaneries, funding for training courses etc. need to be found from within the overall NES budget and for which there are competing pressures. NES has a specific responsibility to commission training to meet workforce needs for some 57 specialties in different locations across Scotland.

— Undergraduate medical education. While five universities receive direct per capita funding from the Scottish Funding Council for undergraduate medical students, NES meets and performance manages the “Additional Costs for Teaching” paid to service health boards based on undergraduate training delivered within the service.

ii. Define the principles underpinning PGMET [recommendations 1, 2]

While operational policies are largely determined by NES, the principles and policies underpinning PGMET, eg those relating to MMC, are determined through Scottish Government MMC governance arrangements in which NES participates. These in turn are considered within a UK context.

iii. Act as the professional interface between policy development and implementation on matters relating to PGMET [recommendations 3, 18]

NES already fulfils that role in Scotland but it does not seek to be the sole source of advice to the Scottish Government on PGMET matters.

iv. Develop a national perspective on training numbers for medicine working within the revised medical workforce advisory machinery [recommendations 12, 13, 17]

National workforce planning for Scotland across all health professions is a matter for the Scottish Government and on which NES may provide advice. In respect of postgraduate medical education, NES enables recruitment to meet establishment targets for each specialty set by the Government. The Government also separately determines the numbers to enter Scottish medical schools.

v. Ensure that policy and professional and service perspectives are integrated in the construct of PGMET curricula and advise the Regulator on the resultant synthesis [recommendation 14]

NES maintains close links with the regulators: The Postgraduate Medical Education and Training Board as well as the General Medical Council with which it has a Memorandum of Understanding. Matters concerning the delivery of training to meet curricular standards and possible changes in the curricula to meet service requirements are considered.

vi. Coordinate coherent advice to Government on matters relating to medical education [recommendation 18]

NES is one source of such advice though by no means the only one. For example the medical Royal Colleges and their faculties, often working through The Academy of Royal Colleges and Faculties in Scotland, provide advice to both NES and the Scottish Government.

vii. Promote the national cohesion of Postgraduate Deanery activities [recommendations 24, 25]

This is a key task for NES. The four Scottish deaneries are not independent and are an integral part of the NES organisation and accountable to it. The four postgraduate deans report to myself as Medical Director.
viii. Scrutinise SHA medical education and training commissioning functions, facilitating demand led solutions whilst ensuring maintenance of a national perspective is maintained [recommendation 22]

There is no analogous provision in Scotland. NES directly undertakes commissioning of postgraduate medical education and training across Scotland and does so in partnership with the profession and the service.

ix. Commission certain subspecialty medical training [recommendation 12]

Sub-specialty and specialty training are commissioned in agreement with national establishments set by the Scottish Government.

x. Act as the governance body for MMC and future changes in PGMET [recommendation 6]

The governance arrangements for MMC in Scotland lie with the Scottish Government (see ii above).

COMMENT

10. The NES approach to supporting health professional education and development may be unique. It faces significant challenges in making a balanced use of resources and in responding to demands for new and changing service roles.

11. One reason that this particular formula for delivering this service may be successful is that of scale. Scotland is geographically a large and diverse territory by UK standards making particular challenges for delivering education and training. Although its population approximates to a single large English deanery its distribution is variable. Scale then supports a key factor in enabling NES to meet its objectives—close working relations with key players and partners eg: the Scottish Government; the 14 health boards responsible for service delivery; as well as, importantly, independent Scottish and UK professional and regulatory bodies.

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