



Remedy UK Response to:

Recruitment to specialty Training
Proposals for improvement in
2008

Introduction

Our response to this discussion document is based upon responses received by email, message boards and a survey posted on the RemedyUK website. 821 responses were received. The demographic data of the respondents is shown in Appendix 1. While care must be taken in extrapolating data from such surveys, in many cases overwhelming support for a single option is expressed. These findings are supported by additional correspondence and consultation.

General Comment

We agree that ‘major changes to medical training should only be made after careful piloting’ (1.1.1). The previous system, which was by no means perfect, was significantly better than the current system. The option remains to revert to the previous system for selection to specialty training, which has served both the profession and patients well for decades. This is supported by our survey respondents.

Reversion to SpR appointment system (pre 2007)?	Number	Percentage
Yes	675	82.72%
No	94	11.52%
Don't Know/ No Opinion	47	5.76%
Total	816	100.00%

Table 1: Level of support for reversion to deanery system used for SpRs prior to 2007

Decision- making process and involvement of stakeholders

General Comment

There must be places for training grade doctors on Commissioned Working Groups (2.2.2). Ideally these should be those who have been through selection in 2007 and those who are facing MMC in 2008.

Part 1: A fair and reliable Selection Process

We accept that ‘Selection fairness and reliability is a major challenge’ (3.1) but not as a result of ‘many more potential applicants than training posts available’, but as a result of the disastrous implementation of MMC and MTAS to date.

There were questions about whether the application form and selection method was fit for recruiting the best doctors to the best specialty in the right location’ (3.1.3). We would argue that there is no doubt that it was a poor system.

Rather than ‘almost certainly’, applicants for 2008 will definitely be joined by many of the 14,000 doctors failed by the 2007 selection. It is essential that we have fair and open competition for these doctors.

Much more detail is required about ‘Selection centres’: What are these? Who will staff them? How will these staff be trained? What quality assurance methods will be in place?

Proposals for shortlisting in 2008

Five options are presented in the paper

White space option, which we reject. Interviewing all applicants is only feasible in small UoAs/ specialties and is very wasteful of resources. It cannot be supported. CV-based shortlisting is our preferred option. We would stress that the CVs need to be flexibly designed, on a per-specialty basis, so that applicants can demonstrate their excellence and previous achievements. Invigilated testing and invigilated test with shortlisting are both too wasteful of resources and are unvalidated outside of General Practice.

Do you agree that selection in 2008 should be through local processes of shortlisting followed by interviews using a nationally agreed timetable?

We support local recruitment and shortlisting with individual variation, and are in favour of an initial shortlisting followed by interviews. The process must also be subject to audit and quality assurance procedures.

This view is supported by comments received in consultation and results from our survey below.

Shortlisting preference for 2008?	Number	Percentage
Continue with 2007 process	6	0.73%
Interview all eligible applicants	30	3.67%
Nationally agreed structured CV application	225	27.51%
Machine- marked Shortlisting	20	2.44%
Invigilated assessments	22	2.69%
Shortlisting at deanery level	514	62.84%
Don't Know/ No Opinion	1	0.12%
Total	818	100.00%

Table 2: Shortlisting Preferences for 2008

Shortlisting preference for 2008?	Number	Percentage
Continue with 2007 process	6	0.74%
Interview all eligible applicants	23	2.82%
Nationally agreed structured CV application	264	32.35%
Machine- marked Shortlisting	39	4.78%
Invigilated assessments	49	6.00%
Shortlisting at deanery level	423	51.84%
Don't Know/ No Opinion	12	1.47%
Total	816	100.00%

Table 3: Shortlisting Preferences for 2009

We reject the idea of a nationally agreed timetable, unless there can be multiple entry points per year.

Do you agree that shortlisting should be through consideration of structured (CV-based) application forms using a national, specialty-specific form containing a common core?

Yes, we believe that a structured CV based and speciality specific system is the best approach. We believe that this will allow candidates to express appropriate experience and additional important factors in their career to date, thus making selection fairer.

Do you think that the selection process in 2008 should be different in application to ST1 compared to ST2 and ST3 (ST4 in paediatrics and psychiatry)? If so, how should it be done for each?

Our survey showed that 52% of respondents favoured a different selection procedures and 38% preferred a universal selection process.

We believe that this question lacks clarity. Is there a suggestion of the introduction of an entirely new, non- validated assessment tool?

CV's have historically been used to select doctors for posts at all levels and that this should continue for ST1 doctors, and all grades.

If there is an argument that candidates cannot be fairly selected to specialties on the basis of minimal experience, the solution is to select into specialty training at a later stage and thus decouple ST2 and 3. This is more in keeping with the original MMC programme as outlines in 'Unfinished Business'.

What do you think needs to be considered within the piloting in 2008 of the two selection methodologies, the machine-marked tests and the selection centre method?

These methods must be piloted in parallel with the traditional selection process. The new methods (machine marked tests and selection centres) should not form a part of the appointment of candidates. The CV/ Interview- based system should be used to appoint, and those results compared to the 'mock' machine marked tests/ selection centres. This will allow detailed analysis and assessment of the potential merits or disadvantages of such systems before they are used for selection.

Views on a National or Local Application form

Which is your preference for 2008 and why - a national specialty-specific form containing a common, structured CV-based core, or local application forms?

The idea of a standardised CV/application form is a good one, since it makes it easier for recruiters to find the information they need quickly and consistently. However it is unlikely to be ready in time for 2008. This should be an ideal to work towards for 2009.

What important improvements would you wish to see made to the application forms for 2008?

Revert to CV- based applications.

National Computer System or Local Deaneries System

What is your preference for IT support in 2008?

While support the idea of a paperless system for applications at the deanery level, we do not support a national selection and matching system.

We believe that the underlying processes for recruitment need to be resolved before any IT solution can be developed.

For this reason we would suggest that a paper-based system be used in 2008. Our survey demonstrates lack of support for a national computer system for applications.

Type of computer system	Number	Percentage
A national computer system	144	17.56%
A deanery level system	646	78.78%
Don't Know/ No Opinion	30	3.66%
Total	820	100.00%

Table 4: National or Deanery Computer System

The Number of Applicant Preferences and How Preferences Should Be Treated

Which is your preferred option and why?

We support local applications with no national matching scheme. There is therefore no requirement for preferences.

A national application system is cumbersome and as we have seen in 2007, any mistakes or delays create large scale problems.

We have also looked at mathematical modelling of Preference Systems which has been undertaken by Dr James Teo and which has been sent as a separate submission to the Department of Health. In brief, he has modelled the outcomes that could be expected if 'strong' and 'good' candidates apply in competition with one another simultaneously. His results show that the 'clumping' effect, whereby strong candidates crowd out the weaker ones, is very hard to eliminate in concurrent preference-based system. This can produce perverse results for individuals.

This view is supported by respondents to our survey.

Option for applicant preferences in 2008?	Number	Percentage
More preferences considered concurrently	189	23.05%
Fewer preferences considered concurrently	22	2.68%
Consider preferences consecutively	48	5.85%
A mixture of concurrent and consecutive	109	13.29%
Local application with no national matching	414	50.49%
Don't Know/ No Opinion	38	4.63%
Total	820	100.00%

Table 5: Options for Applicant Preferences

The Size of UoA's

What do you consider are urgent issues to address for 2008 in terms of size of UoAs?

The large UoAs were a great problem for recruiters and applicants. For the recruiters the problem was that there were large numbers of applications to process. Applicants were unable to specify where they wanted to work, which has caused much domestic turmoil and upset especially in the large UoAs. Large UoAs also took away the incentive for Trusts/Programs to offer a good training program.

We, and our survey respondents support, smaller UoA's.

We agree with the BMA JDC that these should be based around individual rotations or specialty schools.

Should UoAs:	Number	Percentage
Option 1: Be made smaller	600	74.53%
Option 2: Be made larger	55	6.83%
Option 3: No change	150	18.63%
Total	805	100.00%

Table 6: Support for change in size of UoAs

National Timetable

Should there be an integrated national timetable for 2008 recruitment to specialty training (excluding Academic Clinical Fellows whose recruitment will be separate and earlier)?

57% of respondents to our survey supported a national timetable, 39% did not.

As previously mentioned, we support local selection and appointment and multiple entry points per year.

While we accept that a national timetable may offer some merits, it is very difficult to integrate a national timetable with local selection and recruitment. For this reason, we do not support a national timetable at this stage.

Other Issues

Eligibility Criteria – should the 2007 entry requirements and eligibility requirements be changed for 2008 recruitment? For example, should the maximum limit of 12 months of training in a specialty for entry to ST1 remain (as proposed by the BMA Junior Doctors’ Committee)? Should the maximum permitted period of experience for applications to ST2 be increased or even removed (also proposed by the BMA Junior Doctors’ Committee)?

Eligibility criteria – we would like to see a relaxation of the tight eligibility criteria, and a removal of the ‘maximum’ time limits on entry. These maxima are completely contrary to the idea of competency-based training, and act to the disadvantage of trainees who have followed an unconventional career path. Nearly 66% of respondents support removing this maximum time limit.

Support a max. experience limit?	Number	Percentage
Yes	232	28.33%
No	540	65.93%
Don't Know/ No Opinion	47	5.74%
Total	819	100.00%

Table 7: Support for a maximum experience limit for posts.

Long listing – should long listing be carried out by each Deanery/UoA or be done nationally e.g. by one lead Deanery for all applicants nationally or for a particular specialty?

Long-listing should be carried out by individual Deaneries. The criteria for long listing need to be radically simplified.

Offer to Applicants in 2008

What is your view on the proposal to move to three staggered application processes with staggered start dates in future, beginning with two in 2008 (August and December)?

We support multiple application points, as do our survey respondents

Should there be multiple entry points?	Number	Percentage
Yes	729	89.01%
No	64	7.81%
Don't Know/ No Opinion	26	3.17%
Total	819	100.00%

Table 8: Support for multiple entry points

A second entry point should be established this year. There are many reasons for this.

It will allow applicants who have accepted a job that they did not want to reapply for a job they wanted.

It will reduce the workload for the subsequent recruitment round

It will prevent service gaps developing within training programs during the course of the year.

A second entry point this year could be managed on the same lines as Round 2.

Do you agree that, provided appropriate mechanisms are in place there could be an early recruitment for the specialty of anaesthetics in 2008 to enable a start date of 1 April as well as 1 August and 1 December? Are there any other specialties that could have an early recruitment starting in April 2008?

We agree that there could be early recruitment for anaesthetics.

Transferable Competencies

What are your views on transferable competences to allow easier movement between specialties and increase flexibility in both training and workforce planning?

We support transferable competences and common training to assist transition between specialties- a principle of the original MMC reforms. While this may be of benefit to some trainees, other who make a 'sea-change' jump (e.g from anaesthetics to general practice) may find that the specialties have only very general skills in common.

What further work do you think needs to be undertaken in this area?

Detailed thought into how this would occur, how these candidates would apply, how their competencies would be assessed and how to decide at what level they would transfer to.

FTSTA's

What do you see as the benefits and disadvantages of FTSTAs?

At present there are few. FTSTAs have been regarded as a dead-end jobs, a dumping ground for those doctors failed by the MTAS system. There very limited opportunities for those doctors to re-enter training. The issue of the 14,000 doctors without training posts- the New Lost Tribe- must be addressed as a matter of urgency.

We generally support the idea of a broad education, and we also support the idea of allowing trainees to change career paths. Unfortunately the opportunities for FTSTAs to progress into senior grades are very restricted.

If there was decoupling of ST2 and ST3 with no automatic right-of-transfer from ST2 to ST3 then FTSTAs would become much more desirable jobs. They would then permit trainees to gain 'tasters' in a specialty. In this context we would also support the idea of 6-month FTSTAs.

This is an area that must be addressed for 2008. While we accept that the number of doctors trained must be linked to workforce planning, it has also been shown that the Government is particularly poor at predicting demand 5 years in advance.

Uncoupling

Do you agree with the concept of different models of training and different offers made by different specialties in 2008? What are the reasons for your view?

We support uncoupling and open competition for higher training. We believe that;

ST1 trainees do not have the knowledge to make correct career choices. We do not believe that a lifelong marriage can be made on the basis of a single blind date.

It is essential to have a period where trainees can discover whether or not they have an aptitude for a given specialty, particularly when they have had no experience in the specialty in FY. They also need to demonstrate they have adequate practical skills eg in surgery.

There needs to be ‘discharge with honour’ when a trainee decides to switch to another specialty.

Entry into higher grades must be competitive; the competition needs to be based around their performance in that particular specialty rather than in their FY subjects.

Our survey supports this opinion;

Support decoupling for applicants in 2007?	Number	Percentage
Yes	517	62.90%
No	249	30.29%
Don't Know/ No Opinion	56	6.81%
Total	822	100.00%

Table 9: Support for decoupling for applicants appointed in 2007

Support decoupling from 2008 onwards?	Number	Percentage
Yes	631	77.05%
No	122	14.90%
Don't Know/ No Opinion	66	8.06%
Total	819	100.00%

Table 10: Support for decoupling from 2008 onwards

A sub analysis of responses by grade (the ST1-2 ‘haves’ and the FTSTA and LAT/LAS ‘have nots’) show that 45.4% of those with ST1 or ST2 posts favour decoupling for the 2007 cohort. There is greater level of support for decoupling amongst those doctors without training posts

	Yes	No	Don't Know
ST1-2	119(45.4%)	123(46.9%)	20(7.6%)
FTSTA	81 (88%)	8 (8.7%)	3 (3.2%)
LAT/LAS	43 (95%)	2 (4.44%)	0 (0%)

Table 11: Support for decoupling posts allocated in 2007, by grade

	Yes	No	Don't Know
ST1-2	177 (67.6%)	60 (22.9%)	25 (9.5%)
FTSTA	86 (93.4%)	2 (2.2%)	4 (4.3%)
LAT/LAS	42 (93.3%)	1 (2.2%)	2 (4.4%)

Table 12: Support for decoupling posts allocated in 2008, by grade

Do you have a view about particular specialties – which offer model would work best and why?

Model 2, open competitive entry. Those not securing a training post could apply for FTSTA’s secure in the knowledge that they can apply the following intake.

All of the models have a logical flaw in that they assume 100% of entrants at a given level will exit on-time at the end of a given time period. This assumption is flawed, for the following two groups of reasons:-

Failure to pass competencies, failure to pass exams, etc.

Spending insufficient time in-post due to late starts (Round 2) or to badly-planned rotations which miss out key competencies, or prolonged sick leave or other absences.

A 'drop-out' factor needs to be included in all the models, with identified ways in which stragglers and late entrants can be managed. This will also have implications in entrants from lower grades who may find their entry into the system blocked by people who have failed to progress.

There also needs to be adequate and informed career guidance given to unsuccessful applicants.

Appendix 1: Respondent Demographics

Table 1: Respondent Grade

Grade	Number	Percentage
Medical Student	7	0.87%
FY1	11	1.36%
FY2	58	7.19%
ST1	105	13.01%
ST2	158	19.58%
ST3-5	86	10.66%
FTSTA	92	11.40%
Clinical Research Fellow	67	8.30%
Registrar (with NTN)	93	11.52%
Registrar (LAT/LAS)	45	5.58%
Staff grade	20	2.48%
Associate specialist	3	0.37%
Consultant	50	6.20%
GP Reg	5	0.62%
GP	6	0.74%
Retired	1	0.12%
Total	807	100.00%

Table 2: Respondent Work Location

Location of workplace	Number	Percentage
England	686	85.54%
Northern Ireland	9	1.12%
Scotland	67	8.35%
Wales	30	3.74%
Overseas	10	1.25%
Total	802	100.00%

Table 3: Respondent Year of Graduation

Year of graduation	Number	Percentage
2007	11	1.37%
2006	46	5.72%
2005	76	9.45%
2004	108	13.43%
2003	130	16.17%
2002	107	13.31%
2001	66	8.21%
2000	68	8.46%
1999	34	4.23%
1998	33	4.10%
1997	16	1.99%
1996	19	2.36%
1995	15	1.87%
1994	11	1.37%
1993	12	1.49%
Prior to 1993	45	5.60%
Not yet graduated	7	0.87%
Total	804	100.00%