SUBMISSION TO THE HEALTH SELECT COMMITTEE ON

'MODERNISING MEDICAL CAREERS'

on behalf of

RemedyUK

Background information and summary **2**

Underlying Principles of MMC **3**
Creation of Training Programs 3
Structure and flexibility of Training Pathways 4
Education of Junior Doctors 6
The Tooke Review – Aspiring to Excellence 7

The strengths and weaknesses of the MTAS project. **8**
Overall design of the Selection process 8
Shortlisting and interviewing 9
Computer and other Failures of due process 10
Matching and Allocations to jobs 11

Remedy's oppostion to MTAS and MMC **11**

Flexibility of the Workforce and Manpower Planning **12**
The number of Doctors in the UK 12
The Number of Doctors in Training 14
The Subconsultant Grade 15

Who was responsible for MMC and MTAS **15**

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BACKGROUND INFORMATION AND SUMMARY

1. RemedyUK is a pressure group established in 2006 to raise concerns about doctors training and workforce planning. It arranged the protest march in March 2007 at which 12,000 doctors expressed their frustration over MTAS and MMC, sought a judicial review of the process and has lobbied for change. It is now a subscription based organisation and has been recognised as a stakeholder by the MMC England Program Board.

2. We believe that:-

a. The objectives of MMC were unclear. It appears to produce doctors that are less well trained than previously, as rapidly as possible, with a narrower skill base. The decline in educational standards has been exacerbated by the deleterious effects of the New Deal and Working Time Directive on clinical experience.

b. Reform of the SHO grade was necessary but was implemented badly. The new career structures are unrealistically rigid and are divisive. They require trainees to commit themselves to a specialist programme too early in their careers. A major underlying problem with the SHO grade – limited access to the higher levels of training – has not been addressed.

c. Flexibility for individual doctors to plan appropriate careers has been sacrificed in order to reduce time in the training grade.

d. We welcome the report by Sir John Tooke, and would like to see his recommendations fully adopted.

e. The MTAS project had many weaknesses. The original shortlisting worked so badly that it needed to be changed mid-recruitment. The Matching Algorithm, a fundamental component which should have allocated doctors to their job preferences, also failed. There were security breaches and failures of due process.

f. Manpower and workforce issues in medicine are an inherently difficult problem, because the delays involved in implementing change span many years. A few years ago there was a perceived shortage of doctors, yet we now expect to have a surplus. The number of doctors-in-training has been determined by the service requirements of the grade, rather than by the calculated requirements for future consultants.

g. The establishment of a pre-Consultant grade seems inevitable, and needs to be openly addressed.

h. The entire project was overambitious, poorly conceived and mismanaged. Objections were raised by those directly involved with training and career planning, but these objections were often ignored.

i. Few of the bodies concerned with introducing MMC can be proud of their achievements. We are especially unhappy that PMETB, a body set up to regulate training, has appeared impotent in preventing this disaster.

UNDERLYING PRINCIPLES OF MMC

3. The aims of MMC were poorly defined, changed over time and were sometimes conflicting. We have considered the underlying principles of MMC, as stated in 2003[1] and examine whether they were conceptually sound and well implemented.

CREATION OF TRAINING PROGRAMS

4. MMC recommended that:-

> ***All postgraduate medical training should be organised in structured programmes (usually a series of co-ordinated placements) with progress monitored against clear curricula.***
>
> ***Individual programmes should be available to meet individual needs.***
>
> ***Training should be trainee-centred and programmes should reflect a variety of career choices, from those who decide on a particular career early on to those who need more time to do so and to those who want to train part-time.***
>
> ***Programmes should be broadly-based at first and lead on to greater specialisation where appropriate***
>
> ***A clear structure is necessary to encourage and support the development of academic, research and teaching skills and to support those who opt for an academic career***

5. Prior to 'Unfinished Business', approved SHO posts were often of short duration. Reorganisation into formal programmes provided more structured training and negated the need for repetitive job applications. Ten years previously the SpR grade had been successfully reorganised into formal rotations and many benefits were apparent. To extend this concept to SHO training was an attractive idea.

6. However free-standing short-term posts had provided much-needed flexibility for trainees who were unsure of their career aspirations or abilities. Nearly one quarter of

SHOs changed their career preference during their SHO training. Figures from the BMA cohort study confirmed that that even five years after graduation 7% were still undecided on their career, and 17% had changed their career plans within the preceding 12 months. The Tooke review confirmed these findings, and indicate that any programme must offer trainees a simple route to change careers

7. Flexibility for trainees to change, plan and tailor their careers was a laudable, compassionate and sound part of the initial design. It was largely lost in implementation, which became UoA-centred rather than trainee-centred. We believe this change occurred because of the perceived overriding imperative to shorten training.

8. The progression from general to more specialised training was also a good idea, but the manner by which this would be done was not developed. In Core Medical Training, doctors will be allocated to their future subspecialty by a mechanism as yet unknown. The principle of Acute Care Common Stem Training, an excellent idea in principle, was largely given up for manpower planning reasons.

9. Academic medicine has been disadvantaged by the intricacies of the recruitment system and the rigidity of the training pathways.

STRUCTURE AND FLEXIBILITY OF TRAINING PATHWAYS

10. MMC recommended that:-

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

Training should as far as possible be seamless and conducted within a grading structure which supports this process.

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

Rigorous counselling and career advice should be available throughout training

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

[1] *Modernising Medical Careers, The response of the four UK Health Ministers to the consultation on Unfinished Business: Proposals for reform of the Senior House Officer grade (2003)*

11. There is a clear conflict here. A broad-based and flexible education is likely to take longer than the bare minimum. Yet shortening time in training was made an explicit requirement, probably as a deliberate attempt to flood the market with minimally-trained doctors.

12. The attempt to reduce training time to the bare minimum also required that there should be once-a-year recruitment, timed so that doctors leaving Foundation Year could immediately enter into specialty training. Once-a-year recruitment is disadvantageous because:-

a. It makes it difficult to replace doctors in training who leave during the course of the year., other than with locums, and will create difficulties filling consultant vacancies that arise during the year. It presents program directors, HR staff and recruiters with logistical problems.

b. There is an impact on service provision in August when many trainees change jobs simultaneously.

c. It increases the stakes for trainees, who need to wait a year if their application is unsuccessful.

d. Trainees who enter a specialty for which they are unsuited need to wait a year before they can transfer.

13. We believe that MMC forced doctors to select their careers at an inappropriately junior level, when they have insufficient experience or knowledge. This view was echoed in the Tooke report.

14. Doctors entering a career for which they do not have the necessary skills or aptitude, or who take longer than the minimum to complete their training, need appropriate advice and support to pursue alternative careers. In an attempt to disguise these issues, MMC flowcharts and pathways showed no routes or destinations for drop-outs.

15. A second conflict arises between the interests of flexibility and the interests of job security. The offer of a 7-year training post[2] appeared to provide job security and was championed by the BMA[3]. But this job security comes at a price.

a. Run-through training is divisive and creates two tiers of doctors. Those appointed have job security, which encourages complacency; those that are not appointed are insecure and perceived as second-class doctors.

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[2] The majority of Run-through training programs are seven years in duration. A minority are of different duration.

[3] The BMA has a joint role as both a Trade Union and a Professional body.

b. Trainees who wish to change programmes will find they are locked-in, even if they are unsuitable for the career they have chosen, because of difficulties in getting another appointment, and the lack of 'discharge with honour'.

16. Runthrough Training was presented as a solution to the 'lost tribe' of SHOs who got stuck in career bottlenecks mid-career and were unable to progress. The number of SHO posts exceeded the number of SpR posts that were available for creating complete run-through programs. These surplus SHO posts were still required for service provision. Rather than solving the problem, MMC covertly disguised it by renaming the 'lost tribe' posts as FTSTAs[4] - the Modern Lost Tribe.

17. FTSTAs are dead-end posts from a career perspective. The opportunities for future progression are restricted, since future entry into training posts depends on filling 'dead men's shoes' The original promise of MMC was that "***Further work is needed to develop a framework to ensure that those who are not selected initially for their chosen field have opportunities to continue in training It is not acceptable that they should at this stage fall out of the training system.***" These opportunities are still not apparent, and FTSTA post-holders have no reliable information on which to base future career planning.

EDUCATION OF JUNIOR DOCTORS

Training must be supported by strong educational management and underpinned by skilled trainers

It will prepare doctors to work in multi-profession settings and employ shared learning and cross-professional training where necessary

Training should be applied to clear, consistent UK-wide standards

In general, assessment should be competency-based and should be focused on outcomes with the ability to perform as the underpinning competence

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

The end product of the training process, whether a hospital doctor or a general practitioner, should be a high-quality, well-trained and accredited doctor who can deliver the care and treatment patients need in the modern NHS

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

18. No changes have been made to the employment contract of trainers, and trainers are still uncertain what is expected of them.

[4] Fixed Term Specialty Training Appointment

19. The concept of 'Competence' is superficially attractive, since it requires trainees to demonstrate they have achieved the requisite skills to progress. The models which have largely been adopted break down the concept of 'Competence' into a series of many individual 'Competencies'. Trainees need to get each of these Competencies signed off at appropriate points in their training. This model is unsatisfactory for the following reasons:-

a. The Competencies model assumes that overall ability can be broken down into a series of individual skills that can each be tested separately. There is considerable evidence that attainment of separate competences alone does not imply the fluent, integrated, judgment-based professional performance necessary for independent practice. This requires experience over and above any basic competence.

b. Assessment of Competencies is carried out locally with no standardisation or consistency. Consultants are generally reluctant to give unsatisfactory assessments, except in the most extreme circumstances, since it harms the trainer-trainee relationship and can result in overt hostility or reprisals.

20. Unlike previous generations of doctors, who appeared to be thrown in at the deep end and given clinical responsibility that they were not ready for, recent changes have taken things too far in the opposite direction. Some doctors now feel they have been infantilised, and are not gaining adequate experience of hands-on clinical decision-making.

21. This problem has been exacerbated by the reduction in training hours produced by the Working Time Directive and the New Deal. Evidence from log-books confirms the reduction in case-workload that present trainees achieve. Reduced hours has also fragmented training, reduced contact between trainees and trainers, and complicated manpower planning.

THE TOOKE REVIEW – ASPIRING TO EXCELLENCE

22. We welcome the interim findings of the Independent Inquiry into MMC, led by Sir John Tooke, and congratulate him and his team for a well-researched and positive review. We share his view that MMC suffered from a lack of clear objective.

23. We hope the corrective actions he recommends are fully adopted. We look forward to seeing details in the final report of the proposed recruitment methods and training program structures.

THE STRENGTHS AND WEAKNESSES OF THE MTAS PROJECT.

24. It is apparent that the MTAS project was rushed, and was implemented despite widespread concerns that it was not yet ready for use. It is also apparent that these concerns were ignored by those in a position of power, presumably for political expediency.

OVERALL DESIGN OF THE SELECTION PROCESS

25. In previous years, individual Trusts and training programs had recruited autonomously at different times in the year. Successful applicants who attended for interview were offered the job on the day of the interview, and were expected to accept or decline. Unsuccessful candidates were then able to apply for other jobs as they became available. Under MMC all jobs were recruited and appointed to simultaneously. This could have resulted in each applicant applying for large numbers of posts, and so a restriction on applications was introduced. Each candidate was limited to apply to up to 4 'Units of Application' (UoA), which they then ranked in order of preference.

26. Each UoA covered a much larger part of the country than in previous years. For example, applicants could apply for the whole of Scotland, or for a 'London' program which included all of North London, South London, Kent Sussex Surrey and parts of the East of England Deanery. Candidates would have little control over where in this large area they were posted. This has been very tough for individuals given jobs far from home in the larger UoAs, and we consider it unreasonable to expect doctors to apply for jobs without knowing where they might be working.

27. The Preferencing process whereby applications were considered for different jobs simultaneously was conceptually flawed. It was likely to prevent good applicants from being considered for posts because they were 'crowded out' by the very strong candidates who would receive four interviews.

a. Since the strong candidates would have gained more interviews than weaker ones, interview panels would have gained the false impression that they had attracted a strong field of applicants; there is good evidence that this occurred in the less popular UoAs exactly as predicted.

b. Less strong candidates would be denied any interviews and less popular posts would remain unfilled. Bizarrely, unfilled posts and unplaced doctors could arise simultaneously.

28. SHO Contracts of employment were prematurely terminated to facilitate the introduction of MMC. Doctors who had been appointed (sometimes against stiff

opposition) into SHO posts were effectively forced to reapply for their own jobs. Some doctors were unsuccessful.

SHORTLISTING AND INTERVIEWING

29. Questions on the application form, and the scoring system, made use of criteria which had been designed by the Work Psychology Partnership. The WPP had been given incorrect information regarding the likely levels of competition for jobs, and they designed the selection process solely for use at the most junior level. In the event, the same selection questions were used at all levels. The scoring did not give sufficient weight to academic achievement and past experience, and was a test of aptitude rather than skill, which consultants found difficult to mark consistently. The system had not been validated for selection into specialty training on this scale.

30. Justice Goldring summarised "A***s it seems to me, the evidence as a whole suggests fundamentally that even as envisaged, and apparently the product of wide consultation, the shortlisting process was flawed. The application form was unreliable as a measure of ability. It resulted in able candidates not being shortlisted when they should have been and less able candidates being shortlisted when they should not have been." (***para 74).

31. Midway through recruitment, the rules were changed. The Douglas review, set up to address the unfairness and problems with the original shortlisting, made two important changes.

a. They advised that all interviews should be informed by the use of CVs, so as 'to strengthen the interview process. This meant that applicants who had already been interviewed were been disadvantaged in comparison to those interviewed later.

b. They also insisted that all candidates should have at least one guaranteed interview, regardless of their shortlisting scores. This decision can be criticised on the following grounds:-

    i. The original interviews were not disallowed. A good candidate, who deserved 4 interviews, would still only receive one. Yet a weak applicant may have already had 4 interviews placing him at a considerable advantage.

    ii. It would be difficult for interview panels to maintain consistency in scoring between the original interviews and the later 1b "guaranteed interviews'. These would be held at a different time with a different panel. The interviewers would have preconceived ideas about this cohort of applicants.

32. Following the announcement of the guaranteed interview scheme, both the National Director of MMC and the National Clinical Advisor to MMC resigned their posts. Alan Crockard acknowledged that "***the overriding message coming back from the profession is that it has lost confidence in the current recruitment system***". Shelley Heard confessed that "***I find myself able to***

support few of the decisions that the Review Group has taken since they undermine principles which are at the core of MMC".

COMPUTER AND OTHER FAILURES OF DUE PROCESS

33. There were numerous reports of handling errors by the computer system, given by both candidates and Deanery staff/assessors. This included reports of applications where the preferencing had spontaneously changed, eligibilities changed, candidates invited to interviews which they had already been to, lost applications and other errors. In a report by Prof Steve Field, Regional Postgraduate Dean for West Midlands it was stated that there had been, "***Countless problems with data loss - we lost over 1300 applications on the day before the closing date and had many separate episodes of data loss - candidates also appeared on the screen unannounced during the short listing period! - As a consequence, the staff have no confidence in the system.***"

34. Consultant recruiters witnessed many other failures of due process. For example, some forms were not scored by all panellists, or were scored in a great rush, there were inconsistent applications of standards and recruitment panels were improperly constituted. There were panels who resigned in protest; others threatened to follow suit. To dissuade them from doing this, Deans promised that Round 1 would only fill 'the very best candidates' leaving substantial opportunities available in Round 2. This promise was reneged on, with up to 90% of posts in some specialties being filled in Round 1.

35. Applicants who used tried to ascertain how their application had been scored by a Data Protection Act enquiry were blocked from so doing. The Department of Health claimed that MTAS was an examination[5] and therefore scores could not be divulged.

36. There were two security breaches, described by the Secretary of State as "utterly deplorable". On one occasion, an unprotected Excel spreadsheet containing the full application forms was placed in a publicly accessible folder. The risks of placing such highly confidential data into a publicly accessible area should have been recognised by anyone with a basic understanding of computer security. A second security breach came to light the following day, whereby visitors to the website could access other candidates' messages on the website messaging facility.

37. The evidence from Methods Consulting, who ran the computer system, suggests that in the early stages the technical performance of MTAS was within agreed limits. However they had expected that key inputs - such as the application form questions, person specifications, list of specialties and UoAs – would be provided to them in good time to be built into the system and tested. None of these inputs were finalised on time -

[5] Had MTAS truly been an examination it should have been considered by the PMETB Assessments Committee.

changes to the application form were being made in January, for example. In addition there were a considerable number of late and unplanned changes which distracted development effort, such as the reconfiguration of UoAs while the round was open for applications. As a consequence the development work was delayed and testing time squeezed.

MATCHING AND ALLOCATIONS TO JOBS

38. The Matching Algorithm in MTAS did not give the results that were expected and was abandoned. This is the part of MTAS that allocated individual applicants to their highest-ranking job offer. It was euphemistically described at the judicial review as being a "Work in progress". It is astonishing that MTAS went live before the most mission-critical component had been properly tested and debugged.

39. This failure, which came to light in late April, meant that there was no central process whereby the various job offers could be coordinated. Instead of the ordered and proper issuing of jobs that MTAS had promised, UoAs were forced to enter into a free-for-all., which resulted in candidates being offered jobs in a random order, rather than in the ranking that they had expressed.

40. Doctors were hastily placed in jobs that were not their first preference. They were pressurised into accepting these jobs, even when their first-choice job became available later, by being given a short time to accept or decline, no opportunity to change their minds and the threat of GMC referral if they withdrew.

REMEDY'S OPPOSTION TO MTAS AND MMC

41. On March 17th 2007 RemedyUK organised protest marches against MMC and MTAS in London and Glasgow. These were attended by 12,000 people; an unprecedented number. This gives an indication of the general opposition amongst doctors to the new scheme.

42. RemedyUK sought judicial review of MTAS. The case was heard by Justice Goldring in the High Court of Justice Administrative Court on 22nd May 2007.

a. In summary, the grounds for the case were as follows. MTAS was unfair, both in its original conception and as a result of the modifications introduced by the Douglas Review (Modified MTAS). These unfairnesses amounted to an abuse of power. There were two possible outcomes that were sought if the judicial review had been successful – one was a complete re-run of the process. The alternative offered was that the process should stand, but that all appointments that were made were to Temporary Training Posts with short tenure. This would have permitted hospital

posts to be filled in time for the August 1st deadline, but would have allowed those unsuccessful to compete in the near future under a fair system.

b. Whilst acknowledging that there were conspicuous unfairnesses in MTAS, which were recognised as having 'disastrous consequences' the judicial review was rejected for the following groups of reasons:-

   i. The application for judicial review was actively opposed by the BMA, the doctors' Trade Union.

   ii. The judicial review challenged the Douglas review, rather than the whole of MTAS/MMC. The Douglas review had the necessary expertise and representation to reach their decision, and had reached a decision which was rational given the circumstances.

   iii. It would not be appropriate to 'don the garb of policy maker'.

c. In his summing up, the judge suggested that given the circumstances a substantial number of posts should be held back fro Round 2 so that those unsuccessful could be considered. As discussed in paragraph 34, this advice was not heeded.

FLEXIBILITY OF THE WORKFORCE AND MANPOWER PLANNING

THE NUMBER OF DOCTORS IN THE UK

43. In March 2007 the Fourth Report from the Health Committee on Workforce Planning reported that ***"There has been a disastrous failure of workforce planning".*** The UK is not unique in having such difficulties. The development of Foundation Trusts is likely to make workforce planning harder in the future.

44. In 1999, concerns were expressed about the low number of doctors in the UK, which stood at 1.7 per 1000 head of population. This was the lowest figure in Europe; the average number was 3.4 per 1000. A contemporary study[6] correlated this ratio with mortality rates. The NHS Plan aimed to reduce the reliance on doctors from abroad, and sought to create. A temporary and short-term expansion of recruitment of foreign doctors was necessary to facilitate this.

45. An increase in the supply of doctors was achieved by:-

[6] BMJ 1999;318:1515-1520 (5 June).

a. Increase in Medical School size/output. Over a 10 year period the number of British medical students has doubled: 3949 qualified in 1997; by 2005 7830 students entered medical school.

b. Increase in non-UK doctors. The number of doctors recruited from outside UK outstripped those graduating from the UK after 2000. This is demonstrated by the following figures:-

   i. Between 2002 and 2005 there were 60,000 registrations with the GMC. Of these, 31% were UK graduates, 16% were EU graduates and 53% were non-EU graduates.

   ii. The number of non-EU doctors has been increased[7].

Year	1999	2000	2001	2002	2003	2004	2005
UK	72.4	72.2	71.9	70.5	69.5	67.8	66.4
EU	5.6	5.4	5.4	5.5	5.5	5.6	5.7
Non-EU	22	22.4	22.7	24	25	26.7	27.8

46. Historically there have always been swings in medical manpower, and the peaks and troughs have been levelled by recruiting doctors from abroad often to fill jobs that are unpopular or difficult to recruit into. It appears that the Department of Health felt unthreatened by the short-term oversupply that it created, believing that they could easily discard tens of thousands of doctors recruited from overseas at will when they became surplus to requirements. This was both a cynical and false assumption. The government attempt to limit immigration of doctors from outside the EU was challenged by BAPIO in a judicial review; this is now awaiting appeal. The number of EU doctors wishing to work in this country was also underestimated.

47. Sir Liam Donaldson, questioned by the HSC[8] on oversupply of doctors stated his position clearly three times: ***"My own view is that I do not really accept the assessment that there is an oversupply of doctors."…"We are still behind and I do not see ourselves as producing an excess of doctors at all"….“We have to evaluate the need specialty by specialty, but on the whole, given the position internationally, the trends in the burden of disease, the growth of technology, the feminisation of the workforce, I think we shall need more doctors."***

[7] Department of Health figures (Fourth Report of the Health Committee session 2006-7)
[8] Minutes of Evidence" (from 12th May 2006) Health Committee (Published 15th March 2007)

THE NUMBER OF DOCTORS IN TRAINING

48. Doctors in training make a significant contribution to the service.

49. In order to plan the number of doctors-in-training that are required, there are two basic models which could be adopted. Whichever model is adopted, the end-result may be either a shortage or surplus, since the time scale between implementing and realising change is over 10 years, and unanticipated events can arise during this time.

50. These two models are:-

i. An estimate is made of the predicted number of consultants and specialists that will be needed in the future, taking into account factors such as predicted retirements, international movement and changes in the future requirements for consultants/specialists. The number of training posts is then adjusted so as to satisfy these requirements, possibly with a small surplus so as to ensure competition and to compensate for any wastage.

ii. The number of junior doctors necessary to maintain the present or predicted service levels (and especially on-call rotas) can be estimated. This number will then determine the number of future trained doctors. Any surplus production of consultants/specialists will result in a cohort of fully trained specialists with no future career in this country.

51. The second model seems to have been largely adopted by MMC, which has given the larger number of training posts. The number of training posts has been further increased by:-

i. Pressure to maximise the number of training posts created; some stand-alone trust-grade jobs were incorporated into training programs.

ii. The demands of the New Deal and the Working Time Directive resulted in an increased number of junior doctors in order to satisfy service requirements. Further reduction in hours may increase this number.

52. Modernising Medical Careers was not directly responsible for the issues described above, which are determined by national and international pressures. But it exacerbated the problem in the following ways:-

a. The offer of a Run-through post to a doctor makes a commitment to them for the full duration of training. This makes it harder to fine-tune the numbers over a short time period.

b. Flexibility in the design of Training Programs has already been discussed in paragraph 11 above. There is an inherent conflict between flexibility and security. A rigid system such as MMC has provided job security at the expense of inflexibility.

THE SUBCONSULTANT GRADE

53. We are now training more specialists in this country than we are likely to be able to employ as Consultants. The development of a pre-Consultant grade seems inevitable.

54. Terminology in this field is confusing and emotive, and there is a stigma attached to the phrase 'subconsultant'. We suggest the term pre-Consultant is more appropriate. This grade ***de facto*** exists as the 'Locum Consultant'; a post which provides significant career development for doctors who have completed their training. This grade should be reviewed. Postholders should have some degree of tenure, and clear terms and conditions of employment. Some flexibility in job plan would be appropriate, and there should be adequate CPD allowance.

55. Development of this grade should reflect the changing nature of the population of doctors, especially the changing percentage of women in medicine. It seems likely that there will be an increasing demand from doctors to be employed less than full time or flexibly.

WHO WAS RESPONSIBLE FOR MMC AND MTAS

56. One of the key roles for this Select Inquiry is to determine what went wrong, and how this can be prevented from happening again. The Tooke Report suggests that the failure of MMC cannot be blamed on any one person or body, because many bodies were involved. Had the project succeeded we could expect those taking major roles to have put themselves forward for commendations and awards. Instead the project has been a failure, and although the National Director and his deputy offered their resignations, other key players remain in post.

57. MMC was the brainchild of the Chief Medical Officer, and he was responsible for its conception. The BMA has repeatedly called for his resignation.

58. Although many different bodies and agencies were involved, MMC was largely driven by the Department of Health. There is good evidence that they consulted with other bodies but that the results of these consultations were not always heeded. The complex structure of the project made accountability difficult to ascertain. The MMC Board claim to have been actively distanced from involvement in MTAS by the Department of Health.

59. CoPMED were given operational responsibility for MTAS. As 2007 approached it became apparent that MTAS may not be ready in time for the launch; the 331 Gateway

Review gave it a red status. It is unclear why CoPMED did not call for a delay, especially in view of the subsequent failure of the MTAS Matching Algorithm.

60. The Deanery HR staff were presented with a Herculean task, which was almost impossible to achieve given the resources made available to them, and they largely coped very well.

61. NHS Consultants spent a lot of time shortlisting and interviewing on behalf of the Deaneries. Some of this was done in weekends and during annual leave, especially over February half-term holiday. Many of them found this frustrating and an inefficient use of their time. The relationship between Deaneries and these NHS Consultants, and lines of accountability, needs to be more closely defined.

62. PMETB are one of the regulators of Medical Education. They were intimately involved in the design of MTAS. On 25th August 2006, it was presented to them by Sarah Thomas (CoPMED) and Fiona Patterson and Maura Kerrin (Work Psychology Partnership). On 21st September Mark Dexter, PMETB Head of Policy, wrote to thank them. In his letter he wrote:- "***The overarching strategy outlined broadly meets the relevant sections of PMETB Generic Standards for Training (Domain 4), including the Principles for Entry to Specialist Training set in the context of the governing legislation and our duty to the service – covered in The General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003"*** He asked for further details, and informed them that PMETB "***will wish to revisit and review the operation of the new system, once it has been established, against our Generic Standards for Training including the Principles for Entry to Specialist Training and in the context of our statutory responsibilities."***

63. Further evidence of PMETBs involvement came to light in evidence given to the judicial review by Nic Greenfield, who gave evidence that " ***the change in culture to a competency based system … was instigated by PMETB".*** He also gave evidence that PMETB had laid down specific requirements regarding the composition of appointments panels.

64. PMETB has issued Generic Standards for Training, which were intended to ensure that entry into Specialty Training was managed by an 'open fair and effective' recruitment system. Remedy has been unable to determine whether or not, in the opinion of PMETB, MTAS was indeed open fair and effective. We contend that it was not. If MTAS fails this generic standard, we submit that PMETB should not have permitted doctors appointed through MTAS2007 to enter Runthrough training.