

**REVIEW OF RECRUITMENT INTO
SPECIALTY TRAINING
IN NORTHERN IRELAND**

September 2007

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EXECUTIVE SUMMARY AND RECOMMENDATIONS

- 1.1 This Review was commissioned by Michael McGimpsey MLA, Minister for Health, Social Services and Public Safety, on 22nd May 2007. This was a time of controversy and concern regarding arrangements for the recruitment process for specialty medical training in Northern Ireland and followed a review of the recruitment process in the NHS instigated in March 2007 by Patricia Hewitt, Secretary of State for Health. The timescale for completion of the review over the summer has been extremely challenging but necessary as there is a real urgency in ensuring that we learn the lessons from our recent experience and incorporate them as far as possible in the arrangements for 2008, which will commence shortly, and beyond.
- 1.2 The Terms of Reference of the Review are shown in **Appendix 1**. The Review Team (**Appendix 2**) undertook a series of meetings with key stakeholders, identified as:
 - DHSSPS
 - Health and Social Care Employers
 - Junior Doctors
 - NIMDTA
 - BMA (NI Junior Doctors Committee & Consultants Committee)
 - Northern Ireland Medics
 - Chairs and Directors of Training Committees
- 1.3 At meetings, a series of core questions were put to stakeholders and evidence gathered from their responses. From this and other material collected in the course of the Review the Team made its conclusions about the recruitment process in Northern Ireland and developed a number of recommendations.
- 1.4 In general, the 2007 recruitment process has succeeded in ensuring that doctors with sufficient skills and experience were employed by August 2007 and the Review has received no evidence of any detrimental impact on patient care. In addition, there has been no significant unemployment of junior doctors. Nonetheless, significant flaws in the process have also been identified. These relate mainly to the on-line recruitment system, the application form and the shortlisting process used this year. There were also notable problems relating to how information was communicated to candidates during the recruitment exercise.
- 1.5 The Review Team also identified what went well in the recruitment process. Evidence from the key stakeholders showed that trainees were in favour of an on-line application system, although it needs to be robust and fit for purpose. The three station method of interviewing was welcomed by junior doctors in training. It was also noted that the initial shortlisting exercise had, with the exception of emergency medicine and

core medical training, accurately identified those who were more successful at interview.

- 1.6 It was also the overwhelming view of those we met that Northern Ireland should remain part of the national recruitment system. While the 2008 recruitment exercise will need to be managed locally and there will be changes to the application stage in the process, both junior doctors and Training Committees were in agreement that Northern Ireland should be closely aligned to a national recruitment framework.
- 1.7 The Review Team has therefore carefully considered the information and data collected and made of number of **recommendations** to the Minister of Health, Social Services and Public Safety. These are set out below;

RECRUITMENT

- It is the view of the Review Team that there are significant risks associated with any delay in finalising decisions on the process for recruitment in 2008, and that the Minister should proceed on the basis of the recommendations contained in this Report as a matter of urgency. It is therefore critical that decisions are made as soon as possible, and by the end of October at the latest, so that preparations can be initiated for the process next year. For 2009 and beyond, the Department, in liaison with NIMDTA, should build on this foundation to further consolidate the local process for recruitment to specialty medical training having due regard to developments elsewhere in the UK.

Person Specification

- Person specifications should give greater weight to previous experience and should be specialty specific.
- While the limit of no more than 12 months training in a specialty for entry to ST1 should remain, there should be no maximum period of experience for applications to ST2.
- Candidates who are eligible to apply for a position at a higher level should not be considered for a lower level within a specialty.
- Transferable competencies need to be further considered and consistency is required in how overseas experience and experience in another specialty is valued and weighted.
- The position of international medical graduates requires further clarification and should recognise the continued reliance of the service on these individuals.

Application Forms

- Application Forms need to be specialty specific and designed in a way that is consistent with attracting a pool of suitably qualified candidates.
- On-line applications are supported in principle, but the technology must be robust and a model such as HPSSjobs.com which has a credible track record should be considered.
- For 2008, application forms should be CV based. In the longer term, the opportunity should be taken to develop appropriate competency based questions for future recruitment exercises.
- Shortlisting criteria should be developed by each specialty and be compatible with national standards and the process should continue to be anonymised as far as possible.
- The application process should be compatible with the national framework. Consideration should be given to allowing each trainee a total of four units of application or implementing the option of concurrent consideration of the first two preferences, followed consecutively by consideration of the third and fourth preferences as outlined in the recent consultative proposals issued by the Department of Health, England.

Interviews

- Questions at interview should be designed to draw out relevant experience and the process should continue to allow for the evaluation of portfolios.

Communication and Timing

- Having regard to the desirability of an integrated national timescale, synchronisation of the timing of the critical elements of the recruitment process with England, Scotland and Wales is important and should be maintained.
- The Department should, as a matter of urgency, initiate discussion with NIMDTA to ensure that trained staff are in post for the next recruitment round and take whatever steps are necessary to improve communication before and during the process for 2008.
- There should be more time in the process for NIMDTA to ensure effective communication with trainees prior to the commencement of the recruitment process. For 2008, NIMDTA should make particular effort to develop and implement a comprehensive communication plan which will restore confidence in the process.

- The Department should work with NIMDTA to ensure that, prior to and during future recruitment, sufficient trained staff are available to provide a more responsive and personalised response to queries from trainees.
- There should be sufficient time in the process for the completion of application forms.

Selection to General Practice

- Recruitment for GP training should continue to be treated separately, but consideration needs to be given to co-ordinating the timing of offers with that of specialty recruitment. There would be merit in allocating the choice of GP rotation by rank rather than timing of acceptance.

SPECIALTY TRAINING

- In addressing this part of the Terms of Reference, the Review Team were conscious of the work of the Tooke review and one of the consistent messages from all key stakeholders is that the future training of medical staff in NI must continue to operate in, and be fully compatible with, a national framework. This is considered essential to ensure that professional standards are maintained, that there is an adequate pool of suitably qualified trainees throughout the UK and that local trainees are not disadvantaged in respect of national and international recruitment. The following views were therefore relayed to Professor Tooke in the course of the Review and a copy of the Report has been forwarded to him to ensure that our findings are considered as part of his Review.
- While there should be appropriate flexibility to respond to local issues, training of medical staff in NI must continue to operate in, and be fully compatible with, a national framework reflecting the outcome of the current review of Modernising Medical Careers being undertaken by Professor Sir John Tooke.
- There needs to be greater flexibility in career progression, both within specialty training and for those who are initially unsuccessful in their application.
- While run through training works well for some specialties, in others consideration should be given to reintroducing a selection process at ST2. This may require honouring the commitment to those trainees who successfully applied for run through training in 2007.

MEDICAL WORKFORCE PLANNING

- Further consideration should be given to the long-term viability of FTSTA posts, and the need to address the lack of confidence felt by key stakeholders that they offer a realistic pathway to specialty training. It is important that the number of such posts is an integral part of, and consistent with, the overall workforce strategy.
- The Department commissioned a review of Medical Workforce Planning in September 2006 and should continue to actively pursue implementation of the recommendations contained in the Report. **(Appendix 6)**.
- The Department should continue to commission external 3 yearly reviews of medical workforce planning and in the short-term should engage with key stakeholders to determine if further improvements can be made to improve confidence in the workforce planning model and ensure that it reflects the future needs of the service.
- Some trainees felt that if they undertook undergraduate training in NI, they should be able to plan their career in NI. This was never the case and is unrealistic and this needs to be communicated to undergraduates in the Faculty of Medicine and Dentistry, QUB.
- The Department should seek to identify the investment required over the next three years **(Appendix 7)** to increase the number of STR trainee posts in line with service requirements.
- There is an urgent need for the Department to re-examine with HSC bodies how the service component of junior training posts in Surgery and Obstetrics and Gynaecology can be delivered so that the numbers entering these specialties can be more aligned with training opportunities and service requirements.
- The Department, together with the Faculty of Medicine and Dentistry, QUB should review current arrangements for careers guidance both during undergraduate and post-graduate training and develop and implement an action plan as appropriate. This should include the routine provision of information on historical competition ratios and current and projected workforce requirements which could also be included on the NIMDTA website.

THE WAY FORWARD

- 1.8 The Review Team has considered the process used this year to recruit into specialty training in some detail. A wide range of recommendations have been made with the aim of charting a local way forward for 2008 and beyond, and to help restore the confidence of the medical profession in the system. While a number of the recommendations will take some time to put in place and need to take account of any national reforms to

the process that may result from the Tooke Review, a number can be implemented straightaway.

On 12 September 2007, in the latter stages of this Review, the Department of Health, England (DoH) issued consultative proposals for changes to MMC England processes in 2008 with responses required by 25 September 2007. The proposals were in two parts, the first relating to recruitment and selection and the second to flexibilities in education and training. It is proposed that the Programme Board will submit recommendations to Ministers on 1 October for decision by mid-October. The DoH then anticipates planning, design and testing from October to December with information and guidance on 2008 processes issued in November/December and recruitment commencing in January 2008.

- 1.9 The proposals in respect of the recruitment were similar in many respects to the recommendations contained in this Review, but will be subject to further discussion before final decisions are made. Having considered the options proposed for next year, and other developments in the remainder of the UK, we see no reason to change our recommendations.
- 1.10 It is the view of the Review Team that there are significant risks associated with any delay in finalising decisions on the process for recruitment in 2008 and that the Minister should proceed on the basis of the recommendations contained in this Report as a matter of urgency. It is therefore critical that decisions are made as soon as possible, and by the end of October at the latest, so that preparations can be initiated for the process next year. For 2009 and beyond, the Department, in liaison with NIMDTA, should build on this foundation to further consolidate the local process for recruitment to specialty medical training having due regard to developments elsewhere in the UK.
- 1.11 It is the Review Team's expectation that the 2008 process will take the following route:
 - ❖ Recruitment into specialty training will begin in November 2007 and will be managed locally by NIMDTA
 - ❖ NIMDTA will take steps to communicate the revised process and timescales involved to all trainees
 - ❖ To ensure that local junior doctors can avail of opportunities to train outside Northern Ireland, the recruitment process will remain part of the national framework in relation to timescales
 - ❖ Doctors in training will use a locally designed application form that is compatible with those used elsewhere in the UK
 - ❖ Shortlisting will remain in place and the interview process used this year will be repeated in 2008.

BACKGROUND TO THE REVIEW

- 2.1 Reform of postgraduate medical training began with changes in Higher Specialist Training introduced by the then Chief Medical Officer (England), Sir Kenneth Calman in 1993. His successor, Sir Liam Donaldson, continued the process with the publication of a consultation paper, *Unfinished Business*, in 2002. The response to this paper was a series of far reaching reforms termed 'Modernising Medical Careers' (MMC). The first of these reforms was the replacement of the Pre-Registration House Officer year with a two year Foundation Programme. This consisted of a series of placements in a variety of specialties and healthcare settings with specific learning objectives for each stage. The process of reform was to be completed by the development of programmes for hospital specialist training and for general practice. The posts used for this training would replace the existing Senior House Officer (SHO) and Registrar posts. In addition to those posts required for run through specialist training, some posts would be available for Fixed Term Specialist Training (FTSTA). Non Consultant Career Grade posts would provide for service in addition to that provided by trainees. The model proposed is illustrated in **Appendix 4**.
- 2.2 In March 2002 in recognition of the growing dissatisfaction with the recruitment process, the Department of Health, Social Services and Public Safety (DHSSPS) commissioned a review of the recruitment processes in Northern Ireland with a view to rationalisation. This Review Group concluded that the existing processes were costly for the health service, junior doctors and senior medical staff, that they ultimately impacted on patient care, and that maintaining the status quo was unacceptable and high risk. It recommended the introduction of a centralised selection and recruitment system for all grades of junior doctor. This was then taken forward at a national level under the Modernising Medical Career reforms. Recruitment to Foundation Posts in 2005 in Northern Ireland and in seven other Deaneries involved a centralised application process (MDAP). This centralised selection and recruitment system at foundation level was successful and was adopted nationally in 2006. Given the success of the MDAP system it was expected that a similar centralised application and selection system could be used to recruit all grades of junior doctor. Subsequently, Northern Ireland became part of the Medical Training Application Service (MTAS), a UK co-ordinated on-line electronic application process.
- 2.3 MTAS initially opened on 25th October 2006 and closed on 5th December 2006 for the recruitment of medical graduates to the August 2007 Foundation Programme, which was successful. It then opened for recruitment into specialist training programmes and fixed term specialty training appointments (FTSTAs) on 22nd January 2007. Applicants were able to apply for up to four training opportunities. All vacancies were advertised on the MTAS website and more detailed information was available to applicants in Northern Ireland on the Northern Ireland Medical and Dental Training Agency (NIMDTA) website. Applicants

were invited to register on MTAS and enrol in the recruitment round and were requested to submit their application before the deadline of 4th February 2007. On 5th March 2007 interviews for Round 1 commenced in Northern Ireland and were due to finish on 4th April 2007. Whilst application was on a UK-wide basis, interviews took place locally via NIMDTA.

2.4 Concerns across the UK regarding the recruitment process began to arise in late February when the results of short listing became apparent. These were in two main forms:

- applicants expressing disappointment at not being called for interview; and
- consultants expressing doubts over the validity of eligibility and short listing criteria.

These concerns became so widespread that a review of the recruitment process was instigated on 5th March 2007 by Patricia Hewitt, Secretary of State for Health. The Review reported at the end of March and its findings indicated that problems with the recruitment process appeared largely confined to short listing. On 15th May Patricia Hewitt further requested that an Independent Inquiry be carried out regarding the MMC. This has been taken forward by Professor Sir John Tooke.

2.5 Locally the options available were considered at a meeting on 3rd April with the Chief Medical Officer (CMO), senior NIMDTA staff, Chairmen of specialty training committees and Training Programme Directors. In order to ensure that the needs of the health service were met and that junior doctors were employed on 1st August 2007, it was agreed to invite to interview all eligible candidates who had applied for a post in Northern Ireland. On 5th April the CMO wrote to all applicants to specialty training in Northern Ireland advising them of the NIMDTA process for the extended round of interviews and of the updated timetable, and MTAS was at this time effectively abandoned in Northern Ireland. However, concerns were raised by the NI Junior Doctors' Committee of the BMA and Northern Irish Medics, the latter proposing that the process for recruiting doctors be abandoned and the implementation of MMC postponed until a review of MMC was undertaken. Nationally MTAS was taken offline on 26th April whilst a full security review took place. NIMDTA remained committed to ensuring that interviews in Northern Ireland went ahead and these were completed by 31st May with a deadline of 10th June to accept or decline offers.

2.6 These issues caused controversy and significant ongoing local and national media attention. On 22nd May during a relevant Assembly debate the Minister for Health in Northern Ireland, Michael McGimpsey, announced a local review of the recruitment process to specialty training. Details of the Terms of Reference and membership of the Review Team are attached at **Appendices 1 and 2**.

2.7 The Review has duly analysed the difficulties experienced, taken account of the lessons learned and charted a local approach to the way forward. It has also contributed to the independent national review of the MMC. However, it should be borne in mind that any issues regarding short-term recruitment and unemployment arising from the 2007 recruitment processes and arrangements for the Foundation Post Round in autumn 2007 remain outside the Team's remit.

Methodology

2.8 The Review Team held its first meeting on 25th June 2007. The key stakeholders were identified as:

- DHSSPS;
- Health and Social Care Employers;
- Junior Doctors;
- NIMDTA;
- BMA;
- NI Medics; and
- Chairs and Directors of Training Committees.

2.9 Relevant documentation was sourced and a series of meetings held with key stakeholders. In particular, open meetings were organised with junior medical staff and held in Craigavon, Altnagelvin, Antrim, Ulster and Belfast City hospitals. The meetings addressed the recruitment process in 2007 and the views of participants on potential improvements to the process. There was also discussion on 'Modernising Medical Careers' and workforce planning. Where appropriate, written submissions were requested. As required by the Terms of Reference, account has been taken of relevant developments elsewhere in the UK, and consequently communication has taken place with colleagues in England, Scotland and Wales. Contact was also established with the Tooke Review and Professor Hayes met with Sir John Tooke on 14 September 2007. A copy of this Report has also been forwarded to Professor Tooke.

CONCLUSIONS AND RECOMMENDATIONS

3.1 Having considered the evidence taken at meetings with key stakeholders and other sources of data, the Review Teams' conclusions and recommendations are set out below. For convenience, they are presented under each of the headings within the Terms of Reference

3.2 **Terms of Reference1 – To examine the local recruitment process to specialty medical training in 2007 and its impact on**

- ❖ **Services for patients**
- ❖ **Employers**
- ❖ **Doctors-in-training**
- ❖ **The Northern Ireland Medical and Dental Training Agency (NIMDTA)**

And make recommendations on a local way forward in time for the next recruitment (and in a way that will restore confidence to the system).

Services for Patients

3.3 There was no evidence presented to the Review that services for patients have been, or will be, affected adversely by the difficulties associated with the recruitment process for specialty training in 2007. Training posts have been filled by doctors with sufficient skills and experience.

Employers

3.4 The most important issue for employers is that training posts are filled with suitable candidates and this was the case. However, the 2007 recruitment process was cumbersome, time consuming and expensive in terms of consultant time as the decision to interview all applicants increased consultant involvement in the interview process.

NIMDTA

3.5 It is clear that there was considerable dissatisfaction on the part of some trainees with NIMDTA. However, it is also clear, and was acknowledged in a number of meetings with stakeholders, that to a significant extent many of the difficulties arose from a lack of clarity nationally which persisted well into the recruitment process. Some trainees gave examples of poor communication on the part of NIMDTA both before and during the recruitment process. However, there is also evidence of the very real commitment and personal effort made by staff within NIMDTA to manage the revisions to the process agreed by the CMO in April. Note is also taken of the pressures arising from the timetable imposed for the introduction of MTAS nationally and the lack of clarity in terms of

available information which inevitably impacted on the quality of the whole process and communication with trainees by NIMDTA.

Doctors in Training

- 3.6 It is important to initially note that, based on information supplied by NIMDTA and detailed later in the Report, it is understood that the difficulties in the recruitment process did not result in any significant unemployment for local trainees in 2007. The number of trainees who accepted posts which were not their first preference is not known. A survey to be conducted by the BMA NI Junior Doctors Committee may provide some evidence in this regard. The flexibility we are proposing in the process for 2008 may allow trainees to re-apply for their first choice specialty. It was also clear that those trainees obtaining FTSTA posts did not consider that they offered a pathway to run-through training at a later date. Generally, trainees who met with the Review team also felt the recruitment process to be inefficient and unfair and reported considerable frustration and anxiety, particularly as regards difficulties relating to the application process and communication. For information, the training pathway for doctors is set out in the diagram in **Appendix 4**.
- 3.7 Candidates short-listed initially were invited for interview (Round1A). Following the Douglas review commissioned by the then Secretary of State for Health, and agreement by the CMO, BMA and NIMDTA in April 2007, all remaining eligible candidates were also invited for interview (Round 1B). It is useful to compare the outcome of the interviews in Round 1A and Round 1B and this can be seen in **Appendix 5**.
- 3.8 Apart from core medicine and emergency medicine, interview scores were significantly higher for candidates in Round 1A than in Round 1B. For example, 322 of 971 candidates interviewed in Round 1A were offered Specialty Training posts. Only 46 of 778 candidates interviewed in Round 1B were offered ST posts. Over half of these 46 posts offered were in core medical training. Thus, apart from core medicine and emergency medicine, the shortlisting process successfully identified those candidates most likely to succeed at interview.
- 3.9 Across all specialities, except core medicine and emergency medicine, there were significant correlations between the shortlisting scores and the interview scores. This correlation was particularly evident at the ST3 level, was less marked at the ST2 level and least marked at the ST1 level. The type of application form used is less suited to identifying the abilities of the more junior trainees.
- 3.10 All doctors completing their Foundation Programme in Northern Ireland and who wished to remain in NI had obtained employment.
- 3.11 Set out below are the relevant figures relating to the Foundation Programme:

- 102 trainees were appointed to run-through training programmes
- 39 trainees were appointed to FTSTA posts
- 10 trainees were appointed to Trust grade appointments.
- 14 trainees will continue in the Foundation Programme.

Almost 90% of successful applicants to ST posts were NI trainees. 86% of successful applicants to all training posts (ST & FTSTA) were NI trainees.

RECRUITMENT PROCESS

Person Specification

3.12 These were generic and not related to the requirements of individual specialties. A particular problem arose for more experienced trainees in the SHO grade who did not yet have additional exam qualifications. Candidates required particular qualifications to apply for ST3 posts. Experienced candidates without these qualifications could be excluded from applying for ST2 posts because of the length of their clinical experience. In addition, there were inconsistencies in how overseas experience and relevant experience in other specialties was counted.

3.13 An additional difficulty arose in how international medical graduates were to be treated. Until last year, international medical graduates appointed to training posts were given permit-free training visas. This scheme was changed; doctors without right of residence could work only if no suitable UK or EEA candidate had applied for the job. Such doctors could apply for permission to work through the Highly Skilled Migrant Programme. While clarity in this regard is required, this is subject to further legal consideration.

Recommendations

- 3.14
- Person specifications should give greater weight to previous experience and should be specialty specific.
 - While the limit of no more than 12 months training in a specialty for entry to ST1 should remain, there should be no maximum period of experience for applications to ST2.
 - Candidates who are eligible to apply for a position at a higher level should not be considered for a lower level within a specialty.
 - Transferable competencies need to be further considered and consistency is required in how overseas experience and experience in another specialty is valued and weighted.
 - The position of international medical graduates requires further clarification and should recognise the continued reliance of the service on these individuals.

Application Forms

- 3.15 Trainees felt that insufficient emphasis was placed on their experience and evidence of achievement. The application required scoring of answers to competency based questions in addition to information about their past experiences. Trainees felt the weighting of scores was biased towards the former, discounting information which before would have appeared on a curriculum vitae.
- 3.16 The competency based questions were not specialty specific. This form of questions had been used in selection for training in General Practice for several years, but had been rejected as it had ceased to be sufficiently discriminatory. Trainers scoring application forms identified some evidence of plagiarism. They also felt that if competency based questions were to be continued, they needed to be speciality specific.

Recommendations

- 3.17
- Application Forms need to be specialty specific and designed in a way that is consistent with attracting a pool of suitably qualified candidates.
 - On-line applications are supported in principle, but the technology must be robust and a model such as HPSSjobs.com which has a credible track record should be considered.
 - For 2008, application forms should be CV based. In the longer term, the opportunity should be taken to develop appropriate competency based questions for future recruitment exercises.
 - Shortlisting criteria should be developed by each specialty and be compatible with national standards and the process should continue to be anonymised as far as possible.
 - The application process should be compatible with the national framework. Consideration should be given to allowing each trainee a total of four units of application or implementing the option of concurrent consideration of the first two preferences, followed consecutively by consideration of the third and fourth preferences as outlined in the recent consultative proposals issued by the Department of Health.

Interview

- 3.18 Trainees generally felt that the interview process was satisfactory and an improvement on previous arrangements. The interview format of three stations (portfolio, clinical scenario and questions) had been used for some time for specialist registrar selection. This was the first time such a format was used for selection at more junior levels.

Recommendations

- 3.19 • Questions at interview should be designed to draw out relevant experience and the process should continue to allow for the evaluation of portfolios.

Communication and Timing

3.20 Trainees felt communication both from MTAS and NIMDTA about the application process was poor. NIMDTA provided generic information about the process in a series of meetings. However, many trainees felt they needed individual advice regarding their situation. It was also difficult for NIMDTA to provide consistent information as changes with regard to the process continued to be made nationally. In the perceived information vacuum, information was obtained from other sources, some of which was incorrect, and generated confusion and anxiety. Trainees found advice and information from NIMDTA during and after the selection process difficult to access and would have preferred a more personal response. Trainees had 2 weeks to complete the application form. Some felt that this was insufficient and those who were completing a week of night-time work felt significantly disadvantaged.

Recommendations

- 3.21 • Having regard to the desirability of an integrated national timetable, synchronisation of the timing of the critical elements of the recruitment process with England, Scotland and Wales is important and should be maintained.
- The Department should, as a matter of urgency, initiate discussion with NIMDTA to ensure that trained staff are in post for the next recruitment round and take whatever steps are necessary to improve communication before and during the process for 2008.
 - There should be more time in the process for NIMDTA to ensure effective communication with trainees prior to the commencement of the recruitment process. For 2008, NIMDTA should make particular effort to develop and implement a comprehensive communication plan which will restore confidence in the process.
 - The Department should work with NIMDTA to ensure that, prior to and during future recruitment sufficient trained staff are available to provide a more responsive and personalised response to queries from trainees.
 - There should be sufficient time in the process for the completion of application forms.

SELECTION TO GENERAL PRACTICE

- 3.22 The selection process for General Practice Training was different from that into training in hospital specialities.
- 3.23 Candidates first sat an invigilated written examination. This was a national examination taken at centres across the UK at a common time. The top 85% of candidates had a further selection process which involved interview and practical assessments. The results of the process were largely satisfactory and are shown in **Appendix 6**.
- 3.24 Some trainees describe being advised to demonstrate their commitment to the specialty by choosing only General Practice programmes for their four options. If they were unsuccessful in the initial examination they were left with no other options.
- 3.25 In addition there were issues concerning the process for making offers. The results of the GP selection process were also available before the results of the hospital specialty selection process. Trainees were informed that choice of training rotation would depend on when they accepted the offer of GP training. Thus, some felt under pressure to accept a training offer in General Practice before the results of the hospital selection process were available.

Recommendations

- 3.26 • Recruitment for GP training should continue to be treated separately, but consideration needs to be given to the co-ordinating the timing of offers with that of specialty recruitment. There would be merit in allocating the choice of GP rotation by rank rather than timing of acceptance.
- 3.27 **Terms of Reference 2 - To address whether the new arrangements for speciality training offer adequate flexibility to adapt to service needs and the career aspirations of junior doctors and in particular:**
- ❖ **The ability of applicants to enter specialty training following an initial unsuccessful attempt at gaining a 'run-through' programme.**
- 3.28 In addressing this part of the Terms of Reference, the Review Team were conscious of the work of the Tooke review and one of the consistent messages from all key stakeholders is that the future training of medical staff in NI must continue to operate in, and be fully compatible with, a national framework. This is considered essential to ensure that professional standards are maintained, that there is an adequate pool of suitably qualified trainees throughout the UK and that local trainees are not disadvantaged in respect of national and international recruitment. The following views were therefore relayed to Professor Tooke in the

course of the Review and a copy of the Report has been forwarded to him to ensure that our findings are considered as part of his Review.

3.29 Trainees and trainers want to be part of a national system.

The aim of 'Unfinished Business' was to improve SHO training so that it was trainee centred, competence assured, service based, quality assured, flexible, coached, structured and streamlined. It did not involve early selection of specialty or the concept of run-through training. In the pursuit of the latter, it is perceived by trainees that flexibility has been lost. This is of particular concern given the anticipated change in the profile of the medical workforce, with higher numbers of trainees seeking part-time employment (the Department's review of medical workforce planning in September 2006 reported feedback from the Faculty of Medicine, QUB that 'both male and female students are seeking to develop their career in a non full-time capacity'). Employing organisations are also concerned to ensure sufficient flexibility in training, employment and terms and conditions to meet obligations under the NI Act 1998 (Section 75) and emerging employment legislation relating to the work/life balance.

3.30 Trainees described being 'locked-out' of (i.e. those who were unsuccessful or obtained FTSTA posts) or 'locked-into' (i.e. those who were successful but remained unsure of their final choice of specialty) run-through training. They believed that there were not opportunities for unconventional career pathways.

3.31 FTSTA posts have little credibility with either trainees or trainers and are not seen as a viable pathway into specialty training. If the position does not change, it is anticipated that there will be few entry points above ST1 in future. Therefore, it seems that an FTSTA, by disqualifying the holder from entry into ST1 in that specialty in the future, in fact worsens their chances of a progressive career in that specialty and will only lead to a career in the service grades. This perception risks re-creating the 'lost tribe' sobriquet previously ascribed to long-term SHOs. As a result, there is little confidence in the stability and longevity of the new arrangements as it is felt that further significant changes are inevitable.

3.32 As regards MMC, Trainees liked the structure, a defined curriculum, regular assessments with feedback, longer contracts and greater continuity. They disliked having to make their choice of specialty too early and the lack of flexibility. Trainers, particularly in Medicine, Surgery and Obstetrics and Gynaecology shared these concerns.

Recommendations

- 3.33
- While there should be appropriate flexibility to respond to local issues, training of medical staff in NI must continue to operate in, and be fully compatible with, a national framework reflecting the outcome of the current review of Modernising Medical Careers being undertaken by Professor Sir John Tooke.
 - There needs to be greater flexibility in career progression, both within specialty training and for those who are initially unsuccessful in their application.
 - While run through training works well for some specialties, in others consideration should be given to reintroducing a selection process at ST2. This may require honouring the commitment to those trainees who successfully applied for run through training in 2007.
 - Further consideration should be given to the long-term viability of FTSTA posts, and the need to address the lack of confidence felt by key stakeholders that they offer a realistic pathway to specialty training. It is important that the number of such posts is an integral part of, and consistent with, the overall workforce strategy.

3.34 Terms of Reference 3 – To examine local medical workforce data identifying potential surpluses/shortfalls and making recommendations to address the findings.

3.35 The effective and efficient provision of health care depends significantly on accurate workforce planning and recent difficulties in this regard in some cases have been shown to have a dramatic impact on the efficacy and quality of services to patients. However, it is also extremely challenging because of the period of time required for training and the significant number of variables that must be assessed. For example, over a 10 year planning cycle, workforce planning needs to provide for service developments and reconfiguration, changes in the profile and structure of the workforce, changes to EU and UK legislative requirements such as the European Working Time Directive, 1998, the implications of 'Modernising Medical Careers', improvements to quality standards, overseas recruitment, new care pathways and technologies, changes in medical practice or terms and conditions of service, the expectations of trainees etc.

3.36 In his submission to the Review, the Chief Medical Officer 'inter alia' advised that in recent years the Department had commissioned a wider review of the medical workforce on a 3 yearly basis and referred us to a September 2006 Report. This is a helpful and comprehensive document and the Review Team would fully support its recommendations. We believe the following conclusions and recommendations should therefore be taken together with the recommendations of the September 2006 report which are reproduced for convenience in **Appendix 7**.

- 3.37 While acknowledging the undoubted difficulty and complexity of medical workforce planning, a number of stakeholders expressed a lack of confidence in the present system and also concern at the implications of errors in this regard on the service, individual specialties and trainees.
- 3.38 The QUB Medical School produces trainees for the UK and not just NI. Although for several years, NI will still require doctors from overseas to fill all its posts, in the future some doctors trained in NI will need to seek employment elsewhere in the UK.
- 3.39 At present, there is a deficit in the number of senior training posts assessed as necessary to fill the anticipated number of Consultant vacancies over the next three years (**Appendix 8**).
- 3.40 In most specialties, there is a balance between posts at junior level and those at a more senior level in the training programme. In two specialties, Surgery and Obstetrics and Gynaecology, there are excess numbers of posts at junior level.
- 3.41 Trainees highlighted a need to improve the quality of careers guidance available to them both as undergraduates and during post-graduate training including information on workforce planning assumptions. In this respect, the Review noted that the Department have recently funded an Associate Dean in NIMDTA for this purpose.

Recommendations

- 3.42
- The Department commissioned a review of medical workforce planning in September 2006 and should continue to actively pursue implementation of the recommendations contained in the Report (**Appendix 7**).
 - The Department should continue to commission external 3 yearly reviews of medical workforce planning and in the short-term should engage with key stakeholders to determine if further improvements can be made to improve confidence in the workforce planning model and ensure that it reflect the future needs of the service.
 - Some trainees felt that if they undertook undergraduate training in NI, they should be able to plan their career in NI. This was never the case and is unrealistic and this needs to be communicated to undergraduates in the Faculty of Medicine and Dentistry, QUB.
 - The Department should seek to identify the investment required over the next three years (**Appendix 8**) to increase the number of STR trainee posts in line with service requirements.
 - There is an urgent need for the Department to re-examine with HSC bodies how the service component of junior training posts in Surgery

and Obstetrics and Gynaecology can be delivered so that the numbers entering these specialties can be more aligned with training opportunities and service requirements.

- The Department, together with the Faculty of Medicine and Dentistry, QUB should review current arrangements for careers guidance both during undergraduate and post-graduate training and develop and implement an action plan as appropriate. This should include the routine provision of information on historical competition ratios and current and projected workforce requirements which could also be included on the NIMDTA website.

GLOSSARY OF TERMS

BMA	British Medical Association
CMO	Chief Medical Officer
CV	Curriculum Vitae
DHSSPS	Department of Health, Social Services and Public Safety
DoH	Department of Health
EEA	European Economic Area
EU	European Union
FTSTA	Fixed Term Specialty Training Appointment
GP	General Practitioner
HPSS	Health and Personal Social Services
HSC	Health and Social Care
IMG	International Medical Graduate
MDAP	Multi Deanery Appointment Process
MMC	Modernising Medical Careers
MTAS	Medical Training Application Service
NHS	National Health Service
NI	Northern Ireland
NIMDTA	Northern Ireland Medical and Dental Training Agency
QUB	Queens University of Belfast
SHO	Senior House Officer
ST	Specialty Trainee
STR	Specialty Training
UK	United Kingdom

TERMS OF REFERENCE

1. To examine the local recruitment process to specialty medical training in 2007 and its impact on
 - ❖ Services for Patients
 - ❖ Doctors-in-training
 - ❖ Employers
 - ❖ The Northern Ireland Medical and Dental Training Agency (NIMDTA)

And make recommendations on a local way forward in time for the next recruitment (and in a way that will restore confidence to the system).

2. To address whether the new arrangements for specialty training offer adequate flexibility to adapt to service needs and the career aspirations of junior doctors and in particular:
 - ❖ The ability of applicants to enter specialty training following an initial unsuccessful attempt at gaining a 'run-through' programme.
3. To examine local medical workforce data identifying potential surpluses/shortfalls and making recommendations to address the findings.
4. To take account of relevant developments elsewhere in the UK during the period of the review.
5. To provide a report to the Minister of Health by September 2007.

MEMBERSHIP OF REVIEW TEAM

Professor Randal Hayes (Chair)	Adviser to NIMDTA, former physician in Belfast City Hospital
Dr Patrick Loughran	Medical Director, Southern Health and Social Care Trust
Mr Patrick McCartan	Chair, Belfast Health and Social Care Trust
Dr Rajesh Rajendran	Chair, BMA(NI) Junior Doctors' Committee
Mrs Elaine Way	Chief Executive, Western Health and Social Care Trust
Mrs Diane Taylor	Head of Education and Training Unit, Human Resources, DHSSPS

DHSSPS Support:

Mr Bernard Mitchell

Mr Graeme Crawford

DEVELOPMENTS ELSEWHERE IN THE UK DURING THE PERIOD OF THE REVIEW

The Terms of Reference required the Review Team to take account of relevant developments elsewhere in the UK during the period of the Review. In responding to this requirement, the Review sought information from the Chief Medical Officers in England Scotland and Wales and Professor Hayes met with Sir John Tooke on 14 September 2007. The results of these enquiries have been reflected as appropriate in our recommendations and our understanding of the current position is as follows.

The Tooke Review

The Secretary of State commissioned an independent review of 'Modernising Medical Careers' (MMC), chaired by Sir John Tooke to examine the framework and processes underlying MMC and make recommendations to inform any improvements for 2008 and beyond.

The review has been asked to clarify and strengthen the principles underlying MMC, examining the extent to which MMC has engaged the medical profession and make recommendations to ensure that it has the support of the profession in the future. It will also look at the implementation processes underlying MMC and the methods used in selection and recruitment and how MMC can deliver a flexible response and can reflect local needs across the UK as well as safeguarding national standards. The Review has advised that it will issue an interim Report the week commencing 8 October 2007 and a final Report in December 2007.

The review will examine:

- the extent to which MMC has engaged the medical profession and to make recommendations to ensure that it has the support of the profession in the future
- the extent to which implementation to date has met the needs of doctors in training, patients, the service and employers
- the governance structures across the UK that underpin MMC and the inter-governmental working arrangements of the four home countries
- the implementation processes underlying MMC and the methods used in selection and recruitment
- factors relating to the wider professional, regulatory, workforce and service environment which may have impacted on the programme.

It will also consider specific issues that have been the subject of stakeholder concern, including:

- the extent and quality of stakeholder engagement with the programme
- the effective engagement of doctors in training and the profession as a whole in MMC and the development of a proper understanding of its aims and benefits
- the appropriate relationship between the acquisition of competence and the pursuit of excellence
- the assessment methodologies used in the selection process including the relative merits of competency-based and more traditional methods of selection and recruitment
- the use of assessment centres in selection and recruitment
- the level of choice on offer at application
- the lack of flexibility available to trainees on run-through programmes
- the role of fixed-term training posts alongside run-through posts
- the relative roles of the Deaneries and the Medical Royal Colleges in delivering components of the programme
- the need for flexibility in implementation across the UK.

England

For 2008, work on junior doctor recruitment will be lead by a Programme Board that will:

- Be accountable for providing governance to the programme and for identifying the policies and practices that are to be recommended to Ministers
- Provide leadership during the design, testing and implementation of the programme and be active champions of the change
- Be the forum where all interests are considered and where any tradeoffs between different interests are reconciled.

A Modernising Medical Careers (MMC) United Kingdom Co-ordinating Group has also been established, with Dr McBride, CMO representing Northern Ireland, to ensure appropriate liaison across the UK.

On 12 September 2007, the Department of Health issued consultative proposals for changes to MMC England processes in 2008 with responses required by 25 September 2007. The proposals were in two parts, the first relating to recruitment and selection and the second flexibilities in education and training. It is proposed that the Programme Board will submit recommendations to Ministers on 1 October for decision by mid-October. It then anticipates planning, design and testing from October to December with information and guidance on 2008 processes issued in November/December and recruitment commencing in January 2008.

Wales

The Wales MMC Steering Group is awaiting the interim report from the Tooke Review before formulating future strategy on recruitment. There is concern that there is clarity across the UK regarding recruitment, since trainees do cross borders (as planned rotations, for out of programme experience or through inter-Deanery transfers). The CMO notes that standalone recruitment in Wales may result in large numbers of applicants and the risk of individual countries leap-frogging each other year on year in an attempt to recruit the best candidates.

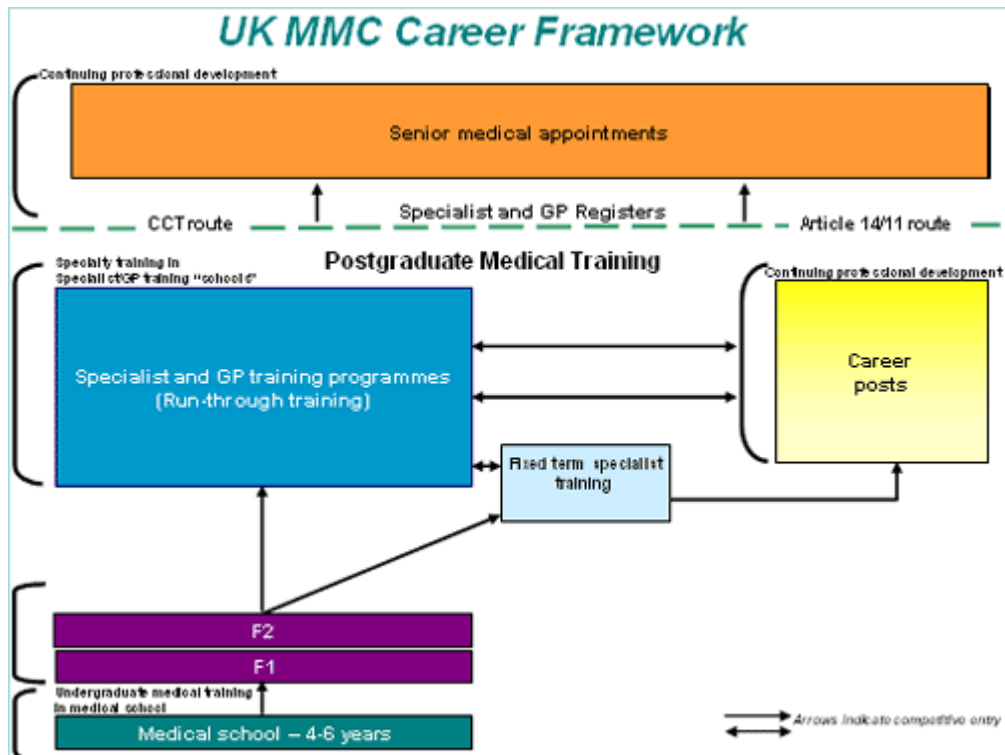
Scotland

Within Scotland, they are in favour of a national portal to application that is UK-wide and computer based. Within that they would want to have a Scottish application form that is CV based and has some scope for specialty specific questions.

They would prefer a UK system of preferencing but would deal with all applications to Scotland if that becomes necessary and intend to set their own shortlisting and selection methods except where UK systems are agreed (e.g. in obstetrics and gynaecology).

They favour a national timetable - for start and end of process as a minimum – but would prefer a more detailed timetable for dealing with rounds of applications and offers.

MMC CAREER FRAMEWORK EXPLAINED



F1 and F2 – Foundation year 1 (F1) and Foundation year 2 (F2) make up the two-year Foundation Programme which all UK medical graduates are required to undertake before progressing to specialty or GP training. These two years effectively replace the pre-registration house officer (PRHO) year and the first year of senior house officer (SHO) training. Foundation doctors are trained and assessed against specific competences set out in the Curriculum for the Foundation Years in Postgraduate Education and Training. This curriculum was agreed with the General Medical Council (GMC) and the Postgraduate Medical Education and Training Board (PMETB).

Foundation schools – Foundation training is managed in a way that brings together medical schools, postgraduate deaneries and health care providers to provide training in a variety of specialties and settings (acute, community, mental health and general practice). This training is supported and overseen by the postgraduate medical deaneries. This administrative body may be referred to as a foundation school.

Specialist and GP training programmes (run-through training) – These are specialist and GP training programmes which candidates who are successful in their application can start directly after the F2 year. Once a doctor is in specialist or GP training, they will have the opportunity to gain a Certificate of Completion of Training

(CCT), subject to satisfactory progress. Each programme will have a curriculum, agreed by PMETB, against which doctors in training will be assessed. The number of years that a trainee spends in training will vary from programme to programme. After a doctor receives a CCT, they will be legally eligible for entry to the Specialist or GP Register and can then apply for an appropriate senior medical appointment.

Specialist/GP training schools – As with foundation training, specialist and GP training programmes will be delivered through a range of organisations, overseen and supported by the postgraduate deans. Similarly, this administrative body may be known as a specialty/ GP training school.

Specialist and GP Registers (CCT route vs Article 14/11 route) – Once a doctor is awarded a CCT by PMETB at the end of a training programme, they will be eligible for entry to the Specialist or GP Register held by the GMC. A doctor who has not completed a specialist/GP training programme may apply for entry to the Specialist or GP Register through PMETB. If PMETB is satisfied, they may be entered on the appropriate register. (This route is defined by Articles 11 and 14 of the General and Specialist Medical Practice (Education Training and Qualifications) Order 2003). Once a doctor is on the register, they are then eligible to apply for an appropriate senior medical appointment.

Senior medical appointments – These may cover, for example, GP principals, other employed GPs, consultants or other specialist roles. These roles will be determined by the service.

Fixed term specialist training – These appointments will be for a fixed period. They will offer training in a specialty which broadly reflects the first and second years of training in that specialty. Training in these posts will be to explicit standards which will be assessed and documented against explicit standards. The duration of these posts is one year.

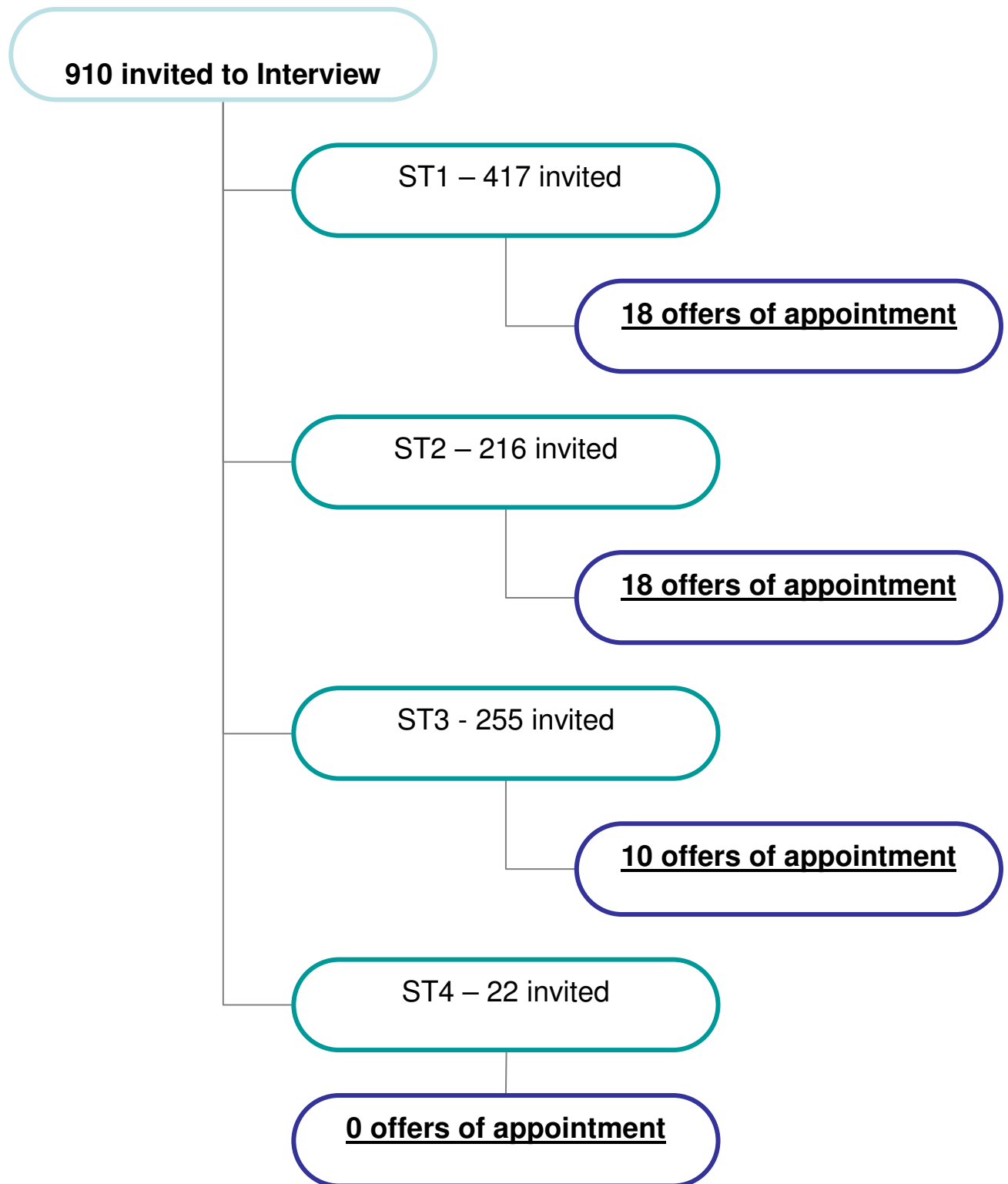
Career posts – These positions are service delivery posts with no formal specialty training elements. However, employer appraisal and relevant continuing professional development will be an essential part of these doctors' careers. These posts will only be available in secondary care.

Competitive entry – Progress through each stage of training will be through open and fair competition.

SPECIALTY RECRUITMENT – ROUND 1A (EXCLUDING GENERAL PRACTICE)

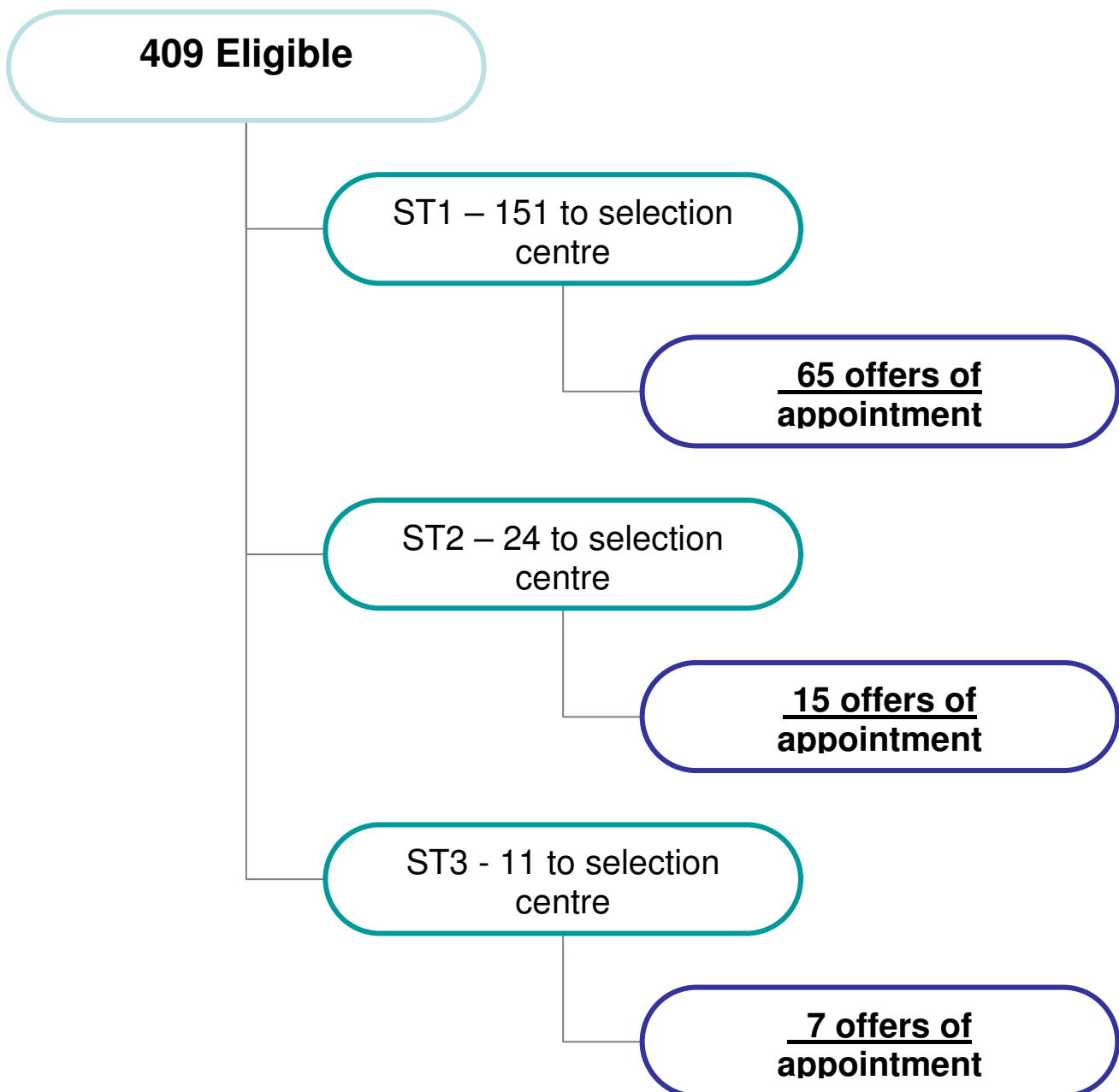


SPECIALTY RECRUITMENT - ROUND 1B



GENERAL PRACTICE RECRUITMENT

Specialty recruitment for General Practice utilised a different selection procedure that did not necessitate a Round 1B solution and the outcomes of this recruitment process are described below.



DHSSPS – REVIEW OF WORKFORCE PLANNING MEDICAL PROFESSIONAL GROUP (SEPTEMBER 2006)

RECOMMENDATIONS

From both the qualitative analysis and the detailed data modelling we can draw conclusions and recommendations in the following areas:

Training places:

Shortages in the GP group and projected demand for more flexible working arrangements suggest that there is a need to increase the number of GP training places. The last review of workforce planning suggested that the number of places should be increased to 75. Modelling indicates that such an increase (in annual increments of 5 places) would meet the projected demands of this part of the workforce by 2011. Subject to availability of funding and capacity to support trainees in the system, it is recommended that this increase be introduced as soon as possible;

In order to ensure that Consultant demands can be met as shown in the models above, the number of undergraduate medical places must be increased as planned over the coming years to at least 250 places;

'Churn' Rates:

There is very limited information with which to track medical professionals movements in and out of the training route. It is critical that information systems are improved to allow for better understanding of 'churn' within the various professional groups, for example, to understand why more than 200 people leave and join the PRHO/SHO group each year. The changes taking place under MMC should assist with this process. This is critical to ongoing workforce planning and development of a sustainable workforce;

Sustainable Recruitment:

The service will be required to manage recruitment from outside HPSS (i.e. people not on a defined training programme in Northern Ireland) in line with increasing rates of supply through the training system. In the short-term external recruitment is required to fill gaps in particular specialties (radiology, anaesthetics, general practice, orthopaedics and laboratory medicine are among the areas where particular difficulties have been highlighted) but in the longer-term reliance on external recruits should not be required to such a large extent, notably at Consultant level. Ultimately, the goal is for a service that is largely self-sustainable;

General Practitioner Data Collection:

For the purposes of accuracy in workforce planning it will be necessary to develop the current information systems to record, monitor and model the general medical practitioner workforce. Conducting survey

research of practitioners on the Performers List or of Out of Hours providers will provide useful workforce planning information;

Flexible Training Opportunities:

although flexible training is available to junior doctors in Northern Ireland, it is extremely limited. The new competency based structure of MMC may better facilitate a 'step-on – step off' approach which could greatly improve the opportunities for women and men to train flexibly or perhaps take breaks in their careers, but this needs to be promoted and supported financially;

Flexible Working:

The workforce models allow for a significant expansion in part-time and other flexible working arrangements due to the gender changes in the student and junior doctor groups, which will flow through to the wider profession over the next ten years. The assumptions around work-life balance also reflect the lack of experience of the profession in managing demands for more flexible working. There is a need to monitor the real impact of flexible working against these generous assumptions by implementing of better information systems. In particular there is a requirement to improve information on GP working hours, and demand for and use of sessional doctors;

Career Guidance for Medical Students:

Undergraduate medical students at QUB have highlighted that there are limited interventions to provide career guidance to students during their undergraduate course of study. There was a clear desire from undergraduates to be kept better informed about available career paths and this type of intervention is important in attracting junior doctors to shortage specialties.

IMPLICATIONS OF FUTURE CONSULTANT PROJECTIONS

MEMO



Department of
**Health, Social Services
and Public Safety**

An Roinn

**Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí**

www.dhsspsni.gov.uk

From: Dr P Woods
Senior Medical Officer

Ref:

Date: 12th September 2007

cc:

To: Bernard Mitchell

Further to your e-mail of 20th August, following your meeting with the Chief Medical Officer and the Department's Director of HR, I enclose, as requested, further analysis of consultant staffing and projections of the potential financial implications of these.

DR P WOODS
Senior Medical Officer

The accompanying table is derived from an earlier version set out for the group on projected specialty training requirements. This latest version represents the next stage in the annual process where the projections are translated into possible action to address shortfalls or excesses. In doing this, additional information other than the crude numeric calculations is taken account of. This mainly derives from the advice of the specialty advisory committees but also is informed by policy development and implementation.

Where changes are projected, these are progressed incrementally and in relatively small steps. This recognises the inherent crudity of the exercise and allows for year on year review. Where sizeable change in training numbers is indicated, this may not be feasible or desirable in a three year span.

The outcome of these projections as summarised in the table is an increase in specialist trainees of 45 by 2010/11.

This equates to;

An additional 11 in 08/09

A further 15 in 10/11

And a further 19 in 11/12.

If one assumes £70,000 per post (to cover basic salary, employers' costs and out of hours costs) this amounts to;

£770,000 in 08/09

£1.82m in 09/10

£3.15m in 10/11.

Given that part of the objective is to secure those experienced doctors who failed to acquire a ST programme in 2007 (assuming there are such people), it is reasonable to rearrange the annual increments so that the highest occurs in 08/09 and diminishes thereafter.

specialty	Consultants in post 2006	Indicative consultant target 2016	Estimated StR needs to meet consultant target	Strs in post August 2007	Action and rationale	Projected Strs		
						2008/09	2009/10	2010/11
General Surgery	71	87	48	40	SAC advised target excessive, maintain numbers steady	40	40	40
Cardiothoracic	9	11	4	5	maintain numbers	4	4	4
Neurosurgery	6	10	4	4	maintain numbers	4	4	4
Orthopaedic	44	71	36	32	SAC advised target excessive, maintain numbers steady	32	32	32
Plastic Surgery	7	18	15	9	Significant increase in consultant numbers since these figures produced	9	9	9
Paediatric Surgery	5	9	3	3	maintain numbers	3	3	3
Urology	14	38	17	6	Incremental increase	8	10	12
ENT	22	30	26	15	SAC advised target excessive, maintain numbers steady	15	15	15
Ophthalmology	28	37	11	13	Incremental reduction	12	11	11

specialty	Consultants in post 2006	Indicative consultant target 2016	Estimated StR needs to meet consultant target	Strs in post August 2007	Action and rationale	Projected Strs		
Endocrinology	28	38	18	18	maintain numbers	18	18	18
Gastroenterology	27	42	16	19	Incremental reduction	18	17	16
Respiratory medicine	26	46	18	19	Incremental reduction	18	18	18
Infectious Disease	1	8	6	1	Can only train 1 StR at present	1	1	1
Pharmacology	3	5	5	2	Can only train 2 StRs at present	2	2	2
Geriatric Medicine	42	57	27	20	Incremental increase	22	24	26
Cardiology	31	55	28	31	Incremental reduction	30	29	28
Dermatology	14	24	13	11	Incremental increase	12	13	13
Neurology	14	37	19	7	Incremental increase	9	11	13
Rheumatology	16	36	20	15	Incremental increase	16	17	18
Rehabilitation	4	9	5	3	Incremental increase	3	4	5
Nephrology	17	26	11	13	Incremental reduction	12	11	11
Palliative Medicine	13	17	5	7	Incremental reduction	6	5	5
GUM	3	8	5	6	Incremental reduction	5	5	5
General Medicine	2	-	-	-				
Acute Medicine	2	25	17	6	Incremental increase	8	10	12

specialty	Consultants in post 2006	Indicative consultant target 2016	Estimated StR needs to meet consultant target	Strs in post August 2007	Action and rationale	Projected Strs		
Histopathology	36	50	17	17	maintain numbers	17	17	17
Haematology	20	31	20	16	Incremental increase	17	18	19
Microbiology	14	22	12	7	Incremental increase	8	9	10
Chemical Pathology	7	12	6	4	Incremental increase	5	5	6
Immunology	1	4	2	2	maintain numbers	2	2	2
Clinical Genetics	4	7	3	3	maintain numbers	3	3	3
Adult Psychiatry	96	165	94	55	Incremental increase	60	65	70
Child/Adolescent	21	37	20	15	Incremental increase	16	17	18
Learning Disability	9	38	20	8	Reservations re. validity of target consultant number	8	8	8
Adult AE Medicine	33	71	28	30	Incremental reduction	29	28	28
Anaesthetics (Incl 1CM)	179	240	102	120	Incremental reduction	115	110	105
Obstetrics/Gynae	66	80	45	51	Incremental reduction	50	49	48
Paediatrics	77	128	80	68	Incremental increase	72	76	80
Radiology	90	152	59	39	Incremental increase	44	49	54
Oncology	22	48	30	35	Incremental reduction	33	32	31
Totals	1124	1829	915	775		786	801	820