Dr ***Rudolf N. Cardinal*** *MA PhD MB BChir MD (Cantab) MRCP CPsychol CBiol MIBiol AIBMS*
[Home address removed from public version of this document.]
Voicemail: +44 (0)7092 340641. Fax: +44 (0)7092 340645.
E-mail: rudolf@pobox.com. Web: http://pobox.com/~rudolf

18 June 2007

Professor Sir John Tooke
Modernising Medical Careers (MMC) Inquiry
4th Floor, Universities UK
20 Tavistock Square, London WC2H 9HD
Telephone: 07982 437588 or 07903 317717; Fax: 020 7380 1482
Email: enquiries@mmcinquiry.org.uk; www.mmcinquiry.org.uk

Dear Sir John,

I am writing to you with a submission containing proposals for the training and appointment of doctors in the UK.

MMC and MTAS have failed us on many grounds. In part the failure is because they are an overambitious and overoptimistic attempt to create inappropriate central job market regulation.

There are several overlapping problems that characterize the job market for doctors. I see the major problems as follows:

1. Doctors apply for a large number of similar jobs across the UK.
2. Employers' preferences for candidates may vary.
3. Many doctors apply for posts simultaneously.
4. Doctors must be allowed to apply for any job for which they are qualified.
5. In 2007, doctors had to apply for very poorly defined jobs.
6. Doctors apply for jobs without necessarily being given contract details.
7. Training requirements inherently conflict with service requirements.
8. Long training for doctors makes workforce planning difficult.
9. How do we implement a new selection scheme now?

I suggest that these problems be addressed with separate solutions. In summary, I suggest:

Each employer is free to select those candidates it sees fit. There is no place for national selection criteria, but employers have the opportunity to use template application forms and a central document clearing house. Doctors and hospitals are free to enter into a national matching scheme that offers well-defined jobs at predicted times. After interview, an algorithm based on the tested American model places candidates in their preferred position, taking into account employers' preferences and joint applications. A timely second round of matching fills any remaining posts, followed by open unregulated competition for any subsequent vacancies.

By entering into an independently run matching scheme, both employer and employee are bound by contract to take the job allocated. Doctors should be free to apply for any job for which they have the necessary minimum requirements. The posts applied for should be specific in both location and job description. No doctor should be discriminated against on the grounds of excess experience or personal circumstances. All doctors should be able to change their career path. Doctors should not be forced heedlessly into less popular specialties but rather unpopular posts should be made more attractive, e.g. by combining specialties.

A third party should define training standards for junior doctors. This would encourage the provision of learning opportunities by hospitals and encourage competition. The responsibility for training standards should be handed back from PMETB to the Royal Colleges, who should be responsible solely for the quality, not quantity, of the training posts available. There remains an important role for specialty examinations.

Adequate workforce planning should ensure that enough consultant posts are available at the end of specialty training. This should be done predominantly at a local rather than national level. The number of entrants into medical school should relate directly to this workforce planning. The advice of economists should be sought when planning changes to this regulated employment market.

That ends the summary. In the nine points that follow, I set out these proposals in more detail. Points 1–6 relate primarily to the application process (and thus to MTAS) while points 4 and 7–8 relate to the wider training structure (and thus to MMC).

1. **Problem: Doctors apply for a large number of similar jobs across the UK.**

   Solution: Create an ***optional centralized application system*** that acts as a trusted third party. I shall call it the ***UK Doctor Application Service*****.**

   - It receives and checks original documents from applicants (GMC certificates, degree certificates, postgraduate qualifications, criminal record bureau checks, passports and immigration status, maybe evidence of previous posts with their educational content and applicants' performance in them, maybe references, maybe PDF copies of applicants' publications, and so on).
   - Employers can check these details via the centralized application system, and can confirm to the applicants that they are or are not satisfied with what they have seen. If they are satisfied, they provide a signed statement or checklist to that effect to the applicant, who does not then have to bring the documents to interview. If employers do not use the system, or are not satisfied by it, they may require the applicant to bring the documents.
   - The service provides one or more template application forms. It may be that many hospitals appointing medical SHOs, for example, find that they ask the same questions of applicants. The service provides standardized application forms that employers *may* choose to use — perhaps including questions such as "what is your previous experience?" or "what qualifications do you hold?" or "please attach a full CV". Applicants applying to several employers who all choose to use the same template save time by filling in one form electronically, rather than sending paper application forms.
   - The American model for this is the Electronic Residency Application Service (ERAS).[1]
   - To emphasize, this third party makes no value judgements whatsoever. It merely facilitates communication and reduces paperwork.
   - The system can be used for individual jobs or posts, or for groups of posts making up educationally approved training programmes or rotations.
   - There are advantages to employers and to employees in using this system, so it is likely to be popular if it is set up well. But it is a stable system if individual employers choose not to use it. Likewise, applicants must use the system when applying to employers who insist on it, and must apply independently of the system if that is what an individual employer wishes, but can apply to multiple employers through the system and outside it simultaneously.
   - The system is fail-safe if it fails early. If this system fails, all parties revert to paper applications and manual verification of documentation. Late failure would cause delays in appointments, so it is important to start the process early. In the USA, for example, the residency applications system begins in early autumn for posts that begin the next July — nearly a year in advance.
   - The system stands alone; it must be piloted before being introduced widely.
   - How should the system be run? (1) This system could be run by central government. The advantage would be to make it free to employers and employees. The disadvantages would be that central government is notoriously poor at computing projects, and that there would be conflicts of interest — for example, government, representing the NHS as an employer, might

[1] http://www.aamc.org/audienceeras.htm

'encourage' the use of application forms that do not meet the desires of individual hospital employers, as exemplified by this year's MTAS. (2) The system could be run by private companies. The disadvantages would be that there would be several such companies, so there would be several competing application services; it would be more expensive since the companies would wish to profit; and individuals would probably not trust sensitive documents to private companies. (3) A not-for-profit independent organization could be created. It could charge individuals a small fee for each application, and employers a fee for using the service.[2] *I suggest option 3.*

2. Problem: Employers' preferences may vary.

Solution: employers must be free to select candidates as they see fit.

- Employers must be able to rank candidates in any way they choose consistent with employment law. If one employer's methods differs from another's, this is not a problem. There are hundreds of hospitals in the UK, each with many specialties, requiring doctors at different levels of seniority. They need not all apply the same criteria. They should be free to shortlist and interview as they see fit. This represents open and fair competition. Moreover, the competition is on both sides: hospitals compete with each other for doctors, just as doctors compete with each other for hospitals. If one hospital offers a place to a candidate based solely on their application form, without bothering to interview, because the candidate appears that good to them, that should be fine. If another chooses to arrange exhaustive interviews, it is their choice. If one is after candidates with a strong academic background, whilst others have no preference as to whether or not the candidate has a PhD, then that is fine. What is *not* fine is to impose a central scoring system on all employers, in the vain hope that (a) they all have the same preferences, and (b) the scoring system adequately captures those preferences. I dispute entirely that a centralized scoring system improves the functioning of the market for doctors and challenge advocates of a central scoring system to produce evidence to that effect.
- One very compelling reason why national selection criteria do not need to be applied is that *it is in hospitals' own interests to select good doctors.* Each employer, acting in its own self-interest, will try to rank doctors in a way that gets them the best. This is a perfect example of a situation in which market forces will provide a good outcome without central regulation. It is also a perfect example of a situation in which inappropriate central regulation produced a highly unsatisfactory outcome in 2007.
- Another major advantage of local processes is that relationships between potential employees and employers can start at interview. This is to the benefit of both parties as, for example, the employee can find out specific details about the job's hours, conditions, training environment, research opportunities, etc., and the employer can ascertain whether they think this individual would likely fit in well with the existing team.
- I will refer to 'hospitals' and 'employers' interchangeably, but there may often be situations in which groups of hospitals function as an employer — for example, when a training rotation involves posts at several hospitals in a region. There are good reasons why hospitals may group together like this. However, there are also substantial advantages to having *small* groupings, competing between each other for doctors. Some of these relate to providing well-defined posts for which doctors can apply (in which the location and nature of the post is clearly set out in advance); this point is discussed further below.
- In general practice, individual practices or primary care trusts take the role of employer.

3. Problem: Many doctors apply for posts simultaneously.

Solution: Create an ***optional centralized preference matching system*** that acts as a trusted third party to maximize applicants' and employers' happiness. I shall call it the ***UK Doctor Matching Programme***, or the 'Match'.

[2] http://www.aamc.org/students/eras/feesbilling/start.htm

- Employers choose to place individual posts inside the matching scheme, or not. Applicants choose to apply within the matching scheme, or not. Outside the matching scheme, it's a free market. Inside the matching scheme, it's a regulated market.
- The key problem is one of making a *synchronized choice*. (An example: two hospitals each have one job available. Dr A prefers Hospital 1 to Hospital 2. Dr B prefers Hospital 2 to Hospital 1. But Hospital 1 prefers B to A and makes B an offer. Hospital 2 prefers A to B and makes A an offer. Neither doctor wishes to accept the post until he knows whether his more preferred hospital will offer him the post. Neither hospital wishes to move on to less-preferred candidates until their first-choice candidate has said yes or no. In computer science, this is called a deadlock. If the hospitals offer jobs at unpredictable times, the end result is also unpredictable, known as a race condition — and other undesirable situations may emerge, such as hospitals trying to be the first to offer jobs so as to get the best candidates, or applicants choosing less-preferred hospitals early so as to ensure a job.)
- Making a synchronized choice is easy. The next problem is to make everyone as happy as possible. The following system, largely based on the National Resident Matching Program (NRMP) in the USA (http://www.nrmp.org), which is optimal in several important technical senses,[3] should be followed:
  - All applicants rank their preferred programmes in the genuine order of their preferences, from their first choice down to the lowest-preferred post they'd accept.
  - All programmes rank their preferred applicants in the genuine order of their preferences, from their first choice down to the lowest-preferred applicant they'd accept.
  - Preferences are strictly confidential: applicants never see employers' preferences, and employers never see applicants'.
  - A simple and transparent algorithm ensures that an applicant is placed in his/her most preferred programme that ranks the applicant and does not fill all its positions with more preferred applicants. The algorithm is described at http://www.nrmp.org/res_match/about_res/algorithms.html. It is theoretically sound, and has been proven over decades of use.
  - Ranking too few programmes/applicants puts applicants/employers at greater risk of not getting a job/not filling their posts.
  - Special consideration must be given to couples. They link their applications, rank their preferred posts in pairs, and a similar algorithm does its best to maximize their happiness and that of their potential employers. The algorithm is described at http://www.nrmp.org/res_match/special_part/ind_app/couples.html. Employers do not need to be aware that an applicant is applying as part of a couple. The algorithm will match to the couple's most preferred pair of programmes where each partner has been offered a position. One half of each 'pair' of choices can be the choice for one person not to be matched at all, creating maximum flexibility.
  - At the end of the process,[4] there may be jobs left over and applicants without jobs. Rather than going straight to a free-for-all as in the USA, in which every minute counts as applicants race for places,[5] a further second-round Match should be run (in which candidates reapply for new posts, and during which candidates and employers alike will probably be a bit less fussy and improve their chances of getting jobs and filling posts). After a second round, anything left over can go to a free-for-all (known in the USA as the Scramble).
- This matching system is more complicated than a central application service, because it requires some honesty and binding commitment from participants.[6] Consequently, it must be

[3] http://kuznets.fas.harvard.edu/~aroth/jama.html
[4] http://www.nrmp.org/res_match/special_part/ind_app/match_results.html
[5] A description of how ridiculous this process can be is at http://www.imgresidency.com/Scramble_Howto.html
[6] Sample policies are at http://www.nrmp.org/res_match/policies/index.html

run by a trusted third party (perhaps, as suggested above, a non-profit-making organization with general support from professional bodies).[7] What are the potential problems?

- The system only solves the problem of simultaneous choice if the choices are binding. Thus, applicants and employers must enter a binding commitment to accept the outcome of the Match. Employers are not permitted to decide that, having ranked a candidate, they will not accept him. Applicants are not permitted to decide that, having ranked an employer, they will not accept a job offered by the matching system. Both would constitute a violation of the agreement each made. Exceptions may be made (for example, for extreme personal circumstances or the discovery of an undisclosed conviction); a third party (the matching programme) is required to adjudicate.[8] Outside these exceptional circumstances, the matching programme disallows withdrawals. Violations can be punished, if need be by preventing the applicant or institution from entering further matches temporarily or permanently. (If this incentive were not sufficient in the UK — for example, if you were applying for training posts that lasted so long that any ban had expired before you had to apply again — an alternative, e.g. financial, penalty could be applied.) As a consequence of clearly defined penalties, in the American system, violations are few.
- The algorithm quite correctly places emphasis on applicants' satisfaction over employers' *when all other things are equal*. Happy employees are vital. But this creates a conflict of interest. If unpopular employers can persuade good applicants to rank them higher than the applicant would truly prefer, for example by promising them that they will rank the applicant top — in slang terms, if the employer can persuade the applicant to "go ugly early" — then applicants are disadvantaged. The American version of this system makes it quite clear to applicants that employers may try this tactic, that the best strategy for the applicant is to rank their preferences honestly, and that any communications outside the official Match preferences are potentially false and may be ignored.[9]
- If the system fails in a given year, the problem of making a good, synchronized set of choices is failed. This is the situation we have faced historically in the UK (as hospitals advertised posts at slightly different times, and doctors wondered whether or not to accept an offer or decline it in the hope of a better result from next week's interview). It is the problem we face in May–June 2007 with the collapse of the MTAS matching scheme, whatever its algorithm might have been. So a system failure would be serious, especially if it came late, but it would not prevent one-to-one, employer-to-applicant job offers from proceeding.
- If applicants enter the Match, they must accept any job they get from it — so although they can apply outside the Match at the same time as applying within it (which might be fine if they were not matched but got an offer outside the scheme), the consequences of rejecting a post offered to them from the Match would be serious. So there will be strong pressure on applicants to apply within the Match, and only within the Match. Given that, there will be strong pressure on employers to place most or all their posts inside the Match, in order to attract the best candidates. So this is a big national system — optimal synchronized preference matching works best when most applicants and posts are inside the scheme — meaning it may start on a grand scale, and meaning that it needs very robust piloting.

- In particular, it is vital not to make this system too complicated. It should *only* deal with applicants' preferences, employers' preferences, and the matching process. Applications themselves are a *separate issue* — the process by which employers generate their preference lists should be completely up to the employers.

[7] http://www.nrmp.org/about_nrmp/index.html
[8] See, for example, http://www.nrmp.org/res_match/policies/case.html
[9] http://www.nrmp.org/res_match/about_res/ensuring.html

- To emphasize, this third party makes no day-to-day value judgements whatsoever itself. It merely facilitates communication (including the communication of preferences) and the entering into of binding agreements between employers and employees.
- There are several possible funding models. In the US, applicants pay a flat fee to enter, no matter how many hospitals they apply to; hospitals pay a flat fee plus a fee per applicant appointed, but do not pay to rank people, so they can rank as many applicants as they wish.[10]
- I have referred to 'jobs' or 'posts' but, as now, these may instead be educationally approved training programmes, such as a set of (e.g.) three four-month posts making up an FY2 year, or four six-month posts making up an ST1–2 training rotation.
- In principle, there could be several 'Matches'. It would be worth considering having one Match for FY1 posts and one Match for all other posts, since there is unlikely to be overlap between doctors applying for FY1-level jobs and doctors applying for jobs requiring full GMC registration. But all posts above FY1 level should be in the same Match, because a doctor might be qualified to apply for a registrar (ST3 equivalent) post in medicine or to change tack and apply for a new specialty at a more junior level (e.g. ST1). This must not be discouraged.
- It will be important to begin the process in good time, as described above.[11]

I note in passing that aside from the American model of doctor recruitment for residency training, this system is also quite similar to the UK Universities selection system, UCAS,[12] which also has to do the job of matching many applicants to many institutions, each with their own preference scheme, nationwide and simultaneously.

4. Problem: Doctors must be allowed to apply for any job for which they are qualified.

Solution: given minimum entry requirements for a particular post, make it a free market.

- It is a given that certain posts demand certain entry qualifications. For example, in 2007, ST1 posts require no previous experience of the specialty. In contrast, an ST3 post in cardiology requires the MRCP examination and suitable experience as a medical SHO or equivalent in approved training posts.
- Allowing any suitably qualified doctor to apply for any given post represents open and fair competition.
- If a doctor wishes to change specialty, this must be permitted.
- If a doctor wants to try a range of specialties before committing to one, this must be permitted, if not encouraged. Different doctors will want to spend different amounts of time 'trying' before they 'buy', and this must be permitted.
- If a doctor has failed to obtain specialty training for a particular specialty before, this must not be a barrier to the doctor trying again, should he/she wish.
- The concept of being 'overqualified' must not be permitted to stand, because doctors can get squeezed out of their desired specialty through this argument. For example, in 2007, ST2 psychiatry required between 12 and 36 months' experience of psychiatry (too much experience made you ineligible), while ST3 psychiatry required MRCPsych Part 1. So someone with too much experience but not enough exams might be ineligible for either.[13] The fact that this situation may not be at all common does not detract from the fact that it is wrong in principle to limit applicants in this way. Over the years, professional examinations (e.g.

[10] http://www.nrmp.org/
[11] Part of the American schedule is at http://www.nrmp.org/res_match/yearly.html
[12] http://www.ucas.com/
[13] Likewise, ST1 psychiatry required less than 12 months' experience while ST2 psychiatry required at least 12 months' experience, leaving candidates having to make critical decisions about whether particular posts 'counted' as experience or not, since they were able to apply at only one level, and hoping that their guess matched the decisions of the longlisting and shortlisting panels.

MRCP) have abandoned the idea of a limited time or a limited number of attempts in which to complete a course of study or obtain a qualification. We should abandon it entirely.

- There should be no limit on the number of posts for which a doctor can apply in a single round. Regarding the centralized Matching scheme, a small fee per application and per person appointed might fund the system and limit the number to something sensible in most cases. But we must never repeat the travesty of 2007 of allowing four applications only; there is no good reason to set a limit at all.

5. Problem: In 2007, doctors had to apply for very poorly defined jobs.

Solution: the 'unit of application' should be very specific — with details being provided of the post(s) and hospital(s) that are part of the job or programme of jobs on offer.

- In 2007, doctors applied for posts such as 'ST1 Core Medical Training, Scotland' or 'ST2 Surgery, London/Kent/Surrey/Sussex'. These are completely inadequate units of application. A doctor who is offered 'ST1 Medicine Eastern' does not know whether this means gastroenterology in King's Lynn or neurology in Southend. If you are married with children and a mortgage in Southend, it's not a short commute to King's Lynn. You might have to move. Your spouse might have to move. Your spouse might be unable to move. Your children might have to move school. It is unacceptable and virtually unheard of to have to apply for a job without knowing the proposed location and job description in detail, some time in advance. The system being used in 2007 is particularly unfair to those who are geographically less mobile, typically those with families.
- Furthermore, in 2007, applicants ranked up to four 'units of application'. They might choose to put 'ST2 medicine Eastern' above 'ST2 medicine London/Kent/Surrey/Sussex'. But actually, they might prefer neurology in London to endocrinology in Southend, whilst also preferring nephrology in Cambridge to respiratory medicine in Canterbury. Applicants should be allowed to express those preferences.

Academic jobs. In passing, I would make a further point with regard to academic jobs. This year, the selection procedure for academic clinical posts failed badly.[14] One consequence of adopting the selection methods I advocate might be an improvement in this. Academic employers, typically university hospitals, could advertise posts such as 'ST1 medicine in Addenbrooke's' (non-academic), 'ST1 academic clinical fellowship in medicine in Addenbrooke's leading to a PhD in areas relating to diabetes', or 'ST3 academic clinical fellowship in medicine in Addenbrooke's in the general area of respiratory medicine, with the academic specialty to be determined later by applicant and supervisor preference'. Candidates could apply to these posts as separate options in the Match, ranking the academic option(s) highly if they desire. Employers might use a method to rank academic applicants that is slightly different from their methods for ranking non-academic applicants. The system allows this flexibility. The standard preference-matching system I advocate would then maximize applicant and employer happiness.

6. Problem: Doctors apply for jobs without being given contract details.

Solution: make it compulsory for employers to provide contracts in advance.

- We must end the fact that doctors are amongst a very small group of employees so disadvantaged by a national employer that they frequently have to apply for jobs with no clear idea of which hospital they will be working in, the shift system in place, or the salary/banding scale on which they will be paid. It certainly seems unfair that doctors must enter what is a binding commitment to a job[15] when the employer can still keep its cards on the table.

---

[14] Medical Academic Staff Committee (May 2007), *Clinical academic training: a lost opportunity*, at http://www.bma.org.uk/ap.nsf/Content/Clinicalacademictraining (also available as a PDF at http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDFVersion4CAT310507/$FILE/Tooke.pdf)

[15] GMC (2006) *Good Medical Practice*, paragraph 49, at http://gmc-uk.org/guidance/good_medical_practice/working_with_colleagues/appointments.asp

- Employers must be responsible for ensuring all post entry requirements are made clear to the applicant, and for providing a copy of the contract(s) the applicant would be expected to sign if they were matched to the post or programme of posts, in advance of the preference ranking process.[16]
- Applicants must be responsible for ensuring that they meet the post entry requirements — otherwise, they may be matched to a job for which they are not qualified, and be unable to take it up.
- The compulsion comes through the Match process: to participate in the Match, an employer must comply. It would be hard to enforce this provision outside the Match, but easy within it. The third-party nature of the Match allows this enforcement. The factors that drive employers to use the Match will indirectly require them to be better employers.
- Incidentally, providing clear details of their posts will also probably increase employers' popularity in the Match, increasing the talent pool available to them. Furthermore, as junior doctors' hours steadily reduce to band 1A, employers may lose their reluctance to provide contractual information in advance. However, compulsion remains important here.
- Having to provide detailed contracts in advance would also require employers to plan their workforce and staffing requirements on a slightly longer timescale than at present. This would be good for employees, and probably for employers.

7. Problem: Training requirements conflict with service requirements.

Solution: Allow trusted third parties to determine whether a post should count for specific training purposes.

- Employers should be free to create posts to meet service requirements. But to create a training post, a hospital must ensure educational standards are met, such as the provision of formal teaching. Educational activities represent time that a doctor is not providing service, so there is a conflict of interest between the hospital's service and training needs. Consequently, hospitals should not be the ones to judge whether a post meets training standards.
- The acceptance by a third party that a posts meets certain training standards is a 'stamp of approval' for a post. Since doctors prefer training posts to non-training posts, there is a useful market force: hospitals that choose to sacrifice some service provision and provide educational activities in order to have a post approved for training will find that these posts attract more and better applicants. This provides some incentive for them to do so.
- Nonetheless, the predominant immediate effect of training on the employer is negative. For example, training junior cardiologists to perform diagnostic coronary angiograms requires a teaching list with a supervising consultant, in which typically 3 angiograms might be performed in a session, whereas a non-training list might serve 8 patients in the same time with a single doctor. Consequently, the real benefit to employers of creating training posts is in the long term, to ensure a supply of senior doctors. As I suggest in point 8 below, mechanisms to enhance the local relationship between training and consultant posts through better workforce planning may improve matters for employers.
- As now, employers should be free to create non-training (service only) posts. However, they should be clearly distinguished so as not to compromise training opportunities for those in training posts.
- A variety of training standards exist. For example, a post in accident and emergency medicine these days may 'count' towards the experience required for the MRCP, MRCS, and FFAEM examinations. The range of 'overall experience' that might allow a doctor to sit the MRCP exam differs from that appropriate to MRCS.
- The body making a judgement as to whether a post should count towards training in a particular specialty should probably be the professional body representing that specialty. At

[16] http://www.nrmp.org/res_match/special_part/inst_officials/about.html

present, the bodies that most closely fit that definition are the medical Royal Colleges. In fact, from 2005, the responsibility for training standards actually rests with the Postgraduate Medical Education and Training Board (PMETB). Nevertheless, it seems advantageous to return responsibility for training to the Royal Colleges, since they are more democratic. For example, any physician of substantial experience may be elected a fellow of the Royal College of Physicians, and be able to influence RCP policy. The democracy may not be perfect (for example, RCP fellowship requires nomination by existing fellows[17]). But far greater accessibility and democracy exists within a professional specialty to influence its Royal Colleges than PMETB, and training standards are a matter principally for the trained professionals in a given specialty. To illustrate this difference in democracy, I could influence the RCP by qualifying as a doctor, gaining the MRCP examination, being elected a Fellow, and voting within the College; it is not clear how I could influence PMETB. Its statutory committees and subcommittees are appointed by its Board.[18] Appointments to the Board are made through the Appointments Commission[19] who make recommendations to the Secretary of State for Health. The Statutory Instrument creating PMETB[20] makes no mention of election; instead its members are appointed by government ministers.

- Special consideration must be given to the FY1 year, since this year also fulfils a requirement for full registration with the GMC. The GMC is therefore one interested party. It might choose to say that satisfactory completion of a set of posts containing four months' medicine, four months' surgery, and four months of something else should lead to full registration. Since the GMC is not primarily a postgraduate educational body, it could just require that the four months' medicine have approval by the medical educational body (such as the RCP) for this purpose, the four months' surgery by the RCS, and so on. Subsequent to this year, all training posts count towards training in one or more specialties, and the appropriate educational professional body should be the judge of the training standard.
- No educational approval body (e.g. Royal College) should deny educational approval to any post that meets its criteria. In particular, educational approval bodies must not deny educational approval because they have filled a 'quota' of training posts — because although the educational approval body should deal with the *quality* of training, the *number* of training posts is an issue of workforce planning, which I deal with below. A quota should exist in a regulated market, but the educational bodies should not be the ones to determine it.

8. Problem: Long training makes workforce planning difficult.

Solution: hospital trusts should determine the number of training posts, with a constraint to match the number of entries to specialist training to the number of consultant posts available in their trust at the end of training.

- Hospitals or trusts should have control of their employment budget and be able to plan their medical workforce, as they are the entities that must respond directly to local clinical needs.
- Allowing hospitals (employers) to be in control of proper workforce planning also allows integration of workforce and financial planning, as recommended by the Health Select Committee 2006–2007 Report on Workforce Planning[21] (pp. 41–42, 50), and to improve planning over longer timescales (ibid., pp. 42–44, 50), since the decision-making body would be the body primarily affected by its own decisions.
- Since we invest a great deal of money nationally in training medical students, it seems sensible to ensure the number of FY1 posts at least matches a given year's output of newly qualified doctors, so as to be able to guarantee employment at least to the point of full GMC

[17] http://www.rcplondon.ac.uk/college/membership/
[18] http://www.pmetb.org.uk/media/pdf/l/q/Committees_Rules.pdf
[19] http://www.pmetb.org.uk/index.php?id=595
[20] http://www.opsi.gov.uk/si/si2003/20031250.htm
[21] http://www.publications.parliament.uk/pa/cm200607/cmselect/cmhealth/171/171i.pdf and http://www.publications.parliament.uk/pa/cm200607/cmselect/cmhealth/171/171ii.pdf

registration for UK-qualified doctors. This accords with the Health Select Committee recommendations (ibid., p. 86). Beyond this, the market should be free.

- As discussed above, the educational approval bodies should not be the ones to determine the number of training posts.
- Let us illustrate the problems with a few possibilities, assuming for the sake of argument 7 years' training for a specialty, with a 'training post' here representing run-through training to the point of qualifying as a consultant.
    1. In our first scenario, we allow an entirely free choice on the part of doctors. Hospitals appoint doctors to their chosen specialty regardless of local or national need. Suppose every doctor wants to become a cardiothoracic surgeon. We end up with too many cardiothoracic surgeons and not enough endocrinologists. *Wholly unrealistic, unless salaries are free to vary.*
        - We can illustrate the consequences of this policy further in a situation with and without salaries that are free to vary.
        - If employers can pay cardiothoracic surgeons at a free-market rate, the oversupply of cardiothoracic surgeons depresses their pay, which will probably reduce the number of doctors training in this specialty (although salaries can change fast, and it takes a long time to train as a cardiothoracic surgeon, so this is very hard on individuals). Meanwhile, our hypothetical endocrinologists' salaries increase, encouraging junior doctors to train in this specialty. Overall, this free market is a good mechanism for regulating supply and demand *except* for the long time-lag involved in training.
        - If the salary scales are fixed nationwide, as at present, there is no such mechanism for autoregulating the market supply. Consequently, we have to regulate it by other means: restricting the number of posts available. I discuss mechanisms for this next.
    2. In another scenario, the government, or a central training body such as PMETB, guesses the number of cardiothoracic surgeons (etc.) required in 7 years' time. That number of doctors are allowed to enter the first year of specialty training now. The quota of cardiothoracic surgeons is allocated across hospitals performing cardiothoracic surgery. *This is plausible.* But this represents central planning, which is notoriously unreliable. What if a hospital decides it should expand or contract a given service? It is constrained in its ability to respond to the clinical need it perceives.
    3. In a third scenario, we allow hospitals to offer training posts in specialties as they see fit. Hospitals work out how many consultants they think they will need in 7 years in each specialty, and offer that many training posts. Doctors compete according to their preferences (and likewise hospitals rank applicants according to theirs, in a fair process as described above). *This is plausible.* But there is a risk: hospitals may actually want more junior doctors than consultants at any one time. In fact, this is more than a risk; it is reality. Although it is a political target to have more consultants on the shop floor, consultants are more expensive. Hospitals might offer more training posts than there will be consultant posts, which would leave doctors fully trained and potentially unemployed, if other hospitals do not compensate for their actions — and there is no reason why they should.
    4. Hospitals, or groups of hospitals, offer training posts in specialties as they see fit, but are constrained such that to offer *n* training posts in a given specialty requires them to offer *n* consultant posts in the same specialty in 7 years (though not necessarily to the same candidates, since a competitive process should continue to operate nationally). *I suggest this solution.*
- Any of these proposals must be complemented by a policy of allowing hospitals to offer non-training (service) posts at junior levels, with the proviso that a doctor accepting a non-training post must be in no way prevented from applying to training posts later. This would provide a temporal buffering capacity, allowing doctors to gain experience and re-compete in a subsequent year should they wish.

- The system advocated above can be extended to a market in which national training centres provide trained consultants to peripheral hospitals. For example, training in positron emission tomography, congenital heart disease, or transplant surgery may be available only in some highly specialized centres. It would be possible for any given other hospital to guarantee a consultant place in 7 years' time, thereby allowing an extra training post at the training centre.
- How should we staff unpopular specialties? Rather than a central quota system, which essentially forces doctors to pursue careers about which they may be unenthusiastic, a local system could allow individual hospitals to increase the attractiveness of otherwise unpopular jobs. Aside from varying salaries (currently not done in the UK), other incentives include pairing a relatively popular specialty and a relatively unpopular specialty. Within medicine, such dual training opportunities include medical microbiology and infectious diseases, clinical immunology and renal medicine, geriatrics and acute medicine, etc. Even triple accreditation is not unknown (e.g. general medicine, respiratory medicine, clinical pharmacology). New combinations of specialties might be created (e.g. psychiatry and neurology). There is scope for yet more flexible training programmes. Dual accreditation is also excellent for trainees, as it improves career prospects, and should be encouraged. Approval for each part of the training programme could be sought from the appropriate educational body, as discussed above.
    - In other countries, such as the USA, salaries vary widely by specialty and location.[22] In this free market, part of the variability comes from the potentially undesirable practice of payment per procedure, while other market forces drive the rest of the variability. In the UK, we pay doctors extra for working longer hours, through banding payments for juniors and consultant on-calls.[23] Teachers have sometimes been paid more for entering unpopular subjects.[24] Paying doctors more to staff less popular specialties is a possibility, but a controversial one: it would be very complicated to administer fairly within a regulated market; the undersupply may not really exist; paying more does not necessarily engender commitment to the specialty; and such a system might be unpopular. I will not pursue this point further, though it remains an option.
- *Immigration and emigration.* It is impossible to plan accurately for immigration and emigration of doctors. Consequently, I suggest that the best available solution is to assume that the number of immigrants equals the number of emigrants plus UK permanent leavers, allowing workforce planners to match training posts to consultant posts. Doctors will emigrate and immigrate but the total numbers will remain the same. Should this in practice not be the case, national market incentives can correct the problem (i.e. raising doctors' salaries nationwide to encourage immigration and discourage emigration, or lowering doctors' salaries to encourage the reverse; in the longer run).
- Within the UK, new doctors only emerge from medical schools. The other net flux of doctors is from people leaving the profession, either temporarily or permanently.
    - *Considering permanent leavers:* we cannot plan with complete accuracy how many people will leave, so it is not reasonable to create fewer consultant posts than training posts in the hope that a proportion of trainees will leave. Overall, we lose from the NHS a total of 15% of UK-trained doctors after 2 years of graduation, 18% after 5 years, still 18% after 10 years, 19% after 15 years, and 23% after 20 years.[25] By far the biggest loss is in the early years, which is perhaps an argument for a very flexible workforce early on, but which permits direct linking of specialist training posts (ST1 and above, 2 years after graduation) and consultant posts (~10 years after graduation). There is still a gap: however, it is unlikely that we could not as a country continue to attract net immigration of doctors to fill this gap. Consequently, it remains sensible to match consultant and trainee numbers.

[22] Lacking an authoratitive source, here is a non-authoratitive one: http://mdsalaries.blogspot.com/
[23] Pay Circulars (M&D) 3/2007 and 4/2007 at http://www.nhsemployers.org/pay-conditions/pay-conditions-2339.cfm
[24] http://news.bbc.co.uk/1/hi/education/3841215.stm
[25] Goldacre MJ, Lambert TW, Davidson JM (2001). Loss of British-trained doctors from the medical workforce in Great Britan. *Medical Education* 35: 337. DOI:10.1046/j.1365-2923.2001.00939.x

    - *Concerning temporary leavers, including maternity leave:* within a run-through training scheme, maternity leave could be dealt with by postponing the 'planned' consultant post that was notionally tied to the training post. (Note as before that this does not tie the individual to the hospital, or the hospital to the individual; it merely ensures that nationwide there are the same number of consultant posts as emerging fully trained doctors.)
- *Concerning sub-specialization:* It is simple in principle to match the number of cardiology trainee (registrar) posts to the number of future consultant cardiologists. It is a little more complex to match the number of general medical trainees, for example, to the future number of consultant physicians — but not much more complex! The number of (e.g.) medical SHO-equivalent posts should be matched to the sum of the number of registrar-level medical training posts across all medical specialties; within each specialty, the number of registrar-level posts should be matched to the number of appropriately timed future consultant posts. Likewise, the number of FY1-equivalent posts should be matched to the total number across all specialties, including general practice. Doing this at a local (hospital/hospital group/trust) level ensures it also happens at a national level, but still allows movement of doctors around the country as they and their employers see fit.
- *Concerning the implementation of such a system:* If a system of matching training to consultant posts is adopted, care must be taken not to disadvantage trainees currently in the system. Consultant posts must not be *taken out* of the existing pool of anticipated consultant posts in order to 'earmark' them specifically for trainees at a given stage. At every level, open competition should be possible, otherwise more senior trainees might be disadvantaged. I do not know if the number of planned consultant posts in every specialty is currently at least equal to the number of trainees in that specialty due to emerge over the next few years, either nationally or at a local level. (If there are too many consultant posts, fine: future trainees will fill the posts. If there are too few consultant posts, trainee numbers in that specialty may need to drop in the future, but there will be existing trainees who will face being fully trained with no UK consultant post to go to.) But if steps are taken to ensure that future entry-level trainee posts are matched in number to future consultant posts, inequality and inequity should fade from the system within the time it takes to train a specialist.
- *Implications for senior/junior ratios.* Overall, this policy must consider the total number of juniors at each stage. Although there will be many individual exceptions, we could take an average career. Here I will guess the numbers, which may be somewhat inaccurate. A school-leaver aged 18 becomes a FY1-equivalent aged ~24, an SHO-equivalent aged ~25, a registrar-equivalent aged ~27, and a consultant aged ~34. They will retire at age ~64. Consequently, of the 40 working years of a doctor's life, 1 is spent as a FY1 or equivalent, ~2 as an SHO, ~7 as a registrar, and ~30 as a consultant. For a balanced workforce, we should therefore have consultants:registrars:SHOs:FY1s or equivalents in the approximate ratio 30:7:2:1, balanced across hospital and general practice, or 3:1 senior:junior. I do not have accurate figures, but it appears that we have a much lower senior:junior ratio than this.[26] Matching post numbers at different levels locally would ensure they were matched nationally, and would also help to further the current political goal of a senior-led service.
- *Medical school intake.* Finally, we must also consider workforce planning across the full timescale from medical school to consultant posts. Clearly it is ideal that the number of students accepted into medical schools matches the number of consultant posts available at the end of the road (say, after approximately 6 years in medical school plus approximately 8–10 years of general and specialist training). Here, many parties have a conflict of interest. A free

[26] An incomplete breakdown of recent medical workforce numbers at different grades is given at page Ev 259 of http://www.publications.parliament.uk/pa/cm200607/cmselect/cmhealth/171/171ii.pdf. In 2004, there were 28,100 consultants, 16,100 hospital registrars, 24,500 other doctors in training, 8,600 'other medical and dental staff', 30,800 GPs including registrars, and 109,200 doctors in total. (These figures are from the Department of Health and do not add up.) If we assume that all 'other medical and dental staff' are seniors (at consultant level), and we promote all GP registrars to senior level, then there were 28,100 + 8,600 + 30,800 = 67,500 seniors and 16,100 + 24,500 = 40,600 juniors, giving a senior:junior ratio that is less than 1.66, whilst the number of years spent at each level would suggest a target of ~3.

market solution would be for students to pay for their own education, gambling that the long-term payoff would be a consultant post. However, since we as a country pay for most of a medical student's very expensive education, and employ the resulting doctors, there is a more obvious conflict of interest. Educating more students than we need doctors wastes money on education, but creates a glut of doctors that would tend to create medical unemployment and drive down doctors' salaries. Educating too few students does the reverse. Central government currently determines the level of funding for both. Matching the two ends of the workforce in some way is optimal, but while the government controls both ends this is a political argument and one I will not enter into.

9. Problem: How to get there from here?

Solution: make the best of the 2007 disaster, but don't make MTAS appointments permanent.

- It is universally acknowledged that there has been unfairness in the appointments system for junior doctors in 2007. It has been debated as to whether it is now too late to make it fair. The verdict[27] is that it is too late. So let us not set unfairness in stone, but make this year's appointments temporary, with a new round of competition when a fairer appointments system has been created. I have suggested such a system in my points above.

In summary, I suggest that a large number of overlapping problems could be solved by using

- local job creation,
- local matching of training posts to subsequent consultant posts,
- local interviewing and ranking of candidates by employers,
- freedom for doctors to apply for any post for which they are qualified,
- third-party educational approval for posts by professional bodies,
- a trusted third-party national application system, optional for employers, and
- a separate trusted third-party matching system, optional, with decisions binding upon those using it, enforcing the provision of detailed information about posts in advance.

Some of these issues, particularly workforce planning, are very complex. May I also respectfully submit that since these problems are not simply to do with health care but also to do with the functioning of a regulated market, that advice from a range of expert economists is sought before any concrete proposals are drawn up?

Thank you for your time, and good luck with your Inquiry.

Yours sincerely,

Rudolf Cardinal

CC:

Royal Colleges

- Prof. Ian Gilmore, President, The Royal College of Physicians (London), 11 St Andrews Place, Regent's Park, London NW1 4LE (the.president@rcplondon.ac.uk)
- Mr Bernard Ribeiro, President, The Royal College of Surgeons of England, 35-43 Lincoln's Inn Fields, London WC2A 3PE (president@rcseng.ac.uk)
- Prof. Neil Douglas, President, The Royal College of Physicians of Edinburgh, 9 Queen Street, Edinburgh EH2 1JQ (president@rcpe.ac.uk)
- Dr T. Joseph McKenna, President, The Royal College of Physicians of Ireland, Frederick House, 19 South Frederick Street, Dublin 2, Ireland (college@rcpi.ie ?)
- Dr Brian Williams, President, The Royal College of Physicians and Surgeons of Glasgow, 232-242 St Vincent Street, Glasgow G2 5RJ (president@rcpsg.ac.uk)
- Dr Judith Hulf, President, The Royal College of Anaesthetists, Churchill House, 35 Red Lion Square, London WC1R 4SG (president@rcoa.ac.uk)
- Prof. Sabaratnam Arulkumaran, President, The Royal College of Obstetricians and Gynaecologists, 27 Sussex Place, Regent's Park, London, NW1 4RG (president@rcog.org.uk)

[27] http://www.remedyuk.net/images/banners/JR%20Findings.pdf

- Prof. David Haslam, President, The Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London SW7 1PU (president@rcgp.org.uk)
- Prof. Adrian Newland, President, The Royal College of Pathologists, 2 Carlton House Terrace, London SW1Y 5AF (president@rcpath.org)
- Prof. Sheila Hollins, President, The Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG (shollins@rcpsych.ac.uk)
- Prof. Janet Husband, President, The Royal College of Radiologists, 38 Portland Place, London W1B 1JQ (janet_husband@rcr.ac.uk)
- Prof. Brenda Billington, President, The Royal College of Ophthalmologists, 17 Cornwall Terrace, London NW1 4QW (president@rcophth.ac.uk)
- Dr Patricia Hamilton, President, The Royal College of Paediatrics and Child Health, 50 Hallam Street, London W1W 6DE (patricia.hamilton@rcpch.ac.uk)
- Prof. Rod Griffiths, President, The Faculty of Public Health Medicine, 4 St Andrews Place, London NW1 4LB (president@fphm.org.uk)
- Mr J. Wardrope, President–Chairman, The College of Emergency Medicine, Churchill House, 35 Red Lion Square, London WC1R 4SG (cem@emergencymedicine.uk.net)
- Prof. Dame Carol Black, Chairman, The Academy of Medical Royal Colleges, 70 Wimpole Street, London WIG 8AX (carol.black@aomrc.org.uk)

Government, the Civil Service, Opposition, other State entities

- The Current Head, Modernising Medical Careers, 6th Floor, New Kings Beam House, 22 Upper Ground, London SE1 9BW **(by post as no e-mail address known)**
- Prof. Peter Rubin, Chairman, Postgraduate Medical Education and Training Board, Hercules House, Hercules Road, London SE1 7DU (peter.rubin@pmetb.org.uk ?)
- The Rt Hon. Patricia Hewitt, Secretary of State for Health, The Department of Health, Richmond House, 79 Whitehall, London SW1A 2NS **(by post as no e-mail address known)**
- The Rt Hon Gordon Brown, Chancellor of the Exchequer, Her Majesty's Treasury, 1 Horse Guards Road, London SW1A 2HQ **(by post as no e-mail address known)**
- Mr Andrew Lansley, Shadow Secretary of State for Health, 153 St Neots Road, Hardwick, Cambridge CB3 7QJ **(by post as no e-mail address known)**
- Mr Norman Lamb, Liberal Democrat Shadow Secretary of State for Health, 15 Market Place, North Walsham NR28 9BP **(by post as no e-mail address known)**
- Lord Hunt of Kings Heath, Minister of State for Quality, The Department of Health, Richmond House, 79 Whitehall, London SW1A 2NS **(by post as no e-mail address known)**
- Sir Liam Donaldson, Chief Medical Officer, Department of Health, Room 114, Richmond House, 79 Whitehall, London SW1A 2NS (cmoweb@dh.gsi.gov.uk)
- Sir Graeme Catto, President, General Medical Council (opce@gmc-uk.org)

Medical postgraduate deaneries

- Col. Jonathan Leach, Director, Defence Postgraduate Medical Deanery, ICT Centre, Birmingham Research Park, Vincent Drive, Edgbaston, Birmingham B15 2SQ (jonaleac@dsca.mod.uk)
- Dr David Bruce, Director, East Scotland Deanery, The Mackenzie Building, Tayside Centre for General Practice, Postgraduate Unit, Kirsty Semple Way, Dundee, DD2 4BF (david.bruce@nes.scot.nhs.uk)
- Prof. D. Huw Jones, Postgraduate Dean, East of England Deanery, Block 3, Ida Darwin, Fulbourn, Cambridge CB1 5EE (Huw.Jones@easterndeanery.nhs.uk)
- Prof. David Black, Dean Director, Kent, Surrey, and Sussex Postgraduate Deanery, 7 Bermondsey Street, London SE1 2DD (dblack@kssdeanery.ac.uk)
- Prof. Elisabeth Paice, Dean Director, London Deanery, Stewart House, 32 Russell Square, London WC1B 5DN (epaice@londondeanery.ac.uk)
- Prof. David Graham, Postgraduate Medical Dean, Mersey Deanery, Regatta Place, Brunswick Business Park, Liverpool L3 4BL (david.graham@merseydeanery.nhs.uk)
- Dr Mike Taylor, Director, North East Scotland Deanery, NHS Education for Scotland, Forest Grove House, Foresterhill Road, Aberdeen AB25 2ZP (michael.taylor@nes.scot.nhs.uk)
- Dr Ronald MacVicar, Director, North Scotland Deanery, Centre for Health Science, Old Perth Road, Inverness IV2 3JH (Ronald.MacVicar@nes.scot.nhs.uk)
- Prof. Jacky Hayden, Dean, North Western Deanery, 4th Floor, Barlow House, Minshull Street, Manchester M1 3DZ (j.hayden@nwpgmd.nhs.uk)
- Dr Graham Rutt, Postgraduate Dean Director, Northern Deanery, Postgraduate Institute for Medicine & Dentistry, 10/12 Framlington Place, Newcastle upon Tyne NE2 4AB (graham.rutt@unn.ac.uk)
- Dr Terry McMurray, Postrgraduate Medical Dean, Northern Ireland Deanery, Northern Ireland Medical and Dental Training Agency, Beechill House, 42 Beechill Road, Belfast BT8 7RL (terry.mcmurray@nimdta.gov.uk)
- Dr Michael Bannon, Postgraduate Dean, Oxford Deanery, The Triangle, Roosevelt Drive, Headington, Oxford OX3 7XP (vbeal@oxford-pgmde.co.uk)
- Prof. Graham Winyard, Dean Director, Severn and Wessex Deanery, Highcroft, Romsey Road, Winchester SO22 5DH (Graham.Winyard@sevwesdeanery.nhs.uk)
- Dr David Blaney, Director, South East Scotland Deanery, GP Unit, The Lister, 11 Hill Square, Edinburgh EH8 9DR (david.blaney@nes.scot.nhs.uk)
- Dr Martin Beaman, Postgraduate Dean, South West Peninsula Deanery, The John Bull Building, Tamar Science Park, Plymouth PL6 8BU (martin.beaman@peninsuladeanery.ac.uk)
- Prof. David Sowden, Postgraduate Dean, East Midlands Healthcare Workforce Deanery, Lakeside House, 4 Smith Way, Grove Park, Enderby, Leicester LE19 1SS (David.Sowden@nottingham.ac.uk)
- Prof. Sarah Thomas, Postgraduate Dean, South Yorkshire & South Humber Deanery, Ground Floor, Don Valley House, Saville Street East, Sheffield S4 7UQ (sarah.thomas@yorksandhumber.nhs.uk)
- Prof. Derek Gallen, Postgraduate Dean, Wales Deanery, School of Postgraduate Medical and Dental Education, Wales College of Medicine, Cardiff University, Heath Park, Cardiff CF14 4XN (pgdean@cardiff.ac.uk)
- Prof. Steve Field, Postgraduate Dean, West Midlands Deanery, Birmingham Research Park, 97 Vincent Drive, Edgbaston, Birmingham B15 2SQ (stephen.field@wmdeanery.org)
- Prof. Stuart Murray, Postgraduate Dean, West Scotland Deanery, Department of Postgraduate Medicine, 3rd Floor, 2 Central Quay, 89 Hydepark Street, Glasgow G3 8BW (stuart.murray@nes.scot.nhs.uk)
- Prof. William Burr, Postgraduate Dean, Yorkshire Deanery, The Department for Postgraduate Medical & Dental Education (Yorkshire), Willow Terrace Road, University of Leeds, Leeds LS2 9JT (w.burr@yorkshiredeanery.com)

Members of the Medical Schools Council

- Prof. Sir John Tooke, Dean, Peninsula Medical School (*primary addressee*; john.tooke@pms.ac.uk)
- Prof. Tony Weetman, Dean, School of Medicine and Biomedical Sciences, University of Sheffield (a.p.weetman@sheffield.ac.uk)
- Prof. Terence Stephenson, Dean, Faculty of Medicine and Health Sciences, The University of Nottingham (terence.stephenson@nottingham.ac.uk)
- Prof. Iain Cameron, Head of School of Medicine, University of Southampton (itc@soton.ac.uk)
- Dr Ken Fleming, Head of Medical Sciences Division, University of Oxford (kenneth.fleming@medsci.ox.ac.uk)
- Prof. Robert Lechler, Vice-Principal (Health), King's College London School of Medicine (at Guy's, King's College and St Thomas' Hospitals) (robert.lechler@kcl.ac.uk)
- Prof. Hugh MacDougall, Dean of Medicine, Bute Medical School, University of St Andrews (medical.dean@st-andrews.ac.uk)
- Prof. Sir Nicholas Wright, Warden, Barts and the London, Queen Mary's School of Medicine and Dentistry (warden@qmul.ac.uk)
- Prof. Alan North, Acting Head of School, School of Medicine, University of Manchester (alan.north@manchester.ac.uk)
- Prof. David Barlow, Executive Dean of Medicine, Faculty of Medicine, University of Glasgow (D.Barlow@clinmed.gla.ac.uk)
- Prof. Irene Leigh, Head of College, Medicine, Dentistry and Nursing, University of Dundee (I.M.Leigh@dundee.ac.uk)
- Prof. John Caldwell, Dean, Faculty of Medicine, University of Liverpool (jcc@liverpool.ac.uk)
- Prof. Yvonne Carter, Dean, Warwick Medical School, The University of Warwick (Yvonne.Carter@warwick.ac.uk)
- Prof. Jon Cohen, Dean, Brighton and Sussex Medical School, University of Sussex (j.cohen@bsms.ac.uk)
- Prof. Michael Sheppard, Dean and Head of School, The Medical School, University of Birmingham (m.c.sheppard@bham.ac.uk)
- Prof. Michael Farthing, Principal, St George's, University of London (m.farthing@sgul.ac.uk)
- Prof. Ian Greer, Dean, Hull York Medical School, The University of Hull (ian.greer@hyms.ac.uk)
- Prof. Mike Greaves, Head of School of Medicine, University of Aberdeen (m.greaves@abdn.ac.uk)
- Prof. Sir Andrew Haines, Dean, London School of Hygiene & Tropical Medicine (Andy.Haines@lshtm.ac.uk)
- Prof. Rod Hay, Head of the School of Medicine, School of Medicine and Dentistry, Queen's University Belfast (r.hay@qub.ac.uk)
- Prof. Richard Hays, Head of School of Medicine, Keele University (r.b.hays@hfac.keele.ac.uk)
- Prof. Edward Hillhouse, Dean of the Faculty of Medicine and Health, University of Leeds (e.w.hillhouse@leeds.ac.uk)
- Prof. Oliver James, Pro Vice Chancellor & Dean of Medicine, The Medical School, University of Newcastle (o.f.w.james@ncl.ac.uk)
- Prof. Ian Lauder, Dean of the Faculty of Medicine and Biological Sciences, University of Leicester (lau@le.ac.uk)
- Prof. Sam Leinster, Dean, School of Medicine, Health Policy and Practice, University of East Anglia (s.leinster@uea.ac.uk)
- Prof. John Savill, Vice-Principal & Head, College of Medicine and Veterinary Medicine, The University of Edinburgh (j.savill@ed.ac.uk)
- Prof. Patrick Sissons, Regius Professor of Physic, School of Clinical Medicine, University of Cambridge (regius@medschl.cam.ac.uk)
- Prof. Stephen Smith, Principal, Faculty of Medicine, Imperial College London (s.k.smith@imperial.ac.uk)
- Prof. Edward Byrne, Executive Dean, Faculty of Biomedical Sciences and Head of the Medical School, University College London (e.byrne@medsch.ucl.ac.uk)
- Prof. Gareth Williams, Dean, Faculty of Medicine & Dentistry, University of Bristol (gareth.williams@bristol.ac.uk)
- Prof. David Wynford-Thomas, Dean of Medicine, School of Medicine, Cardiff University (meddean@cf.ac.uk)
- The Medical Schools Council, Woburn House, 20 Tavistock Square, London WC1H 9HD (admin@medschools.ac.uk)

Primary care trust employers (from list at http://www.networks.nhs.uk/189.php)

- Louise Newcombe, Chief Executive, Bassetlaw PCT, Retford Hospital, North Road, Retford DN22 7XF (Louise.Newcombe@bassetlaw-pct.nhs.uk)
- Prem Singh, Chief Executive, Derby City PCT, Derwent Court, 1 Stuart Street, Derby DE1 2FZ (prem.singh@derbycitypct.nhs.uk ?)
- Derek Bray, Chief Executive, Derbyshire County PCT, Scarsdale, Newbold Road, Chesterfield S41 7PF (derek.bray@derbyshirecountypct.nhs.uk ?)
- Tim Rideout, Chief Executive, Leicester City PCT, St John's House, 30 East Street Leicester LE1 6NB (tim.rideout@leicestercitypct.nhs.uk ?)
- Catherine Griffiths, Chief Executive, Leicestershire County and Rutland PCT, Lakeside House, 4 Smith Way, Grove Park, Enderby, Leicester LE19 1SS (catherine.griffiths@lcrpct.nhs.uk)
- John McIvor, Chief Executive, Lincolnshire Teaching PCT, Cross O'Cliff Court, Bracebridge Heath, Lincoln, Lincolnshire LN4 2HN (john.mcivor@lpct.nhs.uk)
- John Parkes, Chief Executive, Northamptonshire PCT, Bevan House, Kettering Parkway, Venture Park, Kettering, Northants NN15 6XR (john.parkes@northants.nhs.uk ?)

- Stephen Golledge, Chief Executive, Nottingham City PCT, 1 Standard Court, Park Row, Nottingham NG1 6GN (stephen.golledge@nottinghamcity-pct.nhs.uk ?)
- Wendy Saviour, Chief Executive, Nottinghamshire County PCT, Ransom Hall, Ransom Wood Business Park, Southwell Road West, Rainworth, Mansfield, Nottinghamshire NG21 OER (wendy.saviour@nottinghamshirecounty-pct.nhs.uk)
- Margaret Stockham, Chief Executive, Bedfordshire PCT, Gilbert Hitchcock House, 21 Kimbolton Road, Bedford, Bedfordshire MK40 2AW (margaret.stockham@bedfordshirepct.nhs.uk ?)
- Chris Banks, Chief Executive, Cambridgeshire PCT, Block 23, Heron Court, Ida Darwin Hospital, Cambridge Road, Fulbourn, Cambridge, Cambridgeshire CB1 5EE (chris.banks@cambridgeshirepct.nhs.uk ?)
- Anne Walker, Chief Executive, East & North Hertfordshire PCT, Charter House, Parkway, Welwyn Garden City, Hertfordshire AL8 6JL (anne.walker@herts-pcts.nhs.uk ?)
- Mike Stonard, Chief Executive, Great Yarmouth & Waveney PCT, 1 Common Lane North, Beccles, Suffolk NR34 9BN (michael.stonard@nhs.net)
- Regina Shakespeare, Chief Executive, Luton PCT, Nightingale House, 94 Inkerman Street, Luton LU1 1JD (Regina.Shakespeare@luton-pct.nhs.uk)
- Sheila Bremner, Chief Executive, Mid Essex PCT, Kestrel House, Hedgerows Business Park, Colchester Road, Springfield, Chelmsford, Essex CM2 5PF (sheila.bremner@midessexpct.nhs.uk ?)
- Julie Garbutt, Chief Executive, Norfolk PCT, St Andrew's House, St Andrew's Business Park, Northside, Norwich NR7 0HT (julie.garbutt@norfolk-pct.nhs.uk)
- Dr Paul Zollinger-Read, Chief Executive, North East Essex PCT, 659-662 The Crescent, Severalls Business Park, Colchester, Essex CO4 9YQ (paul.zollinger-read@neessexpct.nhs.uk ?)
- Angela Bailey, Chief Executive, Peterborough PCT, 2nd Floor, Town Hall, Peterborough PE1 1FA (angela.bailey@peterboroughpct.nhs.uk ?)
- Lorraine Cabel, Chief Executive, South East Essex PCT, Harcourt House, Harcourt Avenue, Southend-on-Sea, Essex SS2 6HE (lorraine.cabel@see-pct.nhs.uk ?)
- Pam Court, Chief Executive, South West Essex PCT, Phoenix Court, Christopher Martin Road, Basildon, Essex SS14 3HG (pam.court@swessexpct.nhs.uk ?)
- Carole Taylor-Brown, Chief Executive, Suffolk PCT, Bixley Office, St Clements Main Hospital, Foxhall Road, Ipswich IP3 8LS (carole.taylor-brown@suffolkpct.nhs.uk)
- Aidan Thomas, Chief Executive, West Essex PCT, The Laurels, St. Margaret's Hospital, The Plain, Epping, Essex CM16 6TN (aidan.thomas@westessexpct.nhs.uk ?)
- Anne Walker, Chief Executive, West Hertfordshire PCT, Charter House, Parkway, Welwyn Garden City, Hertfordshire AL8 6JL (anne.walker@herts-pcts.nhs.uk ?)
- Hilary Ayerst, Chief Executive, Barking and Dagenham PCT, Clock House, East Street, Barking, Essex IG11 8EY (hilary.ayerst@bdpct.nhs.uk ?)
- Charles Hollwey, Chief Executive, Barnet PCT, 3rd Floor, Westgate House, Edgware Community Hospital, Burnt Oak Broadway, Edgware, Middlesex HA8 0AD (charles.hollwey@barnet-pct.nhs.uk ?)
- Anthony McKeever, Chief Executive, Bexley Care Trust, 221 Erith Road, Bexleyheath, Kent DA7 6HZ (anthony.mckeever@bexley.nhs.uk ?)
- Nigel Webb, Chief Executive, Brent Teaching PCT, Wembley Centre For Health and Care, 116 Chaplin Road, Wembley, Middlesex HA0 4UZ (nigel.webb@brentpct.nhs.uk)
- Simon Robbins, Chief Executive, Bromley PCT, Bassetts House, Broadwater Gardens, Orpington, Kent BR6 7UA (simon.robbins@bromleypct.nhs.uk ?)
- Rob Larkman, Chief Executive, Camden PCT, 4th Floor, East Wing, St. Pancras Hospital, 4 St. Pancras Way, London NW1 0PE (rob.larkman@camdenpct.nhs.uk)
- Laura Sharpe, Chief Executive, City and Hackney Teaching PCT, St. Leonards Hospital, Nuttall Street, London N1 5LZ (laura.sharpe@chpct.nhs.uk)
- Caroline Taylor, Chief Executive, Croydon PCT, Leon House, 233 High Street, Croydon, Surrey CR0 9XT (caroline.taylor@croydonpct.nhs.uk ?)
- Robert Creighton, Chief Executive, Ealing PCT, 1 Armstrong Way, Southall, Middlesex UB2 4SA (Robert.Creighton@ealingpct.nhs.uk)
- Sally Johnson, Chief Executive, Enfield PCT, Holbrook House, Cockfosters Road, Barnet, Hertfordshire EN4 0DR (sally.johnson@enfield.nhs.uk ?)
- Jane Schofield, Chief Executive, Greenwich Teaching PCT, 31-37 Greenwich Park Street, London SE10 9LR (Jane.Schofield@GreenwichPCT.nhs.uk)
- Mike Wood, Chief Executive, Hammersmith and Fulham PCT, Parsons Green Centre, 5-7 Parsons Green, London SW6 4UL (mike.wood@hf-pct.nhs.uk)
- Tracey Baldwin, Chief Executive, Haringey Teaching PCT, St. Ann's Road, Tottenham, London N15 3TH (tracey.baldwin@haringey.nhs.uk)
- Andrew Morgan, Chief Executive, Harrow PCT, Grace House, Harrovian Business Village, Bessborough Road, Harrow, Middlesex HA1 3EX (Andrew.Morgan@harrowpct.nhs.uk)
- Ralph McCormack, Chief Executive, Havering PCT, St. Georges Hospital, 117 Suttons Lane, Hornchurch, Essex RM12 6RS (Ralph.McCormack@haveringpct.nhs.uk)
- Antony Sumara, Chief Executive, Hillingdon PCT, Kirk House, 97-109 High Street, Yiewsley, West Drayton, Middlesex UB7 7HJ (antony.sumara@hillingdon.nhs.uk)
- John James, Chief Executive, Hounslow PCT, Phoenix Court, 531 Staines Road, Hounslow, Middlesex TW4 5DP (john.james@hounslowpct.nhs.uk)
- Rachel Tyndall, Chief Executive, Islington PCT, 338-346 Goswell Road, London EC1V 7LQ (Rachel.Tyndall@islingtonpct.nhs.uk)
- Andrew Kenworthy, Chief Executive, Kensington and Chelsea PCT, Courtfield House, St. Charles Hospital, Exmoor Street, London W10 6DZ (chief.executive@kc-pct.nhs.uk)
- David Smith, Chief Executive, Kingston PCT, 22 Hollyfield Road, Surbiton, Surrey KT5 9AL (david.smith@kpct.nhs.uk)
- Kevin Barton, Chief Executive, Lambeth PCT, 1 Lower Marsh, London SE1 7NT (kevin.barton@lambethpct.nhs.uk)
- Gill Galliano, Chief Executive, Lewisham PCT, Cantilever House, Eltham Road, Lee, London SE12 8RN (gill.galliano@lewishampct.nhs.uk)
- Melanie Walker, Chief Executive, Newham PCT, Warehouse K, 2 Western Gateway, London E16 1DR (melanie.walker@newhampct.nhs.uk ?)
- Heather O'Meara, Chief Executive, Redbridge PCT, Beckett House, 2-14 Ilford Hill, Ilford, Essex IG1 2QX (heather.omeara@redbridge-pct.nhs.uk)
- Joan Mager, Chief Executive, Richmond and Twickenham PCT, Thames House, 180 High Street, Teddington, Middlesex TW11 8HU (joan.mager@rtpct.nhs.uk)
- Chris Bull, Chief Executive, Southwark PCT, 6th Floor, Mabel Goldwin House, 49 Grange Walk, London SE1 3DY (chris.bull@southwarkpct.nhs.uk)
- Caroline Taylor, Chief Executive, Sutton and Merton PCT, Hamilton Wing, Nelson Hospital, Kingston Road, London SW20 8DB (caroline.taylor@smpct.nhs.uk)
- Alwen Williams, Chief Executive, Tower Hamlets PCT, Trust Offices, Mile End Hospital, Bancroft Road, London E1 4DG (alwen.williams@thpct.nhs.uk)
- Sally Gorham, Chief Executive, Waltham Forest PCT, 3rd Floor, Kirkdale House, 7 Kirkdale Road, Leytonstone, London E11 1HP (sally.gorham@wf-pct.nhs.uk)
- Ann Radmore, Chief Executive, Wandsworth PCT, 2nd Floor, Teak Tower, Main Building, Springfield Hospital, 61 Glenburnie Road, London SW17 7DJ (ann.radmore@wpct.nhs.uk)
- Lynda Hamlyn, Chief Executive, Westminster PCT, Ferguson House, 15 Marylebone Road, London NW1 5JD (lynda.hamlyn@westminster-pct.nhs.uk)
- Yasmin Chaudhry, Chief Executive, County Durham PCT, John Snow House, Durham University Science Park, Durham DH1 3 YG (yasmin.chaudhry@nhs.net)
- Colin Morris, Chief Executive, Darlington PCT, Dr Piper House, King Street, Darlington DL3 6JL (colin.morris@darlingtonpct.nhs.uk)
- Karen Straughair, Chief Executive, Gateshead PCT, Team View, Fifth Avenue Business Park, Team Valley, Gateshead NE11 0NB (karen.straughair@ghpct.nhs.uk ?)
- Mrs Chris Willis, Chief Executive, Hartlepool PCT, 1st Floor, Mandale House , Harbour Walk, The Marina, Hartlepool TS24 0UX (chris.willis@hartlepoolpct.nhs.uk ?)
- Colin McLeod, Chief Executive, Middlesbrough PCT, Riverside House, High Force Road, Riverside Park, Middlesbrough TS2 1RH (colin.mcleod@middlesbroughpct.nhs.uk)
- Chris Reed, Chief Executive, Newcastle PCT, Benfield Road, Newcastle upon Tyne NE6 4PF (chris.reed@newcastle-pct.nhs.uk)
- Mrs Chris Willis, Chief Executive, North Tees PCT, Tower House, Teesdale South, Thornaby Place, Thornaby TS17 6SF (chris.willis@northteespct.nhs.uk ?)
- Chris Reed, Chief Executive, North Tyneside PCT, Equinox House, Silver Fox Way, Cobalt Business Park, North Tyneside NE27 0QJ (chris.reed@northtyneside-pct.nhs.uk ?)
- Chris Reed, Chief Executive, Northumberland Care Trust, Merley Croft, Loansdean, Morpeth, Northumberland NE61 2DL (chris.reed@northumberlandcaretrust.nhs.uk)
- Jon Chadwick, Chief Executive, Redcar & Cleveland PCT, Langbaurgh House, Bow Street, Guisborough TS14 7AA (jon.chadwick@rcpct.nhs.uk ?)
- Karen Straughair, Chief Executive, South Tyneside PCT, Clarendon, Windmill Way, Hebburn, Tyne and Wear NE31 1AT (karen.straughair@stpct.nhs.uk ?)
- Karen Straughair, Chief Executive, Sunderland PCT, Pemberton House, Colima Avenue, Sunderland Enterprise Park, Sunderland SR5 3XB (karen.straughair@suntpct.nhs.uk ?)
- Peter Rowe, Chief Executive, Ashton, Leigh & Wigan PCT, Bryan House, 61 Standishgate, Wigan, Lancashire WN1 1AH (peter.rowe@alwpct.nhs.uk)
- Judith Holbrey, Chief Executive, Blackburn with Darwen PCT, Guide Business Centre, School Lane, Blackburn, Lancashire BB1 2QH (judith.holbrey@bwdpct.nhs.uk)
- Wendy Swift, Chief Executive, Blackpool PCT, Seasiders Way, Blackpool, Lancashire FY1 6JX (wendy.swift@blackpoolpct.nhs.uk)
- Tim Evans, Chief Executive, Bolton PCT, St. Peter's House, Silverwell Street, Bolton BL1 1PP (tim.evans@bolton.nhs.uk)
- Stephen Mills, Chief Executive, Bury PCT, 21 Silver Street, Bury BL9 0EN (stephen.mills@burypct.nhs.uk ?)
- Mike Pyrah, Chief Executive, Central & Eastern Cheshire PCT, Bevan House, Barony Road, Nantwich, Cheshire CW5 5QU (michael.pyrah@cecpct.nhs.uk)
- Mark Wilkinson, Chief Executive, Central Lancashire PCT, Jubilee House, Lancashire Enterprise Business, Leyland, Lancashire PR26 6TR (mark.wilkinson@centrallancashire.nhs.uk ?)
- Sue Page, Chief Executive, Cumbria PCT, 4 Wavell Drive, Rosehill Industrial Estate, Carlisle, Cumbria CA1 2SE (sue.page@cumbriapct.nhs.uk)
- David Peat, Chief Executive, East Lancashire PCT, 31/33 Kenyon Road, Lomeshaye Estate, Nelson BB9 5SZ (david.peat@eastlancspct.nhs.uk ?)
- Rebecca Burke-Sharples, Chief Executive, Halton & St Helens PCT, Lister Road, Astmoor, Runcorn, Cheshire WA7 1TW (rebecca.burke-sharples@hsthpct.nhs.uk ?)
- Trevor Purt, Chief Executive, Heywood, Middleton and Rochdale PCT, 3rd and 5th Floors, Telegraph House, Baillie Street, Rochdale, Lancashire, OL16 1JA (trevor.purt@hmrpct.nhs.uk ?)
- Anita Marsland, Chief Executive, Knowsley PCT, PO Box 23, Nutgrove Villa, Westmorland Road, Huyton, Knowsley L36 6GA (anita.marsland@knowsley.nhs.uk ?)
- Derek Campbell, Chief Executive, Liverpool PCT, 1 Arthouse Square, 61-69 Seel Street, Liverpool L1 4AZ (derek.campbell@liverpoolpct.nhs.uk ?)
- Laura Roberts, Chief Executive, Manchester PCT, Mauldeth House, Mauldeth Road West, Manchester M21 7RL (laura.roberts@manchester.nhs.uk)
- Ian Cumming, Chief Executive, North Lancashire PCT, Derby Road, Wesham, Preston, Lancashire PR4 3AL (ian.cumming@northlancs.nhs.uk)
- Gail Richards, Chief Executive, Oldham PCT, Ellen House, Waddington Street, Oldham OL9 6EE (gail.richards@nhs.net)
- Dr Mike Burrows, Chief Executive, Salford PCT, St James's House, Pendleton Way, Salford M6 5FW (mike.burrows@salford-pct.nhs.uk)
- Leigh Griffin, Chief Executive, Sefton PCT, 3rd Floor, Burlington House, Crosby Road North, Waterloo, Liverpool L22 0QB (leigh.griffin@seftonpct.nhs.uk)
- Richard Popplewell, Chief Executive, Stockport PCT, Regent House, 8th Floor, Heaton Lane, Stockport SK4 1BS (richard.popplewell@stockport-pct.nhs.uk)
- Dr Tim Riley, Chief Executive, Tameside & Glossop PCT, New Century House, Progress Way, Windmill Lane, Denton M34 2GP (tim.riley@tgh.nhs.uk ?)
- Sheena Cumiskey, Chief Executive, Trafford PCT, 2nd Floor, Oakland House, Talbot Road, Old Trafford, Manchester M16 0PQ (sheena.cumiskey@trafford.nhs.uk ?)
- Allison Cooke, Chief Executive, Warrington PCT, 930-932 Birchwood Boulevard, Millennium Park, Birchwood, Warrington WA3 7QN (allison.cooke@warrington-pct.nhs.uk ?)
- Helen Bellairs, Chief Executive, Western Cheshire PCT, 1829 Building, Countess of Chester Health Park, Liverpool Road, Chester CH2 1DU (helen.bellairs@wcheshirepct.nhs.uk)
- Kathy Doran, Chief Executive, Wirral PCT, Admin Block, St. Catherine's Hospital, Church Road, Tranmere, Birkenhead CH42 0LQ (kathy.doran@wirralpct.nhs.uk ?)
- Dr Lise Llewellyn, Chief Executive, Berkshire East PCT, 57-59 Bath Road, Reading, Berkshire RG30 2BA (lise.llewellyn@berkshire.nhs.uk ?)
- Charles Waddicor, Chief Executive, Berkshire West PCT, 57-59 Bath Road, Reading RG30 2BA (charles.waddicor@berkshire.nhs.uk ?)
- Janet Fitzgerald, Chief Executive, Buckinghamshire PCT, 3rd Floor, Rapid House, 40 Oxford Road, High Wycombe HP11 2EE (janet.fitzgerald@buckspct.nhs.uk)
- Gareth Cruddace, Chief Executive, Hampshire PCT, Regus House, Southampton International Business Park, George Curl Way, Southampton SO18 2RZ (gareth.cruddace@hampshirepct.nhs.uk ?)
- Ed Macalister-Smith, Chief Executive, Isle of Wight PCT, St Mary's Hospital, Parkhurst Road, Newport, Isle of Wight PO30 5TG (ed.macalister-smith@iow.nhs.uk ?)
- Barbara Kennedy, Chief Executive, Milton Keynes PCT, Trust Headquarters, Hospital Campus, Eaglestone, Milton Keynes MK6 5NG (barbara.kennedy@mkpct.nhs.uk)
- Andrea Young, Chief Executive, Oxfordshire PCT, The Richards Building, Old Road, Headington, Oxford OX3 7LG (andrea.young@oxfordshirepct.nhs.uk ?)
- Sheila Clark, Chief Executive, Portsmouth City PCT, Trust Central Office, St James Hospital, Locksway Road, Milton, Portsmouth PO4 8LD (sheila.clark@ports.nhs.uk)
- Brian Skinner, Chief Executive, Southampton City PCT, Trust HQ, Western Community Hospital, William Macleod Way, Southampton SO16 4XE (brian.skinner@scpct.nhs.uk ?)
- Darren Grayson, Chief Executive, Brighton & Hove City PCT, Prestamex House, 171-173 Preston Road, Brighton BN1 6AG (darren.grayson@bhcpct.nhs.uk ?)
- Ann Sutton, Chief Executive, Eastern & Coastal Kent PCT, Brook House, John Wilson Business Park, Reeves Way, Chestfield, Whitstable Kent CT5 3QT (ann.sutton@ekentmht.nhs.uk ?)
- Nick Yeo, Chief Executive, East Sussex Downs & Weald PCT, 36-38 Friars Walk, Lewes, East Sussex BN7 2PB (nick.yeo@esdwpct.nhs.uk ?)
- Nick Yeo, Chief Executive, Hastings & Rother PCT, Bexhill Hospital, Holliers Hill, Bexhill-on-Sea, East Sussex TN40 2DZ (nick.yeo@hastingsandrotherpct.nhs.uk ?)
- Marion Dinwoodie, Chief Executive, Medway PCT, 7-8 Ambley Green, Bailey Drive, Gillingham Business Park, Gillingham, Kent ME8 0NJ (marion.dinwoodie@medwaypct.nhs.uk ?)
- Chris Butler, Chief Executive, Surrey PCT, Bournewood House. Guildford Road. Chertsey. Surrey KT16 0QA (chris.butler@surreypct.nhs.uk ?)
- Steve Phoenix, Chief Executive, West Kent PCT, Wharf House, Medway Wharf Road, Tonbridge, Kent TN9 1RE (steve.phoenix@westkentpct.nhs.uk ?)
- John Wilderspin, Chief Executive, West Sussex PCT, The Causeway, Goring by Sea BN12 6BT (John.Wilderspin@westsussexpct.nhs.uk)
- Rhona MacDonald, Chief Executive, Bath & North East Somerset PCT, Trust Headquarters, St Martin's Hospital, Clara Cross Lane, Bath BA2 5RP (rhona.macdonald@banes-pct.nhs.uk)
- Debbie Fleming, Chief Executive, Bournemouth & Poole PCT, Westover House, West Quay Road, Poole BH15 1JF (debbie.fleming@bp-pct.nhs.uk ?)
- Deborah Evans, Chief Executive, Bristol PCT, King Square House, King Square, Bristol BS2 8EE (deborah.evans@bristolpct.nhs.uk ?)
- Ann James, Chief Executive, Cornwall & Isles of Scilly PCT, Sedgemoor Centre, Priory Road, St Austell, Cornwall PL25 5AS (ann.james@ciospct.nhs.uk)
- Kevin Snee, Chief Executive, Devon PCT, Lescaze Offices, Shinners Bridge, Dartington, Totnes, Devon TQ9 6JE (enquiries.devonpct@nhs.net ?)
- Peter Mankin, Chief Executive, Dorset PCT, Hillfort House, Poundbury Road, Dorchester, Dorset DT1 2PN (peter.mankin@dorset-pct.nhs.uk)
- Jan Stubbings, Chief Executive, Gloucestershire PCT, Unit 43, Central Way, Arle Road, Cheltenham GL51 8LX (jan.stubbings@glos.nhs.uk)
- Chris Born, Chief Executive, North Somerset PCT, Waverley House, Old Church Road, Clevedon, North Somerset BS21 6NN (chris.born@nsomerset-pct.nhs.uk ?)
- John Richards, Chief Executive, Plymouth PCT, Building One, Brest Road, Plymouth PL6 5QZ (john.richards@pcs-tr.swest.nhs.uk)
- Ian Tipney, Chief Executive, Somerset PCT, Wellsprings Road, Taunton, Somerset TA2 7PQ (ian.tipney@somersetpct.nhs.uk ?)
- Penny Harris, Chief Executive, South Gloucestershire PCT, 1 Monarch Court, Emerald Park, Emerson's Green, Bristol BS16 7FH (penny.harris@sglos-pct.nhs.uk)
- Caroline Fowles, Chief Executive, Swindon PCT, North Swindon District Centre, Thamesdown Drive, Swindon SN25 4AN (caroline.fowles@swindon-pct.nhs.uk)

- Peter Colclough, Chief Executive, Torbay Care Trust, Bay House, Riviera Park, Nicholson Road, Torquay TQ2 7TD (peter.colclough@torbay-pct.nhs.uk)
- Jeff James, Chief Executive, Wiltshire PCT, Southgate House, Pans Lane, Devizes, Wiltshire SN10 5EQ (jeff.james@wiltshire-pct.nhs.uk)
- Sophia Christie, Chief Executive, Birmingham East & North PCT, 4th Floor, Waterlinks House, Richard Street, Aston B7 4AA (sophia.christie@easternbirminghampct.nhs.uk)
- Stephen Jones and Mike Attwood, Chief Executives, Coventry PCT, Christchurch House, Greyfriars Lane, Coventry CV1 2GQ (chiefexecutive@coventrypct.nhs.uk)
- Mark Cooke, Chief Executive, Dudley PCT, Union Street, Dudley, West Midlands DY2 8PP (mark.cooke@dudley.nhs.uk)
- Dr Sandy Bradbrook, Chief Executive, Heart of Birmingham PCT, Bartholomew House, 142 Hagley Road, Edgbaston, Birmingham B16 9PA (sandy.bradbrook@hobtpct.nhs.uk)
- Simon Hairsnape, Chief Executive, Herefordshire PCT, Vaughan Building, Ruckhall Lane, Belmont, Hereford HR2 9RP (simon.hairsnape@herefordpct.nhs.uk)
- Tony Bruce, Chief Executive, North Staffordshire PCT, Moorlands House, Stockwell Street, Leek, Staffordshire ST13 6HQ (tony.bruce@northstaffs.nhs.uk)
- Rob Bacon, Chief Executive, Sandwell PCT, Kingston House, 438-450 High Street, West Bromwich, West Midlands B70 9LD (robert.bacon@sandwell-pct.nhs.uk)
- Julie Grant, Chief Executive, Shropshire County PCT, William Farr House, Mytton Oak Road, Shrewsbury, Shropshire SY3 8XL (julie.grant@shropshirepct.nhs.uk)
- Sally Burton, Chief Executive, Solihull Care Trust, 20 Union Road, Solihull, West Midlands B91 3EF (sally.burton@solihull-pct.nhs.uk ?)
- Moira Dumma, Chief Executive, South Birmingham PCT, Moseley Hall Hospital, Alcester Road, Moseley, Birmingham B13 8JL (moira.dumma@sbpct.nhs.uk)
- Stuart Poynor, Chief Executive, South Staffordshire PCT, Merlin House, Etchell Road, Bitterscote, Tamworth B78 3HF (stuart.poynor@es-pct.nhs.uk)
- Graham Urwin, Chief Executive, Stoke-on-Trent PCT, Whittle Court, Town Road, Hanley, Stoke-on-Trent, Staffordshire ST1 2QE (Graham.Urwin@northstaffs.nhs.uk)
- Simon Conolly, Chief Executive, Telford & Wrekin PCT, Sommerfeld House, Sommerfeld Road, Trench Lock, Telford, Shropshire TF1 5RY (simon.conolly@telfordpct.nhs.uk)
- Paul Jennings, Chief Executive, Walsall tPCT, Jubilee House, Bloxwich Lane, Walsall WS2 7JL (paul.jennings@walsall.nhs.uk)
- David Rose, Chief Executive, Warwickshire PCT, Westgate House, Market Street, Warwick CV34 4DE (david.rose@swarkpct.nhs.uk)
- Jon Crockett, Chief Executive, Wolverhampton City PCT, Coniston House, West Entrance, Chapel Ash, Wolverhampton WV3 0XE (jon.crockett@wolvespct.nhs.uk)
- Paul Bates, Chief Executive, Worcestershire PCT, Isaac Maddox House, Shrub Hill Road, Worcester, Worcestershire WR4 9RW (paul.bates@sworcs-pct.nhs.uk)
- Ailsa Claire, Chief Executive, Barnsley PCT, Kendray Hospital, Doncaster Road, Barnsley S70 3RD (ailsa.claire@barnsleypct.nhs.uk)
- Simon Morritt, Chief Executive, Bradford & Airedale PCT, Douglas Mill, Bowling Old Lane, Bradford BD5 7JR (simon.morritt@bradford.nhs.uk)
- Martyn Pritchard, Chief Executive, Calderdale PCT, 4th Floor, F Mill, Dean Clough, Halifax HX3 5AX (martyn.pritchard@calderdale-pct.nhs.uk)
- Jayne Brown, Chief Executive, Doncaster PCT, White Rose House, Ten Pound Walk, Doncaster DN4 5DJ (jayne.brown@doncasterpct.nhs.uk)
- Claire Wood, Chief Executive, East Riding of Yorkshire PCT, Health House, Grange Park Lane, Willerby, EastYorkshire HU10 6DT (claire.wood@erypct.nhs.uk ?)
- Christopher Long, Chief Executive, Hull PCT, Highlands Health Centre, Lothian Way, Bransholme, Hull HU7 5DD (christopher.long@hullpct.nhs.uk ?)
- Mike Potts, Chief Executive, Kirklees PCT, St Lukes House, Blackmoorfoot Road, Crosland Moor, Huddersfield HD4 5RH (pauline.kershaw@kirkleespct.nhs.uk)
- Christine Outram, Chief Executive, Leeds PCT, North West House, West Park Ring Road, Leeds LS16 6QG (christine.outram@leedspct.nhs.uk)
- Jane Lewington, Chief Executive, North East Lincolnshire PCT, 1 Prince Albert Gardens, Grimsby, North East Lincolnshire DN31 3HT (jane.lewington@nelpct.nhs.uk ?)
- Cathy Waters, Chief Executive, North Lincolnshire PCT, Health Place, Wrawby Road, Brigg, North Lincolnshire DN20 8GS (Cathy.Waters@nlpct.nhs.uk)
- Janet Soo-Chung, Chief Executive, North Yorkshire & York PCT, The Hamlet, Hornbeam Park, Harrogate HG2 8RE (janet.soo-chung@nyypct.nhs.uk)
- Andy Buck, Chief Executive, Rotherham PCT, Oak House, Moorhead Way, Bramley, Rotherham S66 1YY (andy.buck@rotherhampct.nhs.uk)
- Jan Sobieraj, Chief Executive, Sheffield PCT, 5 Old Fulwood Road, Fulwood, Sheffield S10 3TG (jan.sobieraj@sheffieldpct.nhs.uk)
- Alan Wittrick, Chief Executive, Wakefield District PCT, White Rose House, West Parade, Wakefield WF1 1LT (alan.wittrick@wdpct.nhs.uk ?)

Acute trust employers (from list at http://www.networks.nhs.uk/255.php)

- Eric Morton, Chief Executive, Chesterfield Royal Hospital NHS Foundation Trust, Calow, Chesterfield, Derbyshire S44 5BL (eric.morton@chesterfieldroyal.nhs.uk ?)
- Julie Acred, Chief Executive, Derby Hospitals NHS Foundation Trust, Derbyshire Royal Infirmary, London Road, Derby DE1 2QY (julie.acred@derbyhospitals.nhs.uk)
- Steve Hone, Chief Executive, Kettering General Hospital NHS Trust, Rothwell Road, Kettering, Northamptonshire NN16 8UZ (steve.hone@kgh.nhs.uk ?)
- Andrew Riley, Chief Executive, Northampton General Hospital NHS Trust, Cliftonville, Northampton NN1 5BD (Andrew.Riley@ngh.nhs.uk)
- Dr Peter Homa, Chief Executive, Nottingham University Hospitals NHS Trust, Heathfield House, Hucknall Road, Nottingham NG5 1PB (peter.homa@nuh.nhs.uk ?)
- Jeffrey Worrall, Chief Executive, Sherwood Forest Hospitals NHS Foundation Trust, King's Mill Hospital, Mansfield Road, Sutton in Ashfield, NottinghamshireNG17 0ER (jeffrey.worrall@sfh-tr.nhs.uk)
- Gary Walker, Chief Executive, United Lincolnshire Hospitals NHS Trust, Lincoln County Hospital, Greetwell Road, Lincoln LN2 4AX (gary.walker@ulh.nhs.uk ?)
- Peter Reading, Chief Executive, University Hospitals of Leicester NHS Trust, Gwendolen House, Gwendolen Road, Leicester LE5 4QF (peter.reading@uhl-tr.nhs.uk)
- Alan Whittle, Chief Executive, Basildon and Thurrock University Hospitals NHS Foundation Trust, Nethermayne, Basildon, Essex SS16 5NL (alan.whittle@btuh.nhs.uk)
- Jean O'Callaghan, Chief Executive, Bedford Hospital NHS Trust, Kempston Road, Bedford MK42 9DJ (jean.ocallaghan@bedfordhospital.nhs.uk ?)
- Dr Gareth Goodier, Chief Executive, Cambridge University Hospitals NHS Foundation Trust, Addenbrooke's Hospital, Hills Road, Cambridge CB2 0QQ (gareth.goodier@addenbrookes.nhs.uk)
- Nick Carver, Chief Executive, East and North Hertfordshire NHS Trust, Lister Hospital, Coreys Mill Lane, Stevenage, Hertfordshire SG1 4AB (nick.carver@enherts-tr.nhs.uk ?)
- Peter Murphy, Chief Executive, Essex Rivers Healthcare NHS Trust, Turner Road, Colchester, Essex CO4 5JL (peter.murphy@essexrivers.nhs.uk)
- Mark Millar, Chief Executive, Hinchingbrooke Health Care NHS Trust, Hinchingbrooke Hospital, Hinchingbrooke Park, Huntingdon, Cambridgeshire PE29 6NT (mark.millar@hinchingbrooke.nhs.uk ?)
- Andrew Reed, Chief Executive, The Ipswich Hospital NHS Trust, Heath Road, Ipswich, Suffolk IP4 5PD (andrew.reed@ipswichhospital.nhs.uk ?)
- Wendy Slaney, Chief Executive, James Paget University Hospitals NHS Foundation Trust, Lowestoft Road, Gorleston, Great Yarmouth, Norfolk NR31 6LA (wendy.slaney@jpaget.nhs.uk)
- Stephen Ramsden, Chief Executive, The Luton and Dunstable Hospital NHS Foundation Trust, Lewsey Road, Luton LU4 0DZ (Stephen.Ramsden@ldh.nhs.uk)
- Andrew Pike, Chief Executive, Mid Essex Hospital Services NHS Trust, Broomfield Court, Pudding Wood Lane, Chelmsford, Essex CM1 7WE (andrew.pike@meht.nhs.uk)
- Paul Forden, Chief Executive, Norfolk and Norwich University Hospital NHS Trust, Colney Lane, Norwich NR4 7UY (paul.forden@nnuh.nhs.uk ?)
- Stephen Bridge, Chief Executive, Papworth Hospital NHS Foundation Trust, Papworth Everard, Cambridge CB23 3RE (stephen.bridge@papworth.nhs.uk)
- Nik Patten, Chief Executive, Peterborough and Stamford Hospitals NHS Foundation Trust, Peterborough District Hospital, 3 Thorpe Road, Peterborough PE3 6DA (nik.patten@pbh-tr.nhs.uk ?)
- Chris Pocklington, Chief Executive, The Princess Alexandra Hospital NHS Trust, Hamstel Road, Harlow, Essex CM20 1QX (chief.executive@pah.nhs.uk)
- Ruth May, Chief Executive, The Queen Elizabeth Hospital King's Lynn NHS Trust, Gayton Road. King's Lynn, Norfolk PE30 4ET (ruth.may@qehkl.nhs.uk ?)
- John Gilham, Chief Executive, Southend University Hospital NHS Trust, Prittlewell Chase, Westcliff-on-Sea, Essex SS0 0RY (john.gilham@southend.nhs.uk ?)
- David Law, Chief Executive, West Hertfordshire Hospitals NHS Trust, Hemel Hempstead Hospital, Hillfield Road, Hemel Hempstead HP2 4AD (david.law@whht.nhs.uk ?)
- Chris Brown, Chief Executive, West Suffolk Hospital NHS Trust, Hardwick Lane, Bury St Edmunds, Suffolk IP33 2QZ (chris.brown@wsh.nhs.uk ?)
- Mark Rees, Chief Executive, Barking, Havering and Redbridge Hospitals NHS Trust, Queen's Hospital, Rom Valley Way, Romford, Essex RM7 0AG (mark.rees@bhrhospitals.nhs.uk ?)
- Averil Dongworth, Chief Executive, Barnet and Chase Farm Hospitals NHS Trust, Chase Farm Hospital, The Ridgeway, Enfield, Middlesex EN2 8JL (averil.dongworth@bcf.nhs.uk)
- John Goulstone, Chief Executive, Barts and the London NHS Trust, 9 Prescot Street, Aldgate, London E1 8PR (john.goulstone@bartsandthelondon.nhs.uk ?)
- John Watkinson, Chief Executive, Bromley Hospitals NHS Trust, Farnborough Common, Orpington, Kent BR6 8ND (john.watkinson@bromleyhospitals.nhs.uk ?)
- Heather Lawrence, Chief Executive, Chelsea and Westminster Hospital NHS Foundation Trust, 369 Fulham Road, London SW10 9NH (heather.lawrence@chelwest.nhs.uk ?)
- Fiona Wise, Chief Executive, Ealing Hospital NHS Trust, Uxbridge Road, Southall UB1 3HW (fiona.wise@eht.nhs.uk)
- Graham Smith, Chief Executive, Epsom and St Helier University Hospitals NHS Trust, St Helier Hospital, Wrythe Lane, Carshalton SM5 1AA (graham.smith@epsom-sthelier.nhs.uk)
- Dr Jane Collins, Chief Executive, Great Ormond Street Hospital for Children NHS Trust, Great Ormond Street, London WC1N 3JH (jane.collins@gosh.nhs.uk)
- Tim Higginson, Chief Executive, Guy's and St Thomas' NHS Foundation Trust, Guy's Hospital, St Thomas Street, London SE1 9RT (tim.higginson@gstt.nhs.uk ?)
- Derek Smith, Chief Executive, The Hammersmith Hospitals NHS Trust, Charing Cross Hospital, Fulham Palace Road, London W6 8RF (dereksmith@hhnt.nhs.uk)
- David McVittie, Chief Executive, The Hillingdon Hospital NHS Trust, Pield Heath Road, Uxbridge UB8 3NN (david.mcvittie@thh.nhs.uk)
- Nancy Hallett, Chief Executive, Homerton University Hospital NHS Foundation Trust, Homerton Row, London E9 6SR (nancy.hallett@homerton.nhs.uk)
- Malcolm Lowe-Lauri, Chief Executive, King's College Hospital NHS Foundation Trust, Denmark Hill, London SE5 9RS (malcolm.lowe-lauri@kch.nhs.uk ?)
- Carole Heatly, Chief Executive, Kingston Hospital NHS Trust, Galsworthy Road, Kingston upon Thames, Surrey KT2 7QB (carole.heatly@kingstonhospital.nhs.uk)
- Claire Perry, Chief Executive, The Lewisham Hospital NHS Trust, Lewisham High Street, London SE13 6LH (claire.perry@uhl.nhs.uk)
- Helen Walley, Chief Executive, Mayday Healthcare NHS Trust, Mayday University Hospital, 530 London Road, Croydon CR7 7YE (helen.walley@mayday.nhs.uk ?)
- Ian Balmer, Chief Executive, Moorfields Eye Hospital NHS Foundation Trust, 162 City Road, London EC1V 2PD (ian.balmer@moorfields.nhs.uk ?)
- Kathy Watkins, Chief Executive, Newham University Hospital NHS Trust, Glen Road, Plaistow, London E13 8SL (kathy.watkins@newhamhealth.nhs.uk ?)
- Samantha Jones, Chief Executive, North Middlesex University Hospital NHS Trust, Sterling Way, London N18 1QX (samatha.jones@nmh.nhs.uk)
- Mary Wells, Chief Executive, The North West London Hospitals NHS Trust, Northwick Park Hospital, Watford Road, Harrow, Middlesex HA1 3UJ (mary.wells@nwlh.nhs.uk ?)
- John Pelly, Chief Executive, Queen Elizabeth Hospital NHS Trust, Ranken House, Stadium Road, Woolwich, London, SE18 4QH (john.pelley@nhs.net)
- Kate Grimes, Chief Executive, Queen Mary's Sidcup NHS Trust, Queen Mary's Hospital, Frognal Avenue, Sidcup, Kent DA14 6LT (kate.grimes@qms.nhs.uk)
- Robert J Bell, Chief Executive, Royal Brompton and Harefield NHS Trust, Royal Brompton Hospital, Sydney Street, London SW3 6NP (r.bell@rbht.nhs.uk)
- Andrew Way, Chief Executive, Royal Free Hampstead NHS Trust, Pond Street, London NW3 2QG (andrew.way@royalfree.nhs.uk ?)
- Cally Palmer, Chief Executive, The Royal Marsden Hospital NHS Foundation Trust, Fulham Road, London, Greater London SW3 6JJ (cally.palmer@rmh.nhs.uk ?)
- Andrew Woodhead, Chief Executive, Royal National Orthopaedic Hospital NHS Trust, Brockley Hill Stanmore Middlesex HA7 4LP (andrew.woodhead@rnoh.nhs.uk)
- David Astley, Chief Executive, St George's Healthcare NHS Trust, Blackshaw Road, Tooting, London SW17 0QT (david.astley@stgeorges.nhs.uk ?)
- Julian Nettel, Chief Executive, St Mary's NHS Trust, Praed Street , London W2 1NY (julian.nettel@st-marys.nhs.uk)
- Robert Naylor, Chief Executive, University College London Hospitals NHS Foundation Trust, 250 Euston Road, London NW1 2PG (robert.naylor@uclh.nhs.uk)
- Tara Donnelly, Chief Executive, West Middlesex University Hospital NHS Trust, Twickenham Road, Isleworth, Middlesex TW7 6AF (tara.donnelly@wmuh.nhs.uk ?)
- Dr Lucy Moore, Chief Executive, Whipps Cross University Hospital NHS Trust, Whipps Cross Road, Leytonstone, London E11 1NR (lucy.moore@whippsx.nhs.uk)
- David Sloman, Chief Executive, The Whittington Hospital NHS Trust, Magdala Avenue, London N19 5NF (david.sloman@whittington.nhs.uk)
- Ken Bremner, Chief Executive, City Hospitals Sunderland NHS Foundation Trust, Sunderland Royal Hospital, Kayll Road, Sunderland, Tyne & Wear SR4 7TP (ken.bremner@chs.northy.nhs.uk)
- Louise Robson, Chief Executive, County Durham and Darlington NHS Foundation Trust, Darlington Memorial Hospital, Hollyhurst Road, Darlington DL3 6HX (louise.robson@cddah.nhs.uk ?)
- Ian Renwick, Chief Executive, Gateshead Health NHS Foundation Trust, Queen Elizabeth Hospital, Queen Elizabeth Avenue, Sheriff Hill, Gateshead, Tyne & Wear NE9 6SX (ian.renwick@ghnt.nhs.uk ?)
- Len Fenwick, Chief Executive, The Newcastle upon Tyne Hospitals NHS Foundation Trust, Freeman Hospital, Freeman Road, High Heaton, Newcastle upon Tyne NE7 7DN (len.fenwick@nuth.nhs.uk)
- Ian Dalton, Chief Executive, North Tees and Hartlepool NHS Trust, University Hospital of North Tees, Hardwick Road, Stockton TS19 8PE (ian.dalton@nth.nhs.uk ?)
- Jim Mackey, Chief Executive, Northumbria Healthcare NHS Foundation Trust, Rake Lane, North Shields, Tyne and Wear NE29 8NH (jim.mackey@northumbria-healthcare.nhs.uk)
- Simon Pleydell, Chief Executive, South Tees Hospitals NHS Trust, The James Cook University Hospital, Marton Road, Middlesbrough TS4 3BW (simon.pleydell@stees.nhs.uk ?)
- Lorraine Lambert, Chief Executive, South Tyneside NHS Foundation Trust, Harton Lane, South Shields, Tyne & Wear NE34 OPL (lorraine.lambert@sthct.nhs.uk ?)
- James Birrell, Chief Executive, Aintree University Hospitals NHS Foundation Trust, Aintree House, University Hospital Aintree, Longmoor Lane, Liverpool L9 7AL (james.birrell@aintree.nhs.uk ?)
- Julian Hartley, Chief Executive, Blackpool, Fylde and Wyre Hospitals NHS Trust, Blackpool Victoria Hospital, Whinney Heys Road, Blackpool FY3 8NR (julian.hartley@bfwhospitals.nhs.uk ?)
- David Fillingham, Chief Executive, Bolton Hospitals NHS Trust, Royal Bolton Hospital, Minerva Road, Farnworth, Bolton BL4 0JR (david.fillingham@rbh.nhs.uk)
- Mike Bone, Chief Executive, The Cardiothoracic Centre - Liverpool NHS Trust, Thomas Drive, Liverpool L14 3PE (mike.bone@ctc.nhs.uk ?)
- Mike Deegan, Chief Executive, Central Manchester and Manchester Children's University Hospitals NHS Trust, Cobbett House, Manchester Royal Infirmary, Oxford Road, Manchester M13 9WL (mike.deegan@cmmc.nhs.uk)
- Caroline Shaw, Chief Executive, Christie Hospital NHS Foundation Trust, Wilmslow Road, Manchester M20 4BX (caroline.shaw@christie-tr.nwest.nhs.uk)
- Tony Halsall, Chief Executive, Clatterbridge Centre for Oncology NHS Foundation Trust, Clatterbridge Road, Bebington, Wirral CH63 4JY (tony.halsall@ccotrust.nhs.uk)
- Peter Herring, Chief Executive, Countess of Chester Hospital NHS Foundation Trust, Countess of Chester Health Park, Liverpool Road, Chester CH2 1UL. (peter.herring@coch.nhs.uk)
- John Wilbraham, Chief Executive, East Cheshire NHS Trust, Macclesfield Hospital, Victoria Road, Macclesfield SK10 3BL (john.wilbraham@echeshire-tr.nwest.nhs.uk)
- Jo Cubbon, Chief Executive, East Lancashire Hospitals NHS Trust, Royal Blackburn Hospital, Haslingden Road, Blackburn BB2 3HH (Jo.Cubbon@elht.nhs.uk)
- Tony Curtis, Chief Executive, Lancashire Teaching Hospitals NHS Foundation Trust, Royal Preston Hospital, Sharoe Green Lane, Fulwood, Preston, Lancs. PR2 9HT (tony.curtis@lthtr.nhs.uk)
- Louise Shepherd, Chief Executive, Liverpool Women's NHS Foundation Trust, Crown Street, Liverpool L8 7SS (louise.shepherd@lwh.nhs.uk)
- Stephen Eames, Chief Executive, Mid Cheshire Hospitals NHS Trust, Leighton Hospital, Middlewich Road, Crewe, Cheshire CW1 4QJ (stephen.eames@mcht.nhs.uk)

- Catherine Beardshaw, Chief Executive, North Cheshire Hospitals NHS Trust, Warrington Hospital, Lovely Lane, Warrington, Cheshire WA5 1QG (catherine.beardshaw@nch.nhs.uk ?)
- Marie Burnham, Chief Executive, North Cumbria Acute Hospitals NHS Trust, West Cumberland Hospital, Hensingham, Whitehaven, Cumbria CA28 8JG (marie.burnham@ncumbria-acute.nhs.uk)
- John Saxby, Chief Executive, The Pennine Acute Hospitals NHS Trust, Westhulme Avenue, Oldham OL1 2PN (john.saxby@pat.nhs.uk ?)
- Talib Yaseen, Chief Executive, The Royal Liverpool and Broadgreen University Hospitals NHS Trust, Prescot Street, Liverpool L7 8XP (Talib.Yaseen@rlbuht.nhs.uk)
- Tony Bell, Chief Executive, Royal Liverpool Children's NHS Trust, Alder Hey, Eaton Road, West Derby, Liverpool L12 2AP (tony.bell@rlc.nhs.uk ?)
- David Dalton, Chief Executive, Salford Royal NHS Foundation Trust, Hope Hospital, Stott Lane, Salford M6 8HD (david.dalton@srht.nhs.uk)
- Jonathan Parry, Chief Executive, Southport and Ormskirk Hospital NHS Trust, Town Lane, Southport, Merseyside PR8 6PN (jonathan.parry@southportandormskirk.nhs.uk)
- Ann Marr, Chief Executive, St Helens and Knowsley Hospitals NHS Trust, Whiston Hospital, Warrington Road, Prescot, Merseyside L35 5DR (ann.marr@sthkhealth.nhs.uk ?)
- Dr Chris Burke, Chief Executive, Stockport NHS Foundation Trust, Stepping Hill Hospital, Poplar Grove, Hazel Grove, Stockport SK2 7JE (chris.burke@stockport.nhs.uk ?)
- Christine Green, Chief Executive, Tameside and Glossop Acute Services NHS Trust, Tameside General Hospital, Fountain Street, Ashton-under-Lyne, Lancashire OL6 9RW (christine.green@tgh.nhs.uk)
- Edna Robinson, Chief Executive, Trafford Healthcare NHS Trust, Trafford General Hospital, Moorside Road, Urmston, Manchester M41 5SL (edna.robinson@trafford.nhs.uk)
- Peter Morris, Chief Executive, University Hospital of South Manchester NHS Foundation Trust, Wythenshawe Hospital, Southmoor Road, Wythenshawe, Manchester M23 9LT (peter.morris@smtr.nhs.uk)
- Ian Cumming, Chief Executive, University Hospitals of Morecambe Bay NHS Trust, Westmorland General Hospital, Burton Road, Kendal, Cumbria LA9 7RG (ian.cumming@mbht.nhs.uk ?)
- Bev Humphrey, Chief Executive, The Walton Centre for Neurology and Neurosurgery NHS Trust, Lower Lane, Fazakerley, Liverpool L9 7LJ (bev.humphrey@thewaltoncentre.nhs.uk ?)
- Len Richards, Chief Executive, Wirral Hospital NHS Trust, Arrowe Park Hospital, Arrowe Park Road, Upton, Wirral, Merseyside CH49 5PE (len.richards@whnt.nhs.uk)
- Andrew Foster, Chief Executive, Wrightington, Wigan and Leigh NHS Trust, Royal Albert Edward Infirmary, Wigan Lane, Wigan, Lancashire WN1 2NN (andrew.foster@wwl.nhs.uk)
- Mary Edwards, Chief Executive, Basingstoke and North Hampshire NHS Foundation Trust, Aldermaston Road, Basingstoke, Hampshire RG24 9NA (mary.edwards@bnhft.nhs.uk ?)
- Anne Eden, Chief Executive, Buckinghamshire Hospitals NHS Trust, Stoke Mandeville Hospital, Mandeville Road, Aylesbury, Buckinghamshire HP21 8AL (anne.eden@buckshosp.nhs.uk ?)
- Colin Hayton, Chief Executive, Heatherwood and Wexham Park Hospitals NHS Trust, Wexham Street, Slough, Berkshire SL2 4HL (colin.hayton@hwph-tr.nhs.uk ?)
- Ed Macalister-Smith, Chief Executive, Isle of Wight NHS Primary Care Trust/Acute Services, St Mary's Hospital, Parkhurst Road, Newport, Isle of Wight PO30 5TG (chiefexecutive@iow.nhs.uk)
- Jill Rodney, Chief Executive, Milton Keynes General NHS Trust, Standing Way, Eaglestone, Milton Keynes, Buckinghamshire MK6 5LD (Jill.Rodney@mkgeneral.nhs.uk)
- Jan Fowler, Chief Executive, Nuffield Orthopaedic Centre NHS Trust, Windmill Road, Headington, Oxford OX3 7LD (jan.fowler@noc.anglox.nhs.uk)
- Trevor Campbell Davis, Chief Executive, Oxford Radcliffe Hospitals NHS Trust, John Radcliffe Hospital, Headley Way, Headington, Oxford OX3 9DU (trevor.campbelldavis@orh.nhs.uk)
- Ursula Ward, Chief Executive, Portsmouth Hospitals NHS Trust, Queen Alexandra Hospital, Southwick Hill Road, Cosham PO6 3LY (Ursula.Ward@porthosp.nhs.uk)
- Professor Ann Sheen, Chief Executive, Royal Berkshire NHS Foundation Trust, London Road, Reading RG1 5AN (ann.sheen@royalberkshire.nhs.uk ?)
- Mark Hackett, Chief Executive, Southampton University Hospitals NHS Trust, Tremona Road, Southampton, Hampshire SO16 6YD (Mark.Hackett@suht.swest.nhs.uk)
- Chris Evennett, Chief Executive, Winchester and Eastleigh Healthcare NHS Trust, Royal Hampshire County Hospital, Romsey Road, Winchester, Hampshire SO22 5DG (chris.evennett@weht.swest.nhs.uk)
- Glenn Douglas, Chief Executive, Ashford and St Peter's Hospitals NHS Trust, St Peter's Hospital, Guildford Road, Chertsey, Surrey KT16 0PZ (glenn.douglas@asph.nhs.uk ?)
- Peter Coles, Chief Executive, Brighton and Sussex University Hospitals NHS Trust, Princess Royal Hospital, Downsmere, Haywards Heath, West Sussex RH16 4EX (peter.coles@bsuh.nhs.uk)
- Mark Devlin, Chief Executive, Dartford and Gravesham NHS Trust, Darent Valley Hospital, Darenth Wood Road, Dartford, Kent DA2 8DA (mark.devlin@dvh.nhs.uk ?)
- Prof. Stuart Bain, Chief Executive, East Kent Hospitals NHS Trust, Kent and Canterbury Hospital, Ethelbert Road, Canterbury, Kent CT1 3NG (stuart.bain@ekht.nhs.uk ?)
- Kim Hodgson, Chief Executive, East Sussex Hospitals NHS Trust, Conquest Hospital, The Ridge, St Leonards-on-Sea, East Sussex TN37 7RD (Kim.Hodgson@esht.nhs.uk)
- Andrew Morris, Chief Executive, Frimley Park Hospital NHS Foundation Trust, Portsmouth Road, Frimley, Surrey GU16 7UJ (andrew.morris@frimleypark.nhs.uk ?)
- Rose Gibb, Chief Executive, Maidstone and Tunbridge Wells NHS Trust, Maidstone Hospital, Hermitage Lane, Maidstone, Kent ME16 9QQ (Rose.Gibb@mtw-tr.nhs.uk)
- Andrew Horne, Chief Executive, The Medway NHS Trust, Medway Maritime Hospital, Windmill Road, Gillingham, Kent ME7 5NY (andrew.horne@medway.nhs.uk)
- Sharon Kearns, Chief Executive, The Queen Victoria Hospital NHS Foundation Trust, Holtye Road, East Grinstead, West Sussex RH19 3DZ (sharon.kearns@qvh.nhs.uk ?)
- Nick Moberly, Chief Executive, The Royal Surrey County Hospital NHS Trust, Egerton Road, Guildford GU2 7XX (Nick.Moberly@royalsurrey.nhs.uk)
- Andrew Liles, Chief Executive, Royal West Sussex NHS Trust, St Richard's Hospital, Spitalfield Lane, Chichester, West Sussex PO19 6SE (andrew.liles@rws-tr.nhs.uk)
- Gail Wannell, Chief Executive, Surrey and Sussex Healthcare NHS Trust, Maple House, East Surrey Hospital, Redhill, Surrey RH1 5RH (Gail.Wannell@sash.nhs.uk)
- Stephen Cass, Chief Executive, Worthing and Southlands Hospitals NHS Trust, Worthing Hospital, Lyndhurst Road, Worthing, West Sussex BN11 2DH (stephen.cass@wash.nhs.uk)
- Paul Lilley, Chief Executive, Gloucestershire Hospitals NHS Foundation Trust, 1 College Lawn, Cheltenham GL53 7AG (paul.lilley@gloshs.nhs.uk)
- Sonia Mills, Chief Executive, North Bristol NHS Trust, Beckspool Road, Frenchay, Bristol BS16 1JE (sonia.mills@nbt.nhs.uk)
- Jac Kelly, Chief Executive, Northern Devon Healthcare NHS Trust, North Devon District Hospital, Raleigh Park, Barnstaple, Devon EX31 4JB (jac.kelly@ndevon.swest.nhs.uk)
- Paul Roberts, Chief Executive, Plymouth Hospitals NHS Trust, Derriford Hospital, Derriford Road, Plymouth, Devon PL6 8DH (paul.roberts@phnt.swest.nhs.uk)
- Sue Sutherland, Chief Executive, Poole Hospital NHS Trust, Longfleet Road, Poole, Dorset BH15 2JB (sue.sutherland@poole.nhs.uk ?)
- John Watkinson, Chief Executive, Royal Cornwall Hospitals NHS Trust, Bedruthan House, Royal Cornwall Hospital, Truro TR1 3LJ (john.watkinson@rcht.cornwall.nhs.uk ?)
- Angela Pedder, Chief Executive, Royal Devon and Exeter NHS Foundation Trust, Barrack Road, Exeter EX2 5DW (angela.pedder@rdehc-tr.swest.nhs.uk)
- Tony Spotswood, Chief Executive, The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust, Royal Bournemouth General Hospital, Castle Lane East, Bournemouth, Dorset, BH7 7DW (tony.spotswood@rbch.nhs.uk ?)
- Nicola Carmichael, Chief Executive, Royal National Hospital for Rheumatic Diseases NHS Foundation Trust, Upper Borough Walls, Bath, Somerset BA1 1RL (nicola.carmichael@rnhrd.nhs.uk ?)
- James Scott, Chief Executive, Royal United Hospital Bath NHS Trust, Combe Park, Bath BA1 3NG (james.scott@ruh.nhs.uk ?)
- Frank Harsent, Chief Executive, Salisbury NHS Foundation Trust, Salisbury District Hospital, Salisbury, Wiltshire SP2 8BJ (frank.harsent@salisbury.nhs.uk ?)
- Tony Parr, Chief Executive, South Devon Healthcare NHS Foundation Trust, Torbay Hospital, Lawes Bridge, Torquay TQ2 7AA (chiefexecutive@sdevonhc-tr.swest.nhs.uk)
- Lyn Hill-Tout, Chief Executive, Swindon and Marlborough NHS Trust, The Great Western Hospital, Marlborough Road, Swindon, Wiltshire SN3 6BB (lyn.hill-tout@smnhst.swest.nhs.uk)
- Rev. Mike Williams, Chief Executive, Taunton and Somerset NHS Trust, Musgrove Park Hospital, Taunton, Somerset TA1 5DA (mike.williams@tst.nhs.uk)
- Ron Kerr, Chief Executive, United Bristol Healthcare NHS Trust, Marlborough Street, Bristol BS1 3NU (Ron.Kerr@ubht.nhs.uk)
- Jan Bergman, Chief Executive, West Dorset General Hospitals NHS Trust, Dorset County Hospital, Williams Avenue, Dorchester DT1 2JY (Chief.Executive@wdgh.nhs.uk)
- Lorene Read, Chief Executive, Weston Area Health NHS Trust, Weston General Hospital, Grange Road, Uphill, Weston-Super-Mare, North Somerset BS23 4TQ (lorene.read@waht.nhs.uk ?)
- Gavin Boyle, Chief Executive, Yeovil District Hospital NHS Foundation Trust, Higher Kingston, Yeovil, Somerset BA21 4AT (gavin.boyle@ydh.nhs.uk ?)
- Paul O'Connor, Chief Executive, Birmingham Children's Hospital NHS Foundation Trust, Steelhouse Lane, Birmingham B4 6NH (paul.oconnor@bch.nhs.uk ?)
- Julie Burgess, Chief Executive, Birmingham Women's Healthcare NHS Trust, Metchley Park Road, Edgbaston, Birmingham B15 2TG (julie.burgess@bwhct.nhs.uk ?)
- Paula Clark, Chief Executive, Burton Hospitals NHS Trust, Queen's Hospital, Belvedere Road, Burton upon Trent, Staffordshire DE13 0RB (paula.clark@burtonh.tr-wmids.nhs.uk)
- Paul Farenden, Chief Executive, Dudley Group of Hospitals NHS Trust, Russells Hall Hospital, Dudley, West Midlands DY1 2HQ (paul.farenden@dgoh.nhs.uk)
- Sharon Beamish, Chief Executive, George Eliot Hospital NHS Trust, Lewes House, College Street, Nuneaton, Warwickshire CV10 7DJ (sharon.beamish@geh.nhs.uk)
- Dr Mark Goldman, Chief Executive, Heart of England NHS Foundation Trust, Birmingham Heartlands Hospital, Bordesley Green East, Birmingham B9 5SS (mark.goldman@heartofengland.nhs.uk)
- Martin Woodford, Chief Executive, Hereford Hospitals NHS Trust, County Hospital, Union Walk, Hereford HR1 2ER (martin.woodford@hhtr.nhs.uk)
- Martin Yeates, Chief Executive, Mid Staffordshire General Hospitals NHS Trust, Weston Road, Stafford ST16 3SA (martin.yeates@msgh-tr.wmids.nhs.uk ?)
- Wendy Farrington Chadd, Chief Executive, The Robert Jones and Agnes Hunt Orthopaedic and District Hospital NHS Trust, Oswestry, Shropshire SY10 7AG (wendy.farrington@rjah.nhs.uk ?)
- Penny Venables, Chief Executive, The Royal Orthopaedic Hospital NHS Foundation Trust, Bristol Road South, Northfield, Birmingham B31 2AP (penny.venables@roh.nhs.uk ?)
- David Loughton, Chief Executive, The Royal Wolverhampton Hospitals NHS Trust, New Cross Hospital, Wolverhampton WV10 0QP (David.Loughton@rwh-tr.nhs.uk)
- John Adler, Chief Executive, Sandwell and West Birmingham Hospitals NHS Trust, City Hospital, Dudley Road, Birmingham B18 7QH (john.adler@swbh.nhs.uk)
- Tom Taylor, Chief Executive, The Shrewsbury and Telford Hospital NHS Trust, Mytton Oak Road, Shrewsbury, Shropshire SY3 8XQ (tom.taylor@sath.nhs.uk ?)
- Glen Burley, Chief Executive, South Warwickshire General Hospitals NHS Trust, Warwick Hospital, Lakin Road, Warwick CV34 5BW (glen.burley@swh.nhs.uk ?)
- Julie Moore, Chief Executive, University Hospital Birmingham NHS Foundation Trust, PO Box 9551, Main Drive, Queen Elizabeth Medical Centre, Birmingham B15 2PR (Julie.Moore@uhb.nhs.uk)
- Julia Bridgewater, Chief Executive, University Hospital of North Staffordshire NHS Trust, Royal Infirmary, Princes Road, Hartshill, Stoke-on-Trent ST4 7LN (julia.bridgwater@uhns.nhs.uk)
- David Roberts, Chief Executive, University Hospitals Coventry and Warwickshire NHS Trust, University Hospital, Clifford Bridge Road, Coventry CV2 2DX (david.roberts@uhcw.nhs.uk)
- Sue James, Chief Executive, Walsall Hospitals NHS Trust, Manor Hospital, Moat Road, Walsall WS2 9PS (sue.james@walsallhospitals.nhs.uk ?)
- John Rostill, Chief Executive, Worcestershire Acute Hospitals NHS Trust, Worcestershire Royal Hospital, Charles Hastings Way, Worcester WR5 1DD (john.rostill@worcsacute.wmids.nhs.uk ?)
- Adam Cairns, Chief Executive, Airedale NHS Trust, Airedale General Hospital, Steeton, Keighley, West Yorkshire BD20 6TD (adam.cairns@anhst.nhs.uk)
- Dr David Hicks, Chief Executive, Barnsley Hospital NHS Foundation Trust, Gawber Road, Barnsley S75 2EP (david.hicks@bhnft.nhs.uk)
- Miles Scott, Chief Executive, Bradford Teaching Hospitals NHS Foundation Trust, Chestnut House, Bradford Royal Infirmary, Duckworth Lane, Bradford, West Yorkshire BD9 6RJ (miles.scott@bradfordhospitals.nhs.uk)
- Diane Whittingham, Chief Executive, Calderdale and Huddersfield NHS Foundation Trust, Acre Street, Lindley, Huddersfield, West Yorkshire HD3 3EA (diane.whittingham@cht.nhs.uk ?)
- Nigel Clifton, Chief Executive, Doncaster and Bassetlaw Hospitals NHS Foundation Trust, Doncaster Royal Infirmary, Armthorpe Road, Doncaster DN2 5LT (Nigel.Clifton@dbh.nhs.uk)
- John Lawlor, Chief Executive, Harrogate and District NHS Foundation Trust, Harrogate District Hospital, Lancaster Park Road, Harrogate, North Yorkshire HG2 7SX (john.lawlor@hdft.nhs.uk)
- Stephen Greep, Chief Executive, Hull and East Yorkshire Hospitals NHS Trust, Alderson House, Hull Royal Infirmary, Anlaby Road, Hull HU3 2JZ (stephen.greep@hey.nhs.uk ?)
- Maggie Boyle, Chief Executive, The Leeds Teaching Hospitals NHS Trust, St James University Hospital, Beckett Street, Leeds LS9 7TF. (maggie.boyle@leedsth.nhs.uk ?)
- Julia Squire, Chief Executive, The Mid Yorkshire Hospitals NHS Trust, Rowan House, Aberford Road, Wakefield WF1 4DG (julia.squire@midyorks.nhs.uk ?)
- Andrew North, Chief Executive, Northern Lincolnshire and Goole Hospitals NHS Foundation Trust, Diana, Princess of Wales Hospital, Scartho Road, Grimsby, NE Lincolnshire DN33 2BA (Andrew.North@nlg.nhs.uk)
- Brian James, Chief Executive, The Rotherham NHS Foundation Trust, Rotherham General Hospital, Moorgate Road, Oakwood, Rotherham, South Yorkshire S60 2UD (brian.james@rothgen.nhs.uk ?)
- Iain McInnes, Chief Executive, Scarborough and North East Yorkshire Healthcare NHS Trust, Scarborough General Hospital, Woodlands Drive, Scarborough, North Yorkshire YO12 6QL (iain.mcinnes@acute.sney.nhs.uk ?)
- Chris Sharratt, Chief Executive, Sheffield Children's NHS Foundation Trust, Western Bank, Sheffield S10 2TH (chris.sharratt@sch.nhs.uk)
- Prof. Chris Welsh, Chief Executive, Sheffield Teaching Hospitals NHS Foundation Trust, 8 Beech Hill Road, Royal Hallamshire Hospital, Sheffield S10 2JF (chris.welsh@sth.nhs.uk)
- Jim Easton, Chief Executive, York Hospitals NHS Foundation Trust, York Hospital, Wigginton Road, York YO31 8HE (jim.easton@york.nhs.uk)

Representative groups and other interested parties

- Mr Matthew Shaw, Remedy UK (matshaw@doctors.org.uk / MattShaw@RemedyUK.org)
- Prof. Parveen Kumar, President, British Medical Association, BMA House, Tavistock Square, London WC1H 9JP (pkumar@bma.org.uk)
- The Association of UK University Hospitals (admin@aukuh.co.uk)
- other interested parties, including Drs Rupert Beale, Jane Graham, Robert Winter, John Firth, and Matthew Daniels, whom I thank for invaluable discussion and comments in the preparation of this document.

(end)