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PHASE ONE REPORT

NSW Junior Medical Officer Recruitment Strategy Review

Dr Jo Burnand

Executive Summary

NSW Health currently employs approximately 5,500 junior doctors at an annual cost of over $900 million, to provide direct clinical care of patients, under the supervision of senior doctors, in public hospital and health facilities within NSW. The majority of junior doctors are simultaneously engaged in postgraduate medical training and working in positions that meet the requirements for specialty training.

The annual JMO recruitment campaign signs off on **$700M** in salaries

The recruitment of junior doctors, primarily undertaken through a bulk recruitment campaign, has a number of unique characteristics that differentiate it from other public sector recruitment activities. These include: high volumes of positions and applicants; tight timeframes; and multiple internal and external stakeholders.

Over **45,000** applications were processed for 3,600 positions

By any measure, given these characteristics, the statewide JMO recruitment strategy represents an immensely complex and resource intensive undertaking.

Many of the features of the current NSW JMO recruitment strategy have been developed in an attempt to respond to the complexity derived by trying to balance the needs of multiple stakeholders with competing perspectives.

This review highlights some of the key improvements to the NSW JMO recruitment strategy made over several years and there is clear evidence of strong support for the continuation of a centrally coordinated recruitment campaign, particularly given the complexity and increasing numbers, as the most efficient and cost effective approach to JMO recruitment.

The JMO recruitment campaign costs an estimated **$5M** annually

The review also highlighted a number of key areas of risk and identified potential strategies to be considered in determining a way forward. A number of these strategies call for collaborative work to be undertaken, not only with key internal stakeholders in NSW, but also importantly with medical specialty colleges with the aim of managing the emergent risks and ultimately further improving JMO recruitment processes across the state.

86% of junior doctors working in NSW Health during 2014 were reemployed for the 2015 clinical year. This represents a net change to the junior doctor cohort of **14%.**

Table 1: Summary of recommendations arising from identified risks in the NSW statewide JMO recruitment campaign

	Recommendation	Made in response to the following identified risk	Potential/Actual	Risk Rating	Detailed in the following section of the report
1	The NSW JMO recruitment strategy, characterised by a centrally coordinated bulk recruitment campaign, should continue to be supported as providing the most efficient and cost effective approach to JMO recruitment within NSW.	Some facilities (senior clinicians) wanting to return to locally driven recruitment activities resulting in a lack of coordination across the state, confusion for applicants and increased duplication of effort.	Potential	Moderate	Introduction
2	The roles and responsibilities of those involved in the annual JMO recruitment campaign need further clarification and restatement, with all stakeholders agreeing and accepting their roles and responsibilities.	Lack of clarity of roles and responsibilities leads to duplication of effort and potential gaps in recruitment processes.	Actual	High	Governance
3	Centralised recruitment panels should be supported and expanded to other specialties.	Independent recruitment by LHDs (or training networks) to similar positions across the NSW health system results in applicants attending multiple interview panels and having to manage frequently uncoordinated recruitment activities. Not only is this difficult for individual applicants, it contributes to the duplication of effort and administrative burden across the system.	Actual	High	Centralised recruitment panels
4	The arrangements for centralised recruitment panels, including allocation of appropriate human and fiscal resources to ensure their effective and sustainable operation, needs to be agreed between LHDs.	Many centralised recruitment panels rely on the goodwill of the senior clinicians and JMO Management Units who convene them, often without the appropriate human and fiscal resource allocation. There is a significant risk that current arrangements are not sustainable.	Actual	High	Centralised recruitment panels
5	Further work is undertaken with relevant Colleges to improve the timing of notification and transfer of information with respect to College recommended appointments.	Late notification by Colleges of details of College recommended appointments delays critical onboarding activities (payroll and access to clinical IT systems) that in turn may disrupt clinical service provision.	Actual	Moderate	College recommended appointments

	Recommendation	Made in response to the following identified risk	Potential/Actual	Risk Rating	Detailed in the following section of the report
6	Staffing of JMO management units is reviewed to ensure that they are adequately resourced to undertake designated roles and responsibilities associated with the bulk JMO recruitment campaign.	JMO management units are bearing the brunt of the volume and workload associated with the recruitment campaign and there is a high risk of burnout and loss of critical corporate knowledge to the system.	Actual	High	JMO management units
7	Consideration is given to the development of career pathways and professional opportunities for JMO Managers that strategically supports the sustainability of this critical cohort of the NSW Health workforce.	There are currently limited professional development opportunities or established career pathways for JMO Managers, despite their critical role in the health workforce. This is contributing to attrition of JMO Managers and subsequent loss of corporate knowledge to the system, particularly as it relates to the bulk JMO recruitment campaign.	Actual	High	JMO management units
8	Consideration is given to working with Colleges on the development of a medically focused recruitment and selection training package, aligned with public sector employment requirements.	The majority of panel members and convenors have not recently attended recruitment and selection training. Breaches of policy represent a significant risk and increase the likelihood of an appeal by an unsuccessful applicant. Training in recruitment and selection processes is an important risk management strategy. Engagement in training will improve with a more targeted (to senior clinicians) approach.	Actual	Moderate	Other issues of significance identified during the review
9	Further work is undertaken to migrate the bulk JMO recruitment campaign to a paperless IT system.	Many processes remain manual and paper-based, contributing to an increase in the administrative burden in addition to creating issues with regards to preservation, sharing and storage of documents generated through the recruitment process.	Potential	Low	Other issues of significance identified during the review
10	Communication is improved regarding approval of the FTE to be advertised. This includes LHD's notifying the central panel host unit of the FTE to be advertised.	Delays in approval of FTE for first round advertising increases the number of positions advertised in the 2nd round and in turn this increases the mobility of positions in the latter part of the recruitment period (by increasing the number of positions originally accepted and later declined).	Actual	High	Recruitment process 1. Identify vacancy

	Recommendation	Made in response to the following identified risk	Potential/Actual	Risk Rating	Detailed in the following section of the report
11	The Ministry of Health continue discussions with the Commonwealth Department of Health regarding the timing of notifications on STP funding.	Delays in approval of funding for STP positions increases the number of positions advertised in the 2nd round and in turn this increases the mobility of positions in the latter part of the recruitment period.	Actual	Moderate	Recruitment process 1. Identify vacancy
12	Further work is undertaken on the web-based eRecruit system to enable applicants to more easily locate positions.	Applicants have difficulty locating the specific position that they wish to apply for, leading to frustration and angst on the part of the applicant and increasing the number of enquiries through the local JMO Management Unit during the recruitment period.	Actual	Moderate	Recruitment process 3. Advertise
13	The concept of placing a limit on the number of applications per applicant is explored with key stakeholders.	The current volume of applications (45,000 plus) is creating a very significant administrative burden, particularly for JMO management units.	Actual	High	Recruitment process 4. Application management
14	The current character limit on selection criteria is reviewed.	The current character limit on selection criteria is viewed by some applicants as providing an advantage to internal (to the facility) applicants.	Potential	Low	Recruitment process 4. Application management
15	For highly subscribed positions, consideration be given to removing words to the effect of "eligible to register with the Medical Board of Australia" (or equivalent) and having an unambiguous statement to the effect that applicants must hold current registration with the Medical Board of Australia, in addition to currency of medical practice within the Australian healthcare system.	Many of those involved in the culling of applications report that a large number of applications do not meet the selection criteria yet they still have to be culled creating a significant administrative burden.	Actual	High	Recruitment process 5. Cull
16	The eRecruit system is configured to enable automatic processing of applicants who do not meet the selection criteria as described in above recommendation, without the requirement for a manual review of the application.	Manual review of individual applications is a time consuming process and given the numbers of applications, is a major contribution to the administrative burden.	Actual	High	Recruitment process 5. Cull

	Recommendation	Made in response to the following identified risk	Potential/Actual	Risk Rating	Detailed in the following section of the report
17	The wording of selection criteria used in position descriptions is reviewed to support a more efficient culling process by selection panels. This assumes a more sophisticated description of the role (following a job analysis) that incorporates not just the required clinical competence skill set, but also the non-technical attributes critical to the role.	In a tightening job market, there is an increased risk of challenge by an unsuccessful applicant. Loosely written selection criteria make it more difficult for the selection panel to discriminate between applicants in selecting the most appropriate person for the job.	Potential	Moderate	Recruitment process 5. Cull
18	Work with individual Colleges is undertaken to establish standardised specialty specific selection criteria (this assumes a job specification analysis) at various levels of training, including streamed PGY3-5 positions.	In a tightening job market, there is an increased risk of challenge by an unsuccessful applicant. Loosely written selection criteria make it more difficult for the selection panel to discriminate between applicants in selecting the most appropriate person for the job.	Actual	Moderate	Recruitment process 5. Cull
19	For regional and rural positions, consideration is given to allowing selection criteria to reflect an applicant's interest in, commitment to, and suitability for, rural medical practice.	Rural and regional facilities report a significant administrative burden in processing applications despite an awareness that the majority of current metropolitan based junior doctors rank rural and regional facilities lower than the metropolitan facilities and generally apply to rural and regional facilities as a back up. Conversely many internal applicants of rural and regional facilities seeking employment at the same rural or regional facility for the following clinical year genuinely want to remain at that facility.	Actual	Moderate	Recruitment process 5. Cull
20	Strategies are explored with the aim of reducing the total number of interviews being conducted. This will include a range of strategies such as: improving culling and short-listing techniques; increasing positions utilising preference matching; and increasing the number of centralised recruitment panels.	The large number of interviews being conducted within very tight timeframes carries a significant human resource and fiscal cost to the system. Interview processes not compliant with policy and industrial requirements may be subject to challenge by unsuccessful applicants.	Actual	High	Recruitment process 7. Interview
21	Work with postgraduate medical training providers, including Colleges, is undertaken to explore other methods of assessing applicants in the recruitment process.	Interviews, particularly short interviews (for example 10–15 minutes) may not be reliable in making high stakes decisions. In a tightening job market, there is an increased risk of challenge by an unsuccessful applicant.	Actual	Moderate	Recruitment process 7. Interview

	Recommendation	Made in response to the following identified risk	Potential/Actual	Risk Rating	Detailed in the following section of the report
22	Consideration is given to the creation of a third category list whereby in addition to the eligibility list for successful applicants, potentially eligible but lower ranked applicants could be placed 'on hold'.	The current requirement for conducting referee checks on all those placed on the eligibility list prior to it being approved by the DAO. Collecting and validating referee reports on lower ranked but still eligible applicants holds up the process of sending out offers to successful higher ranked applicants.	Actual	High	Recruitment process 8. Eligibility list
23	Work is undertaken with relevant Colleges to align referee requirements with NSW Health policy and allow for the sharing of referee reports. This is likely to improve the quality of the referee report, in addition to reducing the administrative load on senior clinicians during the recruitment period.	Referee reports are an important part of the recruitment process, yet there is an emerging view that the NSW Health template referee reports do not add value to the recruitment process, particularly when the administrative burden is taken into consideration. There is also a risk that the template referee reports are completed in a tokenistic manner. College endorsed referee reports (which comply with NSW Health policy) are seen as more valid.	Actual	High	Recruitment process 9. Reference check
24	Further work is undertaken with jurisdictions and colleges to improve alignment of recruitment dates with key training milestones within and across training programs. This implies a hierarchical approach to the advertising and recruitment of positions.	Lack of alignment in recruitment timelines (with respect to other jurisdictions' recruitment activities) and key training milestones (as determined by colleges) can have a significant impact on the NSW recruitment process, creating downstream mobility or late filling of vacancies.	Actual	High	Recruitment process 10. Offer position
25	The JMO eRecruit system is configured so that an applicant can only accept one position. In the event that an applicant, having already accepted a position, receives an offer for a more preferred position, the eRecruit system should require the applicant to decline the first position, prior to the applicant being able to accept the second.	An applicant is currently able to accept more than one position. Late notification to facilities by applicants that they are declining a position previously accepted carries the risk that the facility may not be able to fill the vacancy, potentially leading to clinical service disruption.	Actual	Moderate	Recruitment process 10. Offer position
26	Consideration is given to strategies that will reduce the repeated 100-point checks being undertaken on junior doctors during the same recruitment campaign.	Repeated 100-point checks being undertaken on the same cohort of junior doctors duplicates effort, is inefficient and represents a significant administrative burden on JMO Management Units.	Actual	High	Recruitment process 11. Employment screening

	Recommendation	Made in response to the following identified risk	Potential/Actual	Risk Rating	Detailed in the following section of the report
27	Consideration is given to requiring applicants to upload a signed CRC consent form at the time of submitting the application and subsequently providing the original form for validation when they present for interview.	The administrative processes involved in collecting the signed CRC consent form are a significant administrative burden, given the volumes of interviewees. Having individual applicants take responsibility for uploading their own signed form would reduce the burden on JMO Management Units.	Actual	Moderate	Recruitment process 11. Employment screening
28	Length of training contracts should be pursued for as many training programs as possible.	A large number of junior doctor positions are advertised and recruited to each year. There is a significant administrative burden to both senior clinicians and JMO Management Units in undertaking this despite the outcome being a 14% difference to the actual junior doctor cohort.	Actual	High	Recruitment process 12. Offer contract
29	Work is undertaken with LHDs and Colleges to identify the number of available training positions (pathways), including the prerequisite clinical experience and entry points (for both run-through and uncoupled training programs).	With increasing numbers of medical graduates an increasing number of trainees are competing for prerequisite (for College training programs) clinical experience. Access is achieved through recruitment to certain positions. With time, it is likely that bottlenecks will increase, particularly with respect to entry to advanced training. Lack of whole-of-system, integrated knowledge on the number of training positions (including interdependencies) limits effective workforce planning and subsequent recruitment activities.	Actual	High	Recruitment process 12. Offer contract
30	Work is undertaken with LHDs and Colleges to explore the most effective mechanisms of tracking trainees as they progress through the training (employment) pipeline on a length of training contract.	Recruitment to junior doctor positions distributes finite education and training resources to individual junior doctors. Tracking applicants' progress across time will support effective management of those resources.	Actual	Moderate	Recruitment process 12. Offer contract
31	Work is undertaken in collaboration with Colleges to strengthen performance management frameworks for effectively managing underperforming trainees within the employment context.	There is evidence of resistance to fully implementing length of training contracts because of concerns about management of the underperforming trainee, in preference to the historical practice of using the 12-month contract as the ultimate "performance management tool". Not renewing a 12 month contract on a poorly performing trainee represents poor performance management practice and often results in the issues not being adequately addressed and the trainee simply moving on to another facility.	Actual	Moderate	Recruitment process 12. Offer contract

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SECTION ONE

Context

Background

NSW Health currently recruits around 4,000 junior doctors each year who provide direct clinical care of patients, under the supervision of senior doctors, in the public hospital and health facilities within NSW. The majority of junior doctors are simultaneously engaged in postgraduate medical training and working in positions that meet requirements for specialty training.

Historically, junior doctors were employed on temporary contracts, usually of twelve months duration, and each year applied for a position that would provide the appropriate clinical experience and training relevant to their chosen specialty pathway.

The increased structure and formality involved in the recruitment of junior doctors is a relatively recent occurrence. Whilst still advertised annually, twenty years ago, junior doctor recruitment processes were much more informal, undertaken at the facility level, usually with input from senior clinicians, but with very little involvement of hospital human resource departments. Likewise, training pipelines were also far more informal, locally driven and less structured.

The last two decades have witnessed significant changes, not only with respect to increased governance and regulatory requirements of recruitment within the public sector context, with a subsequent impact on junior doctor recruitment activities, but concomitantly, increased regulation and structure of postgraduate medical training programs as determined by the relevant medical specialty college.

This period has also been characterised by significant medical workforce shortages, with high vacancy rates in junior doctor positions across the state, but particularly in outer metropolitan, regional and rural facilities.

The beginnings of the centrally coordinated statewide JMO recruitment strategy emerged in the early 2000's, largely in response to economic drivers, as facilities looked toward more streamlined, standardised and cost efficient approaches to junior doctor recruitment activities.

These included a change from individual hospitals or Local Health Districts[1] (LHDs) independently placing advertisements in the national broadsheets to a centrally coordinated single newspaper banner advertisement for the state, in addition to a move to the general statewide online recruitment system.

Over the ensuing years, commencing in 2005 and in response to a number of identified challenges, further changes were made to the JMO recruitment strategy that built upon the earlier work.

These included: a JMO-specific eRecruit system (JMO eRecruit); a JMO specific recruitment policy; statewide centralised recruitment panels for 17 medical specialties; standardised position titles and letters of offer; and length of training contracts for many specialties.

A dedicated service centre team at HealthShare NSW, with published business processes (which are annually reviewed) and a media strategy also now support these systems and processes.

Over the last few years, increases in the number of medical graduates entering postgraduate medical training in the context of a changing junior medical workforce demographic have significantly altered the dynamics of the annual recruitment campaign.

Competition for junior doctor positions at all stages of the training trajectory is intensifying and recruitment panels are making increasingly high stakes decisions, potentially impacting on both the career *and* employment prospects of individual junior doctors in a way that has not been witnessed in recent decades in Australia, if ever.

There is an increasing imperative to have policy compliant and standardised recruitment processes, supported by robust IT infrastructure, thereby minimising the risk of industrial issues and service delivery disruption.

The improvements to the recruitment system have to a large extent been completed somewhat iteratively, in response to rapidly evolving issues and there are emerging concerns regarding the system's long-term sustainability.

1 Previously referred to as Area Health Services.

There is now a requirement to conduct a systematic review of the statewide JMO recruitment strategy with the dual aims of improving recruitment practice, in addition to managing identified emergent risks.

The Workforce Planning and Development Branch of the NSW Ministry of Health have commissioned this review with the aim to:

- Fulfill the Health Professional Workforce Plan (2012–2022) to improve recruitment practice, and:
- Manage the risks around industrial issues, service delivery and IT vulnerability.

The purpose of the review is to:

- Assess the strategy, processes and policies underpinning the statewide JMO recruitment in NSW and to determine the extent to which these have contributed to improving recruitment practices;
- Determine actual and potential risks with the current JMO recruitment arrangements; and
- Establish recommendations for change, utilising a cost-benefit framework that will best ensure the strategy's future sustainability and continued effective operation.

The terms of reference of the review are at Appendix A.

Methodology

This review is being conducted in two phases. The phase one review commenced at the end of September 2014 and was completed in early January 2015.

Phase two will be completed in 2015 and will involve extensive consultation with key stakeholders to identify agreed ways forward, resources and roles and responsibilites of all those involved in the recruitment process, both within and outside NSW Health.

This report provides a summary of the key findings of phase one.

The approach to phase one of this review is summarised in Figure 1. The Review gathered information, evidence and opinion using the following methods:

Literature review – the literature review was conducted during late 2014. A total of 73 articles were identified in peer-reviewed journals as being broadly relevant to this review. The identified articles and key findings were summarised. A more detailed description of the methodology of the literature review as well as a summary of the included articles is provided at Appendix B.

Document review – in addition to the literature review a number of source documents were identified as being relevant. These included NSW Health documents in addition to documents from recruitment campaigns elsewhere in Australia and overseas. A list of source documents is provided at Appendix C.

Policy Review – Analysis of policies, information bulletins and associated documents as provided by NSW Health.

Consultation with key internal (to NSW Health) stakeholders – The consultation process was conducted through semi-structured interviews and focus groups. Semi-structured interviews were conducted one-on-one, generally face-to-face but in some instances by telephone.

Focus groups were conducted with a selection of applicants, JMO management unit staff and convenors/panel members in addition to HETI and HealthShare NSW staff.

A list of participants in the consultation process is at Appendix D.

Interstate and international comparison of recruitment policies and practices.

Site visits to a selection of NSW sites in addition to interstate visits to Queensland and Victoria. The site visits conducted within NSW are shown in Figure 2.

Surveys of applicants, JMO Management Units, convenors and panel members. On-line survey instruments were developed for each of these groups and made available for a period of four weeks during November to early December 2014. The response rate of the on-line surveys was as follows: applicants (630); JMO management units and administrative staff (69) and senior medical staff, convenors and panel members (288).

Detailed process mapping of current recruitment processes within NSW. The key steps in the JMO recruitment process (Figure 3) were identified during the policy review and consultation with stakeholders. This provided a basis for the detailed consideration of the recruitment process described in section four of this report.

Cost analysis of current JMO recruitment processes within NSW.

Preparation and submission of initial draft report with recommendations.

Analysis of feedback on draft report.

Submission of final report.

Review governance

The project sponsor was the Deputy Director, Workforce Strategy and Culture, Workforce Planning and Development Branch of the NSW Ministry of Health. A Project Reference Group was established to provide direction and support to the consultant during the course of the review. The Membership of the Reference Group is provided at Appendix E.

Figure 1: Summary of review methodology

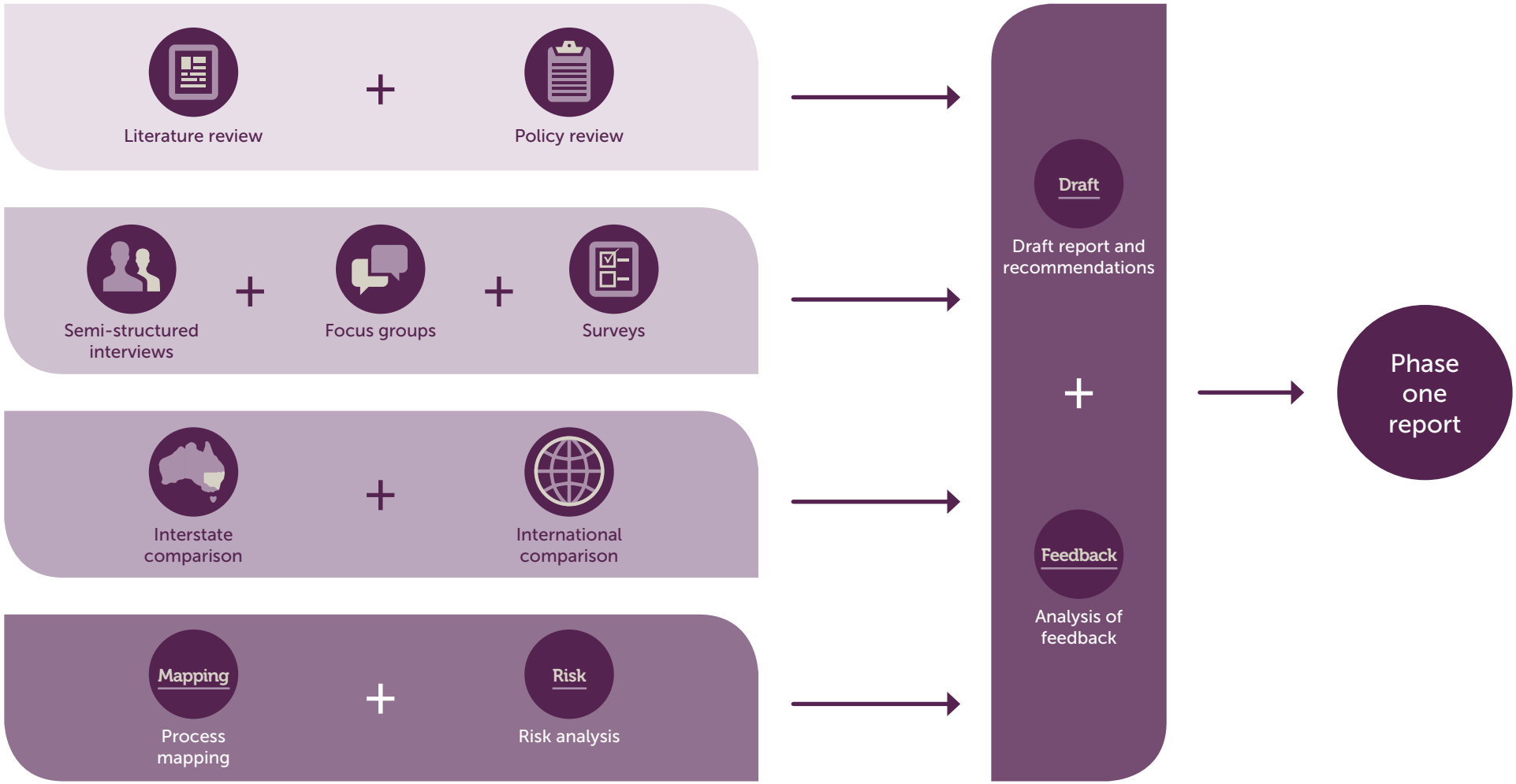


Figure 2: Map of NSW with locations of site visits

Key Assumptions

The following key assumptions, as agreed by the Project Reference Group, have underpinned the review process:

1. The statewide JMO recruitment campaign recruits junior doctors to provide frontline clinical services to patients within NSW Health facilities. Through working in these positions, the majority of junior doctors will be concurrently fulfilling requirements for postgraduate medical training, thereby developing the specialist medical workforce for the future.
2. Recruitment practices should be aimed at recruiting the best people for NSW Health. This implies consideration of geographical distribution, specialty choice and mobility of the medical workforce.
3. Recruitment should be based on the principles of equity, fairness and transparency, supported by current NSW Health policies that facilitate best recruitment practice.
4. The recruitment system should be configured to optimise efficiency whilst maintaining quality of outcome, from the perspectives of the applicant, employer, profession and community.

SECTION TWO

Overview

Introduction

The recruitment of junior doctors has a number of unique characteristics that differentiate it from many other public sector recruitment activities, including: high volumes of positions and applicants; tight timeframes; and multiple internal and external stakeholders. A summary of these characteristics is provided in Table 2 opposite.

By any measure, given these characteristics, the statewide JMO recruitment strategy represents an immensely complex and resource intensive undertaking.

The number of key stakeholders is a key consideration in any analysis of the current approaches to junior doctor recruitment. These include: patients/community; applicants; Ministry of Health; Local Health Districts; JMO management units; clinical heads of departments; HETI and Colleges.

Whilst key stakeholders may all share the same primary aim of wanting to recruit the best possible doctors to a given position, each ultimately brings a somewhat different and in many cases, competing perspective to the recruitment strategy. These are summarised in Table 3 on the following page.

Many of the features of the current NSW JMO recruitment strategy have been developed in an attempt to respond to the complexity derived by trying to balance the needs of multiple stakeholders with competing perspectives.

These challenges are not unique to NSW and an interstate and international comparison undertaken during the review process revealed other models and alternative approaches to junior doctor recruitment. A comparison of some of the features of junior doctor recruitment strategies within Australia is provided in Table 4.

Other states and territories share many features of the NSW JMO Recruitment campaign and these have become standard recruitment practices, also evident in international models, for example the United Kingdom. Similarities include undertaking a bulk recruitment campaign, during specified dates with an on-line application system.

Table 2: Summary of characteristics of junior doctor recruitment campaign

Characteristic	Explanation
Volume	Approximately 3,600 positions are filled as a result the annual bulk recruitment campaign.
Timeframe	The formal recruitment campaign commences in July and runs until second round offers are finalised in October. Preparation for the recruitment period usually begins well ahead of July and recruitment activities can extend up until the commencement of the clinical year.
Applicants (employees) are also trainees	The majority of junior doctors are involved in or working toward formal postgraduate medical training and are employed on temporary contracts aligned with the clinical year, or in many cases, the length of their training program.
Individual applicants apply for multiple positions	Given the nature of postgraduate medical training, particularly in the context of a tightening job market, many applicants will apply for multiple positions, both within and across specialties.
Multiple internal stakeholders	There are multiple internal (NSW Health) stakeholders responsible for the various components of the recruitment strategy, all with different perspectives and sometimes, competing interests. These include the Ministry of Health, HealthShare NSW, HETI, Local Health Districts, Clinical Departments and JMO Management Units
Multiple external stakeholders	Many junior doctor positions are accredited by the relevant medical specialty college for postgraduate medical training, and in some cases, colleges are involved in trainee selection to specific posts.
Interstate recruitment activities	All other states and territories undertake annual recruitment campaigns for junior doctors, usually in similar timeframes, but not necessarily aligned dates.

A significant change to junior doctor recruitment processes across Australia has been the transition to online advertising. All states have websites and manage online application processes although there is variation in the quality of websites.

There are also some important differences between the states. These include NSW having centralised coordination; contracts and paperwork being undertaken by HealthShare NSW as compared with the local health district (or equivalent) or facility; and a specific JMO recruitment policy.

These differences are driven by a number of factors, including historical context and culture but also relate to the fact that NSW has a much larger number of positions and facilities (which are also geographically dispersed) when compared to most other states, (the exception being Queensland).

It is clear that the central coordination of the recruitment process, particularly with respect to a single application platform, uniform dates and standard application forms, supports equity and fairness in recruitment practices from an applicant's point of view.

Table 3: Summary of key stakeholders in JMO recruitment strategy

Stakeholder	Primary perspective on junior doctor recruitment
Patient/Community	Patients have an expectation that junior doctors recruited to work in NSW Health have the appropriate knowledge, skills and experience to provide safe clinical care.
Applicant	Applicants are seeking employment but many are also seeking access to postgraduate training positions. Applicants want streamlined application processes that are easy to navigate and a fair and equitable selection process.
Ministry of Health	Expectation that recruitment processes are compliant with legislative and industrial requirements thereby minimising the risk of an industrial challenge. NSW Health in positioning itself as a preferred employer seeks to recruit the best applicants whilst at the same time, minimising the risk of making an inappropriate appointment.
Local Health Districts	Focus is on junior doctors as clinical service providers, therefore seeking to fill vacancies and avoid disruptions in service provision. Budget considerations require cost efficient process and management of FTE.
JMO Management Units	Focus is on managing the high workload generated by the recruitment process, minimising the risk of process and administrative errors that may lead to either a challenge by an unsuccessful applicant or disruption to clinical service delivery as a result of an inability to fill positions.
Clinical Department Heads	Clinical Heads are primarily interested in recruiting the best trainees (as compared to employees) to their team and want recruitment processes that are simple, time efficient with a minimal amount of bureaucracy and paperwork. Clinical Heads are also Fellows of their respective college.
HETI	Recruitment is seen as the mechanism by which trainees access clinical experience, supervision and education that allows them to meet postgraduate medical training requirements. HETI has responsibility for managing many training Networks across the state.
Medical Colleges	Colleges are responsible for postgraduate medical training within their specialty, including selection of candidates and College Fellows provide the supervision and education of candidates as they work toward meeting college requirements. In some cases, Colleges allocate trainees to specific posts across Australia, and therefore want processes and procedures that are streamlined, efficient and aligned with other states.

Table 4: Comparative analysis of JMO recruitment processes within Australia

Feature	New South Wales	Queensland	Victoria	South Australia	Australian Capital Territory	Tasmania	Western Australia
Number of positions advertised[1]	3,600	4,000	3000	Not known	600	Not known	Not known
Number of facilities[2]	>50	>50	> 40	<10	2	3	<10
On-line application system	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Number of applications processed	45,300	50,000 +	NA	NA	NA	NA	NA
Bulk recruitment campaign	Yes	All facilities use on line system but each hospital advertises own positions	All facilities use on line system but each hospital advertises own positions	All facilities use on line system but each hospital advertises own positions	Yes	All facilities use on line system but each Tasmanian Health Organisation advertises own positions	All facilities use on line system but each hospital advertises own positions
Centrally coordinated	Yes	No	No – except for positions advertised through the match – see below	No	No – but bulk of recruitment undertaken by Canberra Hospital for the ACT	No	No – except for PGY2 positions

1 This is an estimate only and does not include data for states that have decentralised recruitment campaigns.

2 Denotes the number of facilities that primarily employ junior doctors but does not include the total number of facilities where junior doctors work (secondment facilities).

Feature	New South Wales	Queensland	Victoria	South Australia	Australian Capital Territory	Tasmania	Western Australia
Cap on number of applications per applicant	No	Yes – single application form with capacity to apply for up to 5 positions within the state	Varies – for preference matching single application form with capacity to apply for up to 3 positions	No	No	No	No
Preference matching	Yes – for some positions Basic physician training Surgical skills training	No	Yes – for following positions (HMO) PGY2 Basic physician training	No	No	No	No
Centralised recruitment panels	Yes – for some positions	No	No	No	No	THO NW and THO N undertake some joint interviews	No
Length of contract provided	Variable – generally from 12 months up to length of training program	12 months	12 months	12 months	Variable – generally from 12 months up to length of training program	12 months	12 months
Information guide for applicants on recruitment process	No	Yes	No	No	No	No	No

An alternative to the current model would be LHD's independently undertaking recruitment of junior doctors. There are clear disadvantages to this option, recognised by many of those consulted.

LHDs undertaking their own recruitment processes would result in the development, likely to become more marked over time, of variations in practices and processes, resulting in confusion for applicants. There is already evidence of this with respect to the development of slightly different selection criteria for essentially the same job, across LHDs.

Given the numbers of positions; the complexity of training pipelines in the context of a tightening job market, a return to a decentralised model has an additional risk of further increasing the numbers of applications with a concomitant increase in the workload for clinicians and administrative staff involved in the recruitment process.

In a tightening job market, streamlined and standardised processes contribute to managing a risk of challenge from an unsuccessful applicant. Variations in practice across LHDs provide potential opportunities for industrial or legal challenges to the recruitment process.

There is strong support for the current approach taken in NSW with a centrally coordinated bulk recruitment campaign as providing the most efficient and cost-effective mechanism of recruiting, given the complexity and scale of the task. Many of those consulted were supportive of further strengthening centralised processes, particularly with respect to centrally coordinated selection panels. This is dealt with in a later section of the report.

Despite the clear advantages of and support for the current centrally coordinated bulk recruitment strategy, the review identified some key areas for improvement and these are detailed within the body of the report.

The statewide JMO annual recruitment strategy represents an immensely complex and resource intensive undertaking.

Recommendation 1

The NSW JMO recruitment strategy, characterised by a centrally coordinated bulk recruitment campaign, should continue to be supported as providing the most efficient and cost effective approach to JMO recruitment within NSW. **Risk – moderate**

Key points

- Taking into account the number of positions, applicants and facilities, in addition to the complexity and interdependencies that exist across and between medical specialties within the postgraduate medical training pipeline, a centrally coordinated bulk recruitment campaign provides the most efficient and cost effective approach to JMO recruitment within NSW.
- The detailed recruitment policy is a critical component of the recruitment campaign. Compliance with the policy not only supports best practice, it also mitigates the risk of a successful legal challenge from an unsuccessful applicant.
- A centrally coordinated bulk recruitment campaign also supports the principles of equity of access and fairness of JMO recruitment processes within the public sector environment.
- The single eRecruitment platform provides a clear entry point for applicants seeking positions.
- Whilst there is strong support for continuing the centrally coordinated bulk recruitment campaign, it is also evident that there are a number of emerging risks. These are dealt with in the remainder of the report.

Governance

The governance arrangements underpinning the annual JMO recruitment campaign reflect the complexity derived from the reality of a complex system with multiple stakeholders, who have sometimes duplicity of roles and responsibilities but also (at times) competing perspectives or interests.

The Secretary of NSW Health has overall responsibility for the management and oversight of NSW Health with primary powers and responsibilities articulated in the *Health Administration Act 1982* and the *Health Services Act 1997*.

The Governance, Workforce and Corporate Division undertake a range of functions for the effective administration of NSW Health. This Division supports and manages the Secretary's accountabilities as employer of the NSW Health Service, including: statewide industrial matters; public sector employment policy; statewide workforce planning; recruitment and reform strategies; and the strategic development of the NSW Health workforce.

Within this structure, Workforce Planning and Development is responsible for coordinating the annual JMO recruitment strategy. This includes implementation of policy to support the annual recruitment campaign and liaison with key stakeholders, including external partners.

Workplace Relations is responsible for the development of policy for the recruitment and selection of staff and providing advice on employment and industrial matters.

HealthShare NSW provides corporate services and information technology services to public health organisations across NSW under the auspices of a Board appointed by the Secretary. HealthShare NSW manages the electronic recruitment platform, JMO eRecruit and support services used for the annual JMO recruitment campaign.

Local Health Districts (LHDs) were established as distinct corporate entities under the *Health Services Act 1997* from 1 July 2011 and are responsible for the employment of staff within their health district. This includes junior medical staff employed through the annual JMO recruitment campaign.

Whilst each LHD has a human resource unit responsible for supporting the employment of staff, the human resource functions related to the employment of junior medical staff has largely been undertaken by JMO management units, sometimes with very little interaction with the local HR unit. Whilst there are some very experienced JMO Managers working within the NSW system, many do not have an HR background. This issue is further dealt with in Section Three under JMO Management Units.

The Health Education and Training Institute (HETI) is a Chief Executive-governed statutory health corporation which coordinates education and training for NSW Health staff, including junior medical staff. HETI have responsibility for coordinating and providing support to a number of training networks, including basic physician training, surgical skills, psychiatry, and medical administration.

HETI's role in the networked training programs has extended to the coordination of the central recruitment processes during the annual JMO recruitment campaign. Over time this has led to role creep, with HETI program staff now assuming responsibility for functions that would have formerly been undertaken by LHDs, such as organising the interview panels, communicating with applicants and undertaking the 100-point ID checks at interview.

The JMO Recruitment Committee, convened by Workforce Planning and Development and chaired by the Deputy Director, Workforce Strategy and Culture provides oversight of the annual JMO recruitment campaign and meets approximately four times per year.

The membership includes representation from the Ministry (Workforce Planning and Development, Workplace Relations); HETI; HealthShare NSW and the local health districts and other associated health organisations. The majority of those consulted regard this committee as an effective vehicle for managing system wide issues and making improvements.

In addition to the JMO Recruitment Committee, the HealthShare NSW eRecruitment Committee is convened annually, in early November, following the main recruitment campaign.

A series of sub-committee meetings (General Recruitment; Central Recruitment Panel; Surgical Skills; and Basic Physician Training) have replaced the historical "washup" meeting and provide additional opportunities for key internal stakeholders to review issues arising from the recruitment process, with a focus on the eRecruitment system. Whilst some members of the JMO Recruitment Committee attend the eRecruitment Committee, it is not always clear how the two committees interact.

During the recruitment campaign, there is a lot of interaction between Workforce Planning and Development, HealthShare NSW, Workplace Relations and the LHDs, in particular the JMO Management Units. Staff from LHDs, applicants and medical specialty colleges and associations contact "the Ministry" for advice, with sometimes little appreciation of the distinct responsibilities held by the two branches and HealthShare NSW respectively. In many cases, these communications often bypass the local LHD human resource units.

Key points

- The governance arrangements are characterised by multiple stakeholders with different perspectives and often, competing interests.
- Roles and responsibilities are not always clear and there is evidence of duplication of some activities and role creep. There is a risk that this will become more marked with time.
- Whilst the JMO Recruitment Committee provides oversight of the JMO recruitment strategy, its governance role could be strengthened.

This has sometimes led to a blurring of roles and responsibilities, particularly with regard to knowledge management and information transfer.

Recommendation 2

The roles and responsibilities of those involved in the annual JMO recruitment campaign need further clarification and restatement, with all stakeholders agreeing and accepting their roles and responsibilities.
Risk – high

Policy

The mandatory standards to be applied in the recruitment and selection of junior medical staff during the annual JMO Recruitment campaign are articulated in the policy directive, *Recruitment and Selection of Staff of the NSW Health Service*. A number of other information bulletins provide specific information and reinforce elements of the policy directive. The key documents are summarised in Table 5.

The policy directive clearly articulates the mandatory standards required to meet legal and industrial obligations and are an important component of managing risks with respect to the recruitment and selection of staff within the public sector context.

From a policy perspective however, the sheer scale, scope and timeframe of the JMO recruitment campaign have presented significant challenges.

In recognition of some of the unique features of the JMO recruitment campaign, additional standards and amendments have been made, usually in response to emerging issues. These workarounds are encapsulated in Module 4. A comparison of the differences between Module 1 and Module 4 is provided at Appendix F.

There has clearly been considerable effort placed on streamlining the system but this has sometimes come at the expense of quality. The amendments to the standard on referee checks from a requirement to obtain a verbal referee report (Module 1) to the acceptance of an electronically transmitted (if verbally validated) reference (Module 4) are an example of this and this particular issue is covered in more detail in the section on referee checks.

Compared with other jurisdictions in Australia, NSW is unique in providing additional standards covering the JMO recruitment campaign, with all other states relying on a generic (Module 1 equivalent) selection and recruitment policy, sometimes supplemented by additional information bulletins (or equivalent) to cover off issues pertaining to junior medical staff.

Table 5: Key policy documents related to the annual JMO recruitment campaign

Document title	Type	Author(s)
Recruitment and Selection of Staff of the NSW Health Service [PD2012_028] Module 1 and Module 4	Policy Directive	Workplace Relations Workforce Planning and Development
Junior Medical Officer 2015 Recruitment Campaign – Policy and Process Information [IB2014_038]	Information Bulletin	Workforce Planning and Development
Junior Medical Officer – Clinical Year and Term Dates 2014–2018 [IB2014_046]	Information Bulletin	Workforce Planning and Development
Junior Medical Officer – 2015 Recruitment Campaign Dates [IB2014_032]	Information Bulletin	Workforce Planning and Development

The majority of those consulted within the NSW system were aware of the policy directive [Module 1 and Module 4] but there were some exceptions to this. This suggests that training, although available, is not reaching the entire target audience. This is confirmed to some degree by the results of the survey of convenors and panel members that suggest that approximately two thirds of respondents have not attended recruitment and selection training either at all or within the last three years.

A key theme emerging from the consultation process relates to breaches of compliance with the policy. The policy is written in such a way as to promote equitable, fair and transparent approaches to recruitment and selection of staff within the public sector context.

Far from being *"bureaucratic red tape"*, the policy directive is hence an important risk management strategy in the recruitment and selection of junior doctors and compliance protects all those involved in recruitment and selection processes from legal and industrial challenge.

A large number of those consulted within the NSW system, expressed concerns regarding breaches of the policy, particularly with regard to senior medical staff making verbal offers to applicants ahead of preliminary offers being emailed. The reports, although anecdotal, were so widespread that the reviewer formed the view that it is highly likely that this is a significant issue.

Unfortunately, it may be that it will take an inevitable (though likely, highly publicised) legal or industrial challenge by an unsuccessful applicant before the apparent dominant culture, with regards to the importance of complying with the policy, changes.

A number of people raised the lack of sanctions being applied in the context of breaches of policy.

The issue of breaches of recruitment and selection policies and the unintended consequences in terms of the impact in undermining professionalism both from an applicant and system-wide perspective is an important issue and one that has received some attention in the literature.

Concerns regarding ethics and professionalism within recruitment activities involving junior doctors are a focus of some articles in the peer-reviewed literature, (Swanstrom et al 2006). The unintended consequences of breaches of policy (for example by panel members pressuring applicants to declare their preference to a particular training program, despite clearly written advice prohibiting this), is ultimately the message sent to applicants particularly as it relates to a potential discordance between the stated values of the employer (and Colleges).

One strategy to support compliance, at least with respect to processes managed through the eRecruit system has been to build in a number of rate limiting steps so that, for example, applications cannot be progressed in the absence of specified requirements.

This of course has to be balanced with efficiency and there were examples provided of where these specifications had held up processes. These instances are covered under the relevant section later in the report.

Some of those consulted expressed concern that at times it seems as though the eRecruitment system drives the policy rather than the policy driving the system. This also calls to question issues of governance with regards to how changes to the eRecruitment system are approved, albeit that there is an eRecruitment User Forum who receives change request submissions, and an eRecruitment Governance and Reference Group, who advise on issues and future directions of eRecruitment systems.

The majority of those consulted within NSW, who were aware of the policy found that it was clearly written and easy to follow. There were a number of comments to the effect that whilst the policy directive is very detailed in some areas, it remains broad in other areas. An example of this, with particular relevance to the JMO recruitment campaign is section on culling of applicants that contains very little information on the approach.

The majority of those consulted, confirmed through feedback received in the surveys, supported the clarity of detail contained within the information bulletins and generally found these documents to be useful.

Likewise for those who referred to the business process documents, they were generally found to be helpful in navigating the eRecruit platform.

Key points

- The policy directive clearly articulates the mandatory standards required to meet legal and industrial obligations and are an important component of managing risks with respect to the recruitment and selection of staff within the public sector context.
- Given the unique characteristics of the JMO recruitment campaign, it is entirely appropriate that a specific JMO recruitment policy (Module 4) has been developed.

Table 6: Key supporting documents related to the annual JMO recruitment campaign

Document title	Type	Author
Business Process Module 1 [Version 1.6]	Business Process	HealthShare NSW
Business Process Module 2 – Statewide Centralised Recruitment Panel Positions [Version 1.0]	Business Process	HealthShare NSW
HealthShare NSW Internal Business Process NSW Health JMO Recruitment Campaign for 2015 Clinical Year [Version 1.1]	Business Process	HealthShare NSW

Cost analysis

The JMO recruitment campaign is characterised by high volumes and resource intensive processes that are distributed across multiple stakeholders and dispersed across the state.

Calculation of the costs of the JMO recruitment campaign is compounded by the fact that the majority of key internal stakeholders have other (sometimes more primary) responsibilities (senior clinicians, JMO management unit staff, HETI staff) in addition to JMO recruitment activities.

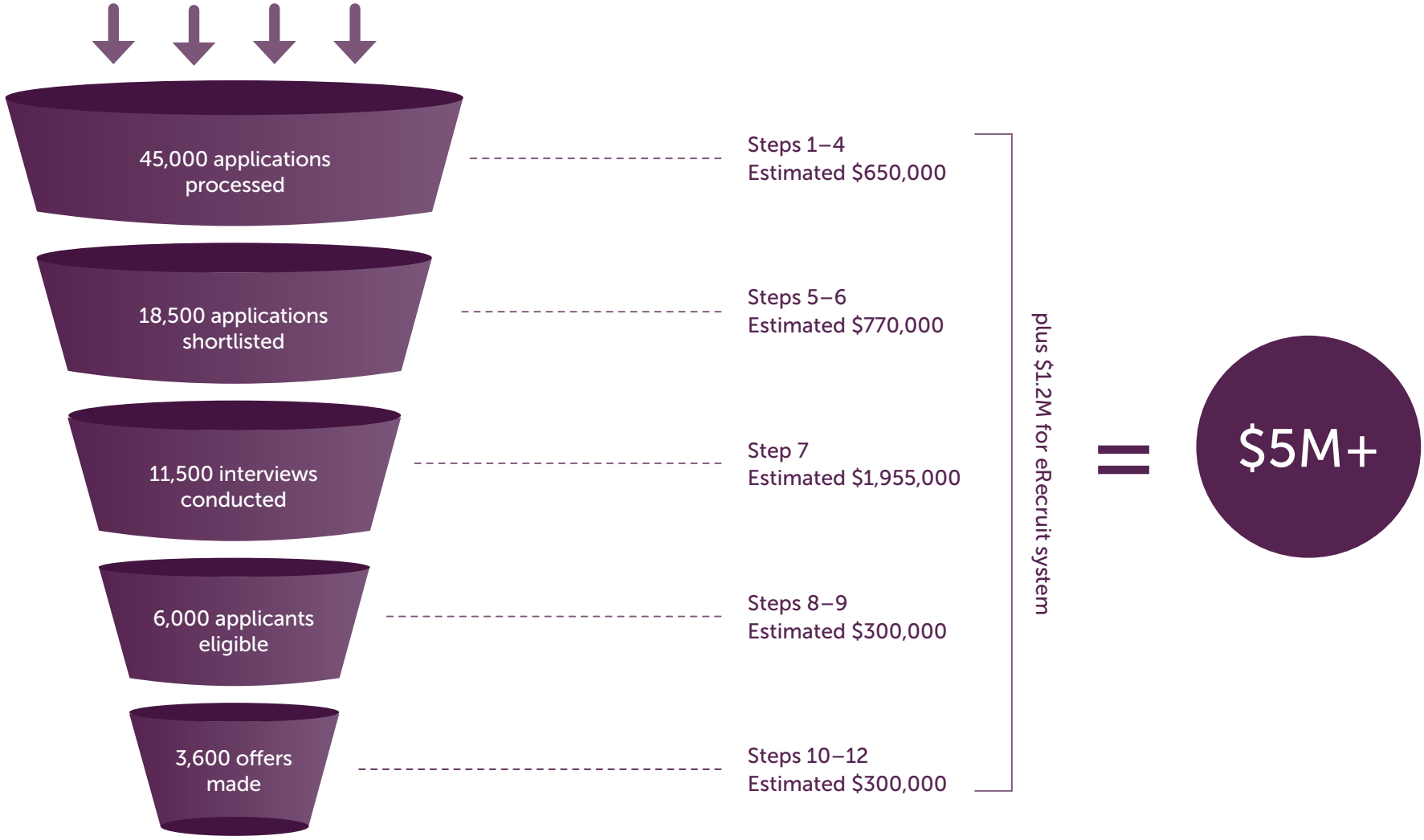
The exception to this, are the HealthShare NSW staff involved in the JMO recruitment campaign who are primarily employed for this responsibility. The budget allocated for the JMO eRecruit system (staff) is therefore shown separately.

The remainder of the calculations of the estimated costs of the JMO recruitment campaign is based on information received during the consultation process regarding the amount of JMO management unit staff and senior clinician time spent at each step of the process.[2] These estimates are conservative and it is likely that the actual costs are higher. The estimated costs are summarised in figure 4 over page.

2 Salary costs has been averaged at $150 per hour for senior clinicians and $60 per hour for JMO Managers.

Figure 3: Overview of process map

Figure 4: Estimated costs of JMO recruitment campaign



SECTION THREE

Key Considerations

Recruitment outcomes

One of the striking features of the bulk JMO recruitment campaign is that ultimately, the majority of junior doctors employed in a given clinical year are reemployed for the following clinical year.

The 2015 annual JMO recruitment campaign had a net change to the existing NSW Health employee cohort of just 14%.

As one senior administrator commented:

"It's like musical chairs, but the administrative burden behind that is huge"

The 14% change to the cohort may be explained by a combination of interns commencing the training pipeline (allocated outside of the bulk recruitment campaign), doctors completing their training and moving to specialty practice and doctors entering the NSW system from interstate.

The remaining 86% are existing employees who will continue working within NSW Health in 2015, and for the majority of those, the year beyond that. Whilst it is acknowledged that the majority will move progressively to more senior roles and many will move across LHD borders, the question must be asked, in light of the human resource and fiscal cost of running the JMO recruitment campaign each year, is whether there is another approach?

Further work on identifying positions and training pathways, combined with length of training contracts may ultimately reduce the total number of positions that are required to be advertised each year. This is discussed in more detail in a later section of the report.

Whilst workforce issues are beyond the scope of this review, it is important to note that the last two JMO recruitment campaigns have seen a downward trend in vacancy rates, at the conclusion of the recruitment campaign, which appears to becoming more pronounced with time.

The change in vacancy rates at the end of the recruitment campaign is evidence of the tightening job market, primarily in response to increased numbers of medical graduates entering the training pipeline.

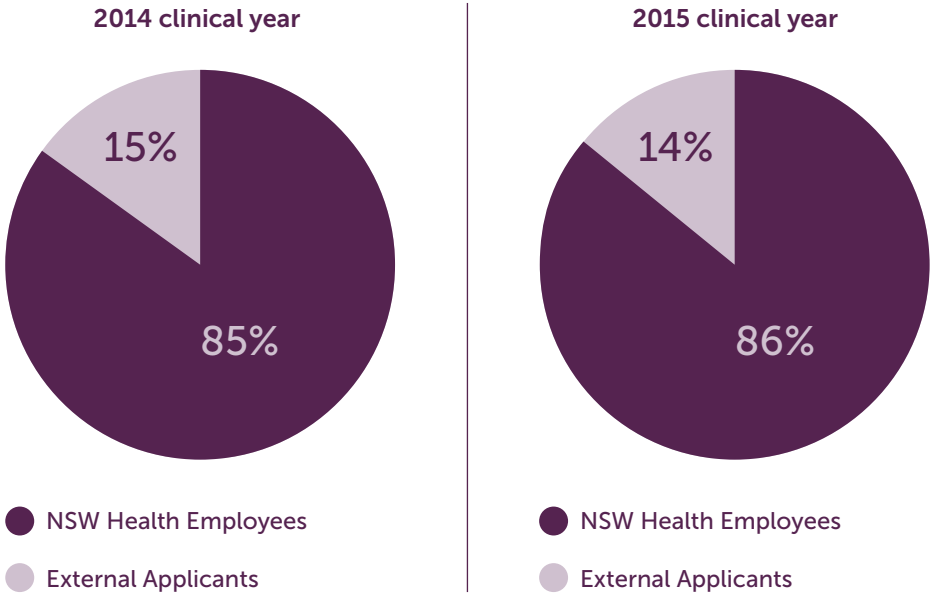
Recruitment to the majority of junior doctor positions is becoming increasingly competitive and selection panels are required to make high stakes decisions, impacting on both employment prospects and access to postgraduate training opportunities for individual doctors.

Whilst increasing numbers do appear to be impacting on the recruitment to positions within metropolitan areas, this is not yet occurring within rural and regional areas. One rural doctor expressed it this way:

"The tsunami hasn't wet our feet yet."

Many rural and regional areas continue to experience challenges recruiting and retaining junior medical staff. The reason for these challenges are complex and beyond the scope of this report. Specific issues identified with respect to rural and regional recruitment are detailed in later sections of the report.

Figure 5: Successful applicants by existing employment status



Centralised recruitment panels

The introduction of centralised recruitment panels in a number of specialties has been a key improvement to the JMO recruitment campaign, with a concomitant streamlining of processes. This has ultimately resulted in a reduction in the number of interviews an individual applicant is required to attend and the number of hours senior clinicians spend on interview panels.

The governance arrangements for centralised recruitment panels have been included, since 2012 in the Policy Directive Recruitment and Selection of Staff of the NSW Health Service [PD2012_028].

There are currently 17 centralised recruitment panels operating during the JMO recruitment campaign, shown in the text box over the page. Each centralised panel is allocated to a host JMO management unit who, on behalf of all stakeholder LHD's provides the administrative support to the recruitment process.

All centralised recruitment panels are subject to the same provisions articulated in the policy directive. Additional information is provided through the relevant information bulletins and business process documents. In most cases, the rules seem to be working well.

The allocation to a particular host unit has been somewhat arbitrary, based on a number of factors including: location of the convenor, historical precedent and willingness of the JMO management unit to undertake the work. The reliance on good will in making the decision as to which JMO Management Unit will act as host is a risk.

There does not appear to be a clear understanding of the funding arrangements to undertake this work and in many cases, given the iterative nature of their development, they have not been adequately resourced. This is a significant issue with regards to sustainability of existing centralised recruitment panels but this has also potentially impacted on the expansion of this strategy to other specialty areas.

The level of complexity, actual numbers recruited to, and number of participating facilities impact upon the workload of both the convenor and host JMO management unit.

There is not necessarily an equitable distribution of the allocation of panels across LHDs and some relatively small JMO management units (in terms of staffing) are managing quite large panels (for example Rehabilitation is currently hosted by the Manly – Mona Vale Hospital JMO Management Unit).

There is a wide variation both in the numbers being recruited to and the mechanics of how each centralised recruitment panel operates. Some are complex undertakings. For example, rehabilitation and gastroenterology both recruit relatively large numbers at all stages of the training continuum across many facilities. In some cases, given the number of positions and facilities involved in that specialty, a single centralised panel is not viable. Other panels recruit much smaller numbers at a single entry point in the training pathway, (for example cardiology and obstetrics and gynaecology).

Further comparative detail on the centralised recruitment panels is provided at Appendix G.

Despite the workload for the hosting JMO management unit, centralised recruitment panels are seen as a significant improvement and on balance there is strong support for them.

> ***"The people who were reluctant to participate now see the benefit."***
> *(Senior doctor)*

Centralised recruitment panels (2015 clinical year)

- Anatomical Pathology Trainee
- Cardiology Advanced Trainee
- Endocrinology Advanced Trainee
- Gastroenterology 1st year and continuing 2nd and 3rd year Trainee
- Haematology Advanced Trainee
- Infectious Diseases Advanced Trainee
- Medical Administration Trainee Training Program
- Medical Oncology Advanced Trainee
- Microbiology Trainee
- Neurology Advanced Trainee
- Nuclear Medicine Advanced Trainee
- Obstetrics and Gynaecology 1st year Trainee
- Ophthalmology 1st year Trainee
- Palliative Care Advanced Trainee
- Rehabilitation Trainee
- Respiratory Medicine Advanced Trainee
- Rheumatology Advanced Trainee

Likewise, trainees, apart from expressing a concern about the size of some panels, generally made positive comments regarding centralised recruitment panels.

> ***"Great, (commenting on the interview process), well organised. Centralised interviews are a great idea."*** *(Applicant)*

One potential risk is the emerging use of spreadsheets containing details of applicants and used to manage rotations. Spreadsheets are circulated between the participating LHDs and HealthShare NSW and concerns were expressed regarding version control and management of data.

Networked recruitment

In addition to the centralised recruitment panels described above, several other programs operate coordinated recruitment activities for the state. The basic physician training and surgical skills networks are coordinated through HETI and run a day of interviews, held at a single location to which all participating facilities either attend or are represented.

As with the centralised recruitment panels, there were many positive comments made by the applicants:

> ***"A very well-organised interview process where all the BPT networks has their interviews at one location, making it easy for applicants to have most of their interviews in a day without having to travel between various hospitals."*** *(Applicant)*

Key points

- The introduction of centralised recruitment panels in some specialties is regarded as a key improvement in the JMO recruitment campaign and should be expanded to other specialties.
- The current reliance on the goodwill of senior clinicians and JMO Management Units in convening centralised recruitment panels is not sustainable and more formal arrangements, including appropriate allocation of resources, needs to be agreed.

Recommendation 3

Centralised recruitment panels should be supported and expanded to other specialties. **Risk – high**

Recommendation 4

The arrangements for centralised recruitment panels, including allocation of appropriate human and fiscal resources to ensure their effective and sustainable operation, needs to be agreed between LHDs. **Risk – high**

College recommended appointments

A number of colleges, particularly in the surgical subspecialties undertake the recruitment and selection of trainees, including the allocation of specific trainees to accredited training posts within NSW Health facilities. These appointments are thus not managed through the eRecruitment system and appointments are made without advertising through NSW Health. The training programs currently undertaking recommended appointments are detailed below. Over 300 positions are currently managed through the relevant specialty training college.

All college recommended applicants are generally appointed as an advanced trainee, and given a contract of 12 months duration, with the exception of orthopaedic trainees who are issued with length of training contracts.

Notwithstanding that the college is undertaking the selection of the trainee, the receiving LHD, as the employer, must still ensure that the doctor is appropriate for employment. This is managed by colleges sending a letter of recommendation to the facility which prompts an employment process, including employment screening and referee verification checks.

College recommended appointments

- Cardio-thoracic surgery
- General Surgery
- Neurosurgery
- Orthopaedic Surgery
- Otolaryngology – head and neck surgery
- Oral and maxillofacial surgery
- Paediatric surgery
- Plastic surgery
- Urology
- Vascular surgery
- Hand surgery
- Dermatology

Issues raised with regards to college recommended appointments relate to the lack of authority the employer has with respect to the actual appointment. This view must be balanced against the idea that colleges ultimately share the same aim as the employer in wanting to select the best candidates for the role, notwithstanding that there may be different views on how this is achieved. Working more closely with Colleges on selection criteria for specific roles may assist in resolving these differences. This is discussed in section four of this report.

One issue that repeatedly came up during the consultation process in relation to college appointed trainees was the timing of details being provided to the employer to enable the commencement of onboarding activities.

This is particularly significant for this cohort of doctors who are typically in their PGY4 + year and have substantial clinical and service provision responsibilities from the first day of their new contract. Many of these doctors will move to different facilities (often across LHD borders) and require access to and training in the different IT and diagnostic (pathology and radiology) systems.

Whilst the unique identifier with respect to the StaffLink number has improved this situation to a great degree, issues remain and point to a requirement for earlier communication between Colleges and LHDs during this phase of recruitment.

Recommendation 5

Further work is undertaken with relevant Colleges to improve the timing of notification and transfer of information with respect to College recommended appointments. **Risk – moderate**

JMO management units

JMO management units (however named and configured) are primarily responsible for managing and coordinating the operational aspects of the JMO recruitment campaign, often in collaboration with the relevant clinical department, including liaising with HealthShare NSW and the Ministry.

In addition to recruitment activities JMO management units are responsible for a wide range of other functions including the day-to-day operational management of the junior doctor workforce, rostering and leave management, performance management and other responsibilities.

A key finding of the review is that JMO management units are bearing the brunt of the JMO recruitment campaign, particularly with respect to managing high volumes of applications within very tight timeframes across the full range of specialties and rotations in which there are complex medical training and clinical service provision interdependencies.

Not all JMO management units are adequately resourced to undertake the volume of work during the recruitment period. Many JMO Managers reported working afterhours and weekends during the campaign in order to manage the workload generated by the recruitment campaign, in addition to their other responsibilities. There is no doubt that JMO Managers (as well as other JMO management unit staff) are under pressure and at significant risk of burnout and that the recruitment campaign is the major contributor to this.

> ***"The recruitment campaign is a very stressful period"***
> ***"There are unrealistic timeframes."*** *(JMO Manager)*

> ***"It (recruitment) knocks out 4 months of the year to keep pace with the timeframes"*** *(JMO Manager)*

Over time, experienced JMO Managers develop critical corporate knowledge of junior doctor positions within their facilities, particularly in relation to local training pathways and skill requirements for specific clinical roles. There was significant concern expressed by many consulted during the review of the risk of loss of this corporate knowledge through staff turnover.

> ***"The system would be very vulnerable if a number of JMO Managers left in succession."*** *(Senior administrator)*

Examples were provided during the review of facilities where the existing longstanding JMO Manager had resigned and the subsequent challenges faced by the organisation in managing the JMO recruitment campaign, in addition to recruiting a new JMO Manager.

These issues are exacerbated by the lack of a formal career pathway and limited professional development opportunities currently available for JMO Managers as a group. This is particularly surprising when one considers the critical role of JMO Managers in the bulk JMO recruitment campaign, where many are responsible for hundreds of junior doctor positions (at a very significant total salary cost) on behalf of their LHD.

Many JMO Managers are viewed by their organisations as the gatekeepers of the recruitment policy, often negotiating with (and to some extent, educating) senior clinicians throughout the recruitment process to ensure compliance.

Most JMO Managers do not have a human resource background and in some instances, the local human resource unit has very limited involvement or input into the JMO recruitment campaign. For JMO Managers who are new to the role, there is little preparation for managing the complexity and volume of the JMO bulk recruitment campaign.

There were a number of concerns expressed regarding the potential of an appeal by an unsuccessful applicant and the subsequent consequences on the JMO Manager. Many JMO Managers clearly feel unsupported and this contributes to the pressure of the role.

Key points

- JMO management units are bearing the brunt of the JMO recruitment campaign, particularly with respect to managing high volumes of applications within very tight timeframes.
- JMO management units are under pressure and there is a significant risk of burnout with subsequent risk of loss of critical corporate knowledge and experience to the health system.
- These issues are exacerbated by the lack of formal career pathway and limited professional development opportunities for JMO Managers.

Recommendation 6

Staffing of JMO management units is reviewed to ensure that they are adequately resourced to undertake designated roles and responsibilities associated with the bulk JMO recruitment campaign. **Risk – high**

Recommendation 7

Consideration is given to the development of career pathways and professional opportunities for JMO Managers that strategically supports the sustainability of this critical cohort of the NSW Health workforce. **Risk – high**

Other issues of significance identified during the review

This section covers additional issues of a broad nature that were identified during the review. Issues relating to the more specific aspects of the recruitment process are discussed in section four of this report.

Current system relies on goodwill of senior clinicians

Many of the recruitment activities are undertaken by senior clinicians who have busy clinical loads, in addition to other responsibilities. To a large extent the current recruitment campaign relies on the goodwill of these individuals. Given the administrative burden associated with junior doctor recruitment, this is not sustainable and there is a significant risk of loss of goodwill over time. A number of strategies aimed at reducing the administrative burden on senior clinicians (and others) are considered elsewhere in this report.

Lack of training of selection panel convenors and panel members

There is an expectation that public sector recruitment activities meet relevant legislative and industrial requirements. Full compliance with the recruitment and selection policy supports this. Training of convenors and panel members is critical in ensuring that all those involved in selection activities are not only aware of the policy but understand their responsibilities with regards to the effective implementation of the policy requirements.

This becomes more critical in a tightening job market where selection panels are making high stakes decisions with a concomitant and increasing risk of an appeal by an unsuccessful applicant.

There are currently two types of training offered to convenors and panel members. The first is on the process of recruitment and selection and the second is on how to use the eRecruit system. In addition to the latter, Help-desk staff support convenors and panel members in navigating the IT system during the recruitment period.

The greater issue relates to training in recruitment and selection processes. Anecdotal evidence gathered during the review, would suggest that the majority of panel members have not recently attended recruitment and selection training and to some degree this was confirmed by the online survey, where less than a third of respondents reported attending training within the last three years. This is seen as a significant risk, particularly in light of interstate experience, which highlights an increasing number of unsuccessful applicants lodging formal appeals.

Robust selection processes, which are compliant with the policy, are a primary risk mitigation strategy in managing appeals. Training is fundamental to this.

Colleges, in selecting candidates for training programs are also vulnerable to appeals and given the common ground, in addition to the fact that the majority of panel members (for junior doctor positions) are also Fellows of their respective College, there may be some worth in the development of more medically focused recruitment and selection training programs.

Recommendation 8

Consideration is given to working with Colleges on the development of a medically focused recruitment and selection training package, aligned with public sector employment requirements. **Risk – moderate**

JMO eRecruit system is well regarded

The JMO eRecruit system is generally well regarded and there was clear evidence of improvements made over the last few years. There were lots of comments comparing the recruiting using the JMO eRecruit system with recruitment undertaken outside of the bulk recruitment campaign that uses the general eRecruit platform. The latter system was reported by those consulted as being much more difficult to navigate.

There were a number of reports with respect to the JMO eRecruit system struggling with volumes during peak times and it is understood that there are plans to move to a new platform for future recruitment campaigns.

Staff at HealthShare NSW involved in the JMO recruitment campaign, including the Help-Desk staff are generally well regarded and viewed as "helpful" by both applicants and JMO management units.

Many processes remain manual and paper based

One surprising feature of the review was that despite the move to online systems, many junior doctor recruitment processes remain manual and paper-based. The extent of this is best depicted pictorially as the photographs collected during site visits demonstrate.

Whilst strategies to reduce the administrative burden are discussed elsewhere in the report, it is clear that further work is also required to migrate the recruitment process and associated documentation to a fully electronic environment.

Recommendation 9

Further work is undertaken to migrate the bulk JMO recruitment campaign to a paperless IT system. **Risk – low**

Figure 6: Examples of JMO management units during the recruitment campaign

There are complex interdependencies in training positions across the system

The complexity and interdependencies between and across specialties, particularly as they relate to PGY3 and PGY4 positions is confirmed.

Applicants are frequently required to gain specific pre-requisite clinical experience prior to being accepted onto a vocational training program. These requirements often dictate applicant's preferences for jobs, particularly as they relate to choice of rotations.

Access to mandatory pre-requisite rotations is becoming more competitive as the system is struggling to provide trainees with core requirements for entry to vocational training programs. Late notice by Colleges of changes to pre-requisite requirements place additional stress on both applicants and the system.

Many consulted expressed the view that there needed to be better alignment of expectations between colleges and employers with regards to access to pre-requisite training requirements. Identification of training pathways as detailed in a later section will improve this.

JMO recruitment ultimately allocates or distributes finite education and training resources to individual junior doctors

The relationship between recruitment activities and postgraduate medical training is complex. The outcome of recruitment provides individual junior doctors access, through their employment, to clinical experience, education and training activities, which ultimately contribute to fulfilling College requirements.

In this respect, recruitment may be viewed as allocating valuable (and finite) education and training resources (including clinical experience and supervision) to individual junior doctors over other junior doctors. The way in which this occurs is not always transparent and there were lots of comments by trainees in relation to this as depicted in the following quote from a trainee:

> *"The remnants of tapping on the shoulder still remain..."*

Strategies aimed at improving the transparency of the recruitment process are dealt with in other sections of this report.

Pre-selection interview and canvassing

There were multiple reports during the consultation process of the pre-selection interview and job canvassing undertaken by potential applicants. For some training programs, there was a view repeatedly expressed by applicants, that unless an applicant visits the relevant facility before the interview and meets with the Head of Department or the Director of Training, then their chances of being successful in being recruited to that position were negligible.

Whilst pre-selection interviews appear to be widespread practice in the JMO recruitment campaign, there is currently minimal advice to the system on how to manage this.

SECTION FOUR

Recruitment Process

1 Identify vacancy

Whilst the initial step of the recruitment and selection process should be relatively straightforward, given the nature of JMO positions, particularly with respect to the interchangeability of PGY3-5 positions, this is not always the case.

This stage requires approval by the delegated authorising officer (DAO) of the funded establishment to be advertised. Many of those consulted reported that late confirmation of the FTE creates significant pressure in the lead up to the opening of the recruitment campaign.

The reasons for later confirmation vary but may include a delay in the local approval processes and non-alignment between the JMO management unit's and clinical department's understanding of the approved funded FTE. In other cases, the delays appear to arise from internal approval processes, particularly with respect to the notification of funding of new positions.

Delays to the approval process are also a particular problem for the centralised recruitment panels, where the host JMO management unit requires confirmation from other LHDs of the approved FTE to advertise.

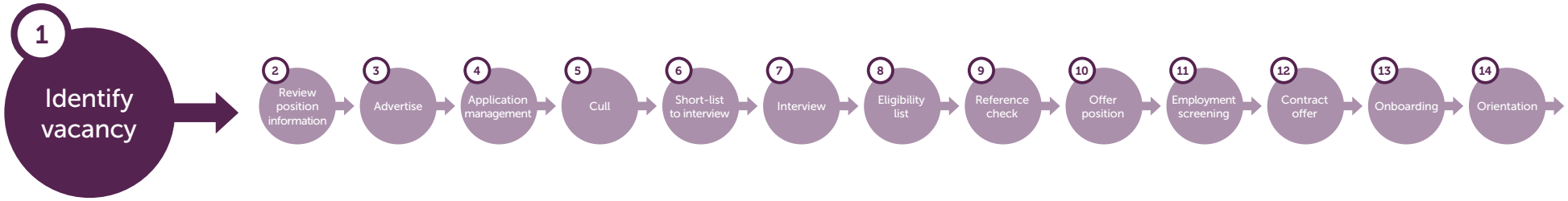
Another area commonly reported as an issue related to those positions that are funded through the Commonwealth Specialist Training Program (STP). Late approval of funding can result in positions not being approved for 1st round advertising. Advertising and filling during 2nd round may create a downstream cascading impact whereby preferred applicants decline previously accepted positions (from the 1st round) in order to take up more preferred STP funded appointments.

Recommendation 10

Communication is improved regarding approval of the FTE to be advertised. This includes LHD's notifying the central panel host unit of the FTE to be advertised. **Risk – high**

Recommendation 11

The Ministry of Health continue discussions with the Commonwealth Department of Health regarding the timing of notifications on STP funding. **Risk – moderate**



2 Review position

The position description provides important information to applicants regarding the nature of the role and the terms of employment. The policy sets out the requirements for information to be contained within the position description, [refer 2.2 of Recruitment and Selection of Staff of the NSW Health Service PD2012_028].

Position descriptions must be reviewed and approved by the Job Owner (usually through the Clinical Head of Department, plus or minus the Director of Medical Services) prior to being loaded onto the eRecruitment system, for approval by the DAO.

For most JMO management units, this process commences well before the formal recruitment period, often as early as March. All position descriptions must be approved and uploaded onto the eRecruitment system in time for the opening of advertising.

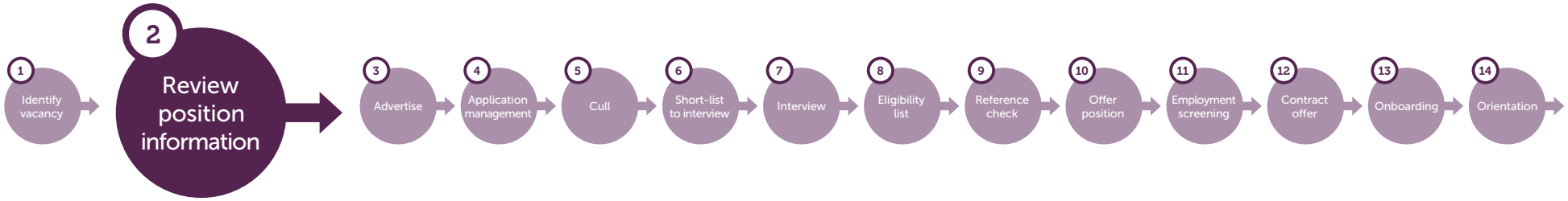
In past recruitment periods, Job Owners have been able to amend position descriptions from the previous version. This has generally been accepted as the most efficient process, however it was noted that for the most recent recruitment campaign, all position descriptions were required to be entered from scratch. This was reported as time-consuming process and concerns were expressed regarding the potential for data entry error requiring multiple downstream checks.

Several other issues were highlighted during the review process on this topic. Given the number of positions, and the slight variation from job to job, most facilities have a very large number of position descriptions with some extending to the hundreds. This volume of position descriptions places a very significant administrative burden on the system, particularly with respect to ensuring currency and accuracy.

In order to comply with the requirements of 2.2 [Recruitment and Selection of Staff of the NSW Health Service PD2012_028] position descriptions have become voluminous and unwieldy documents, which applicants find difficulty in navigating. Much of the information contained within the position descriptions is required but an approach may be to separate this information and provide links to relevant sections.

Selection criteria are a critical component of the position description, particularly with respect to culling applications and yet are often too generic to be useful. A review of a sample of position descriptions revealed that some selection criteria contain job requirements (for example, ability to rotate to rural hospitals or work weekends/after hours) rather than focusing on the essential requirements for the position.

There has been a focus on selection criteria for junior doctor jobs in the literature with some authors reporting increasing use of the sophisticated selection criteria, following a job analysis focusing on technical as well as non-technical aspects of the job, in providing selection panels with a solid foundation from which to select applicants in a highly competitive job market. Further discussion and recommendations on this issue are provided in a later section (5 – Cull).



3 Advertise

All positions advertised through the JMO recruitment campaign are advertised on the eRecruitment platform. The centralised advertisement process has undergone a significant change in the last decade and is one of the key strengths of the JMO recruitment campaign. It was only a decade ago that positions were being advertised separately by facilities within newspapers.

Positions are now advertised usually at the level of the facility, with the exception of those positions managed through either the centralised selection panel or networked positions. Applications are open for a period of three weeks.

The recruitment campaign has historically been supported by a media strategy run in the newspapers at the commencement of the recruitment campaign. The rationale for running a media campaign is to alert NSW, interstate and international doctors that the advertisement period is open, showcasing NSW Health as a sought after employer.

Apart from the obvious political merit of running a print media campaign, the actual usefulness of the accompanying media stories is questionable. It is unlikely that current NSW Health junior doctors require notice through a newspaper that the recruitment period is open. It is noted that recent changes have moved the media strategy to online mediums and this is supported.

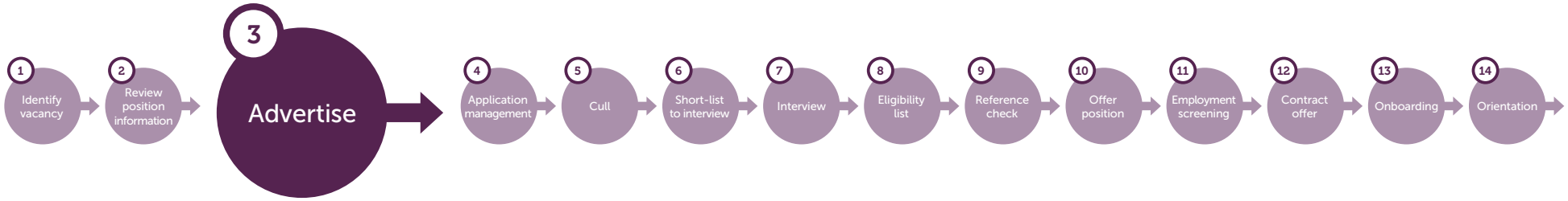
For existing NSW Health junior doctors, information about the bulk recruitment campaign is widely communicated through the JMO Management Unit, notwithstanding the fact that junior doctors are indoctrinated with the understanding that they will generally have to apply for their job each year or at nominated stages of their postgraduate medical training program.

The advertising of positions through the eRecruitment system was strongly supported by the majority of those consulted. There was evidence of continued processes to refine and improve the way in which positions are advertised. The challenge relates to the sheer volume of positions, some very similar, yet different, across the system.

Whilst the eRecruitment platform used for the JMO recruitment campaign is supported, many applicants reported difficulty in locating specific positions and for many this relied on local knowledge that the position existed, which potentially places external applicants (to the facility) at a disadvantage.

> ***"It was very difficult to find the job I was applying for. I had to ring to find out the position number."*** *(Applicant)*

Other places, such as Queensland Health (see diagram over page) and the National Health Service (NHS) in the UK, have developed their recruitment platforms that are user friendly and easy to navigate, even for large numbers of advertised positions.



An important (from an applicant's point of view) piece of information in the advertised position description is the details of the contact person to find out more information on the role. Many applicants reported difficulty in contacting the contact person.

Where the contact person is a senior clinician with a busy clinical load, the pragmatic reality of responding to potentially scores of phone messages or emails within a defined period of time is challenging.

Likewise where the contact person is the JMO Manager, who may have responsibility for coordinating the recruitment of hundreds of positions, difficulties contacting the JMO Manager may be further compounded. For external (to the facility) applicants, the capacity to contact the contact person is particularly important and there is a perception that difficulty in doing so, disadvantages external applicants.

Recommendation 12

Further work is undertaken on the web-based eRecruit system to enable applicants to more easily locate positions. **Risk – moderate**

Figure 7: Screen shot of Queensland Health's home page for the Queensland bulk JMO recruitment campaign

Source – www.health.qld.gov.au/rmo/

4 Application management

This section makes comments regarding application management [refer 2.8 Recruitment and Selection of Staff of the NSW Health Service PD2012_028] in addition to the process by which applicants lodge their applications.

There are several issues to be highlighted with respect to the lodging of applications. The first relates to the sheer number of applications that are lodged. Applicants are currently permitted to apply for as many positions as they wish. Table 7 shows the numbers of applications for the last three recruitment cycles.

Table 7: Total number of applications and applicants by year

	2013	2014	2015
Number of applications	50334	50955	45431
Number of applicants	6223	7003	6743

There were lots of reports that the eRecruit system is slow during peak times and this is not surprising given the volume. For example, in the closing day for applications in 2014, there were over 9,000 applications submitted with approximately 200 applications being lodged per minute during some time periods.

The reason for the number of applications per applicant appears to primarily derive from an increasingly competitive job market with applicants making application to their preferred specialty choice/position level/geographical location but also then making application to a number of positions as a backup.

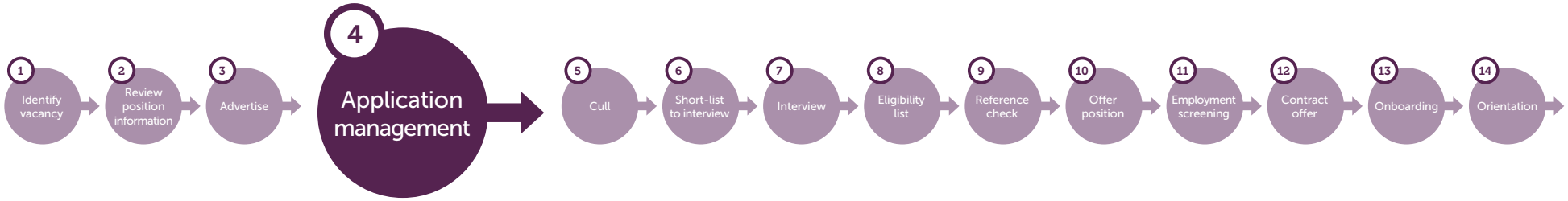
A very large number of applications continue to be received by overseas trained doctors seeking employment in Australia. Table 8 shows the total numbers of applications for the 2015 JMO recruitment campaign per applicant by country of medical degree[3].

Table 8: Total number of applicants for 2015 JMO recruitment campaign by country of medical degree

Country of medical degree	Number of applicants	Number of applications
Australia	3247	19437
Bangladesh	176	2218
Canada*	9	48
China	98	1062
Egypt	79	1169
Germany	36	153

Table continued on next page

3 Table shows countries approved by APHRA for competent authority pathways (marked by *) in addition to those countries having greater than 20 applicants.



Country of medical degree	Number of applicants	Number of applications
India	686	5431
Iran, Islamic Republic of	111	1325
Iraq	61	602
Jordan	28	245
Malaysia	30	159
Myanmar (previously Burma)	123	676
Nepal	44	410
New Zealand*	106	400
Nigeria	38	261
Northern Ireland	24	62
Pakistan	280	3733
Philippines	106	624
Republic of Ireland*	83	390
Russian Federation	55	531
South Africa	30	62
Sri Lanka	195	1785
United Kingdom*	485	2287
USA*	11	27

Standard pathway (AHPRA) overseas applicants also have a higher number of applications per applicant. Table 9 shows the average number of applications per applicant for the 2015 JMO recruitment campaign by country of medical degree.

Table 9: Average number of applications per applicant for the 2015 JMO recruitment campaign by country of medical degree

Country of medical degree	Number of applicants	Number of applications	Average number of applications per applicant
Australia	3247	19437	5.99
Canada	9	48	5.33
New Zealand	106	400	3.77
Northern Ireland	19	62	3.26
Republic of Ireland	83	390	4.69
United Kingdom	485	2287	4.72
USA	11	27	2.45
Other	2270	22469	9.89

Whilst it is acknowledged that there remain some positions within the system that have historically been difficult to fill and have therefore relied on IMG doctors (for example psychiatry and neonatology), the majority of junior doctor positions, in an increasingly competitive market are now able to be filled by doctors who have both registration with the Medical Board of Australia and currency of practice within the Australian healthcare system.

Regardless of the origin of the application, all are required to be processed and given the volume this comes at a high fiscal and human resource cost to the system.

In some states elsewhere in Australia, limits are placed on the number of applications that an applicant may make. For example in Victoria, this limit is 3, whilst in Queensland, the limit is 5. This has the impact of encouraging applicants to be more judicious in the positions they are applying for.

The second issue relates to the capacity of the system to receive information that an applicant may wish to supply in support of their application. Lots of comments were received from applicants in relation to the character limit on the selection criteria. This is seen as a critical issue given the nature of the high stakes decision. The perception from applicants is that the limit on words ultimately advantages those already known to members of the selection panel or program.

A number of comments were also received with respect to the fact that similar jobs across (and sometimes within LHDs) had similar but nevertheless slightly different selection criteria, requiring a different response. Applicants reported considerable frustration on this issue.

> ***"Having to answer very similar, yet not quite exactly the same questions, for each different application at different hospitals but for the same 'job' is time consuming and feels like it could be more streamlined."*** *(Applicant)*

On balance, the majority of applicants involved in face-to-face consultation or who responded to the survey, reported no issues (apart from the system being slow at peak times) with the actual loading up of documents. Generally this was seen as a straightforward process.

The mandatory standard requires that all applicants must:

- Have their application dated on receipt (this can be electronic dating)
- Receive an acknowledgement of receipt of their application (can be an automated email)
- Be advised if the selection process has been delayed or is not to go ahead.

Whilst the eRecruitment system sends an automatic acknowledgment of receipt of application for those successfully submitted, this is often the only notification that an applicant receives until the finalisation of the recruitment campaign.

For those applicants who were culled at an early stage of the process, it may be many months before they receive confirmation that they had ultimately been unsuccessful. This is a particular issue for international medical graduates seeking employment in Australia who do not meet the selection criteria for a given position.

Managing the employment expectations of international medical graduates seeking to relocate to Australia in the current environment of increasing local medical graduates is an important ethical consideration. One approach is to have unambiguous selection criteria, particularly for highly competitive positions. This is further discussed in a later section.

Recommendation 13

The concept of placing a limit on the number of applications per applicant is explored with key stakeholders. **Risk – high**

Recommendation 14

The current character limit on selection criteria is reviewed. **Risk – low**

5 Cull

The mandatory requirements of the policy [refer to 2.9.4 Recruitment and Selection of Staff of the NSW Health Service PD2012_028] require that all panel members must have access to all applicants' entire application and any supporting documentation in addition to the selection criteria and position description. The standard also mandates that applicants should be culled on the basis of selection criteria only.

This implies that the selection criteria are written in such a way as to support the selection panel to robustly determine whether an applicant meets the selection criteria or not. As documented in a previous section, the selection criteria are often too generic to support efficient culling of applicants.

In practice, for many JMO recruitment panels, the process of culling applications is generally undertaken by the Convenor of the panel, occasionally with the remainder of the panel, but more often with the assistance of the JMO management unit staff.

In some instances, particularly general PGY3-4 level positions, JMO management unit staff may undertake the initial cull on behalf of the panel, albeit that the selection panel will ultimately be provided with details of all applicants and be asked to approve the recommendations made. Whilst this may be a pragmatic way to deal with the high volume within the timeframes, it represents a risk and JMO Managers report considerable anxiety lest they make an error or are challenged.

It is clear that a considerable amount of time is spent manually reviewing the details of applications in order to determine whether they meet the selection criteria.

For many positions, hundreds of applications are received. For example for a critical care SRMO job in a tertiary referral hospital, 494 applications were received for 4 positions.

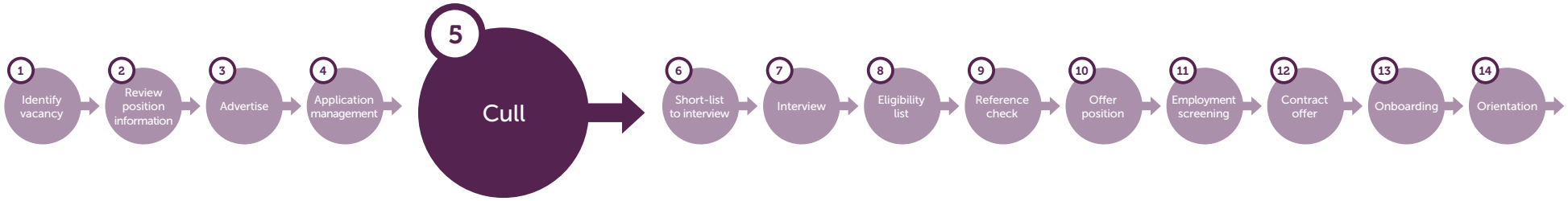
For many positions, a large number of individuals currently applying are subsequently found not to meet the selection criteria, particularly with respect to eligibility for registration with the Medical Board of Australia. The culling of this particular group of applicants, given the high volumes represents a major driver of costs without a discernable benefit to the system.

A potential solution would be to configure the eRecruitment system for the majority of positions to require a current AHPRA registration number to be inputted before an applicant is able to proceed to the next stage on the application process.

This would remove the requirement for selection panels to manually cull applicants who do not meet the selection criteria of holding registration with the Medical Board of Australia or having currency of practice within the Australian healthcare system.

Given the numbers, this is likely to have an immediate significant impact in decreasing the workload on both selection panels and JMO management unit staff.

For example, on the basis of data from the 2015 JMO recruitment campaign, this would have effectively automatically removed nearly half the total number of applications from the system.



Put another way, a very high percentage of applicants to the 2015 JMO recruitment campaign who did not hold current registration with the Medical Board of Australia at the time of application were ultimately found not to be successful. This was also the group with the highest average number of applications per applicant.

This approach may also have a second order impact of allowing the finite resources to be directed toward a more sophisticated discrimination between a smaller number of the most eligible applicants for the limited number of positions.

There has been considerable attention paid in the recent medical literature to the use of selection criteria in postgraduate medical training positions. This reflects a global concern regarding ensuring that the most suitable junior doctors are being selected for specialty training, particularly in the context of increasing numbers.

Fiona Patterson is an organisational psychologist who, with colleagues, has published a number of papers in relation to selection of postgraduate medical trainees. She is regarded as an international expert on job analysis and selection processes within medical specialties and has undertaken a number of studies in this area. (Patterson, Tavabie et al, 2013; Patterson, Lievens et al, 2013; Irish et al, 2010; Patterson, Ferguson et al, 2008).

For Patterson and her colleagues, the focus is not just on the clinical competence skill set, but also on the suitability of a trainee to a particular specialty with a focus on the non-technical aspects of the role. From an employer's perspective the latter is likely to be seen as just as crucial.

Patterson argues that, "To achieve a robust selection system, the most crucial step is to identify both the core skills (competencies) common to all specialties and the competencies that discriminate between specialties." Patterson et al (2008).

The efficient culling of applicants, particularly when they present in large numbers, is predicated on robust selection criteria that allow a selection panel to adequately assess through the review of the CV and statement of claim against the selection criteria, whether an individual applicant meets requirements. It is clear that more robust selection criteria are required for many of the junior doctor positions within NSW to facilitate a more effective selection process.

The comparative analysis of applicants meeting the selection criteria in order to short-list for interview is considered in the following section.

As applicants are culled, there is an expectation that the reason for this is documented clearly. A number of spreadsheets providing documented evidence were examined during the review process.

Generally the information provided on culled applicants is sparse, at least in those spreadsheets reviewed, which is not surprising given the high volumes and tight timeframes. This can present a challenge to the convenor, if later asked by an unsuccessful applicant to provide feedback about why the applicant was unsuccessful. More robust selection criteria may support improved documentation on the definitive reason for culling a particular applicant.

Recommendation 15

For highly subscribed positions, consideration be given to removing words to the effect of "eligible to register with the Medical Board of Australia" and having an unambiguous statement to the effect that applicants must hold current registration with the Medical Board of Australia, in addition to currency of medical practice within the Australian healthcare system.[4] **Risk – high**

Recommendation 16

The eRecruitment system is configured to enable automatic processes of applicants who do not meet the above selection criteria, without the requirement for a manual review of the application. **Risk – high**

4 It is acknowledged that this will not be appropriate for all positions, particularly those specialties and/or geographical locations continuing to experience workforce shortages.

Recommendation 17

The wording of selection criteria used in position descriptions is reviewed to support a more efficient culling process by selection panels. This assumes a more sophisticated description of the role (following a job analysis) that incorporates not just the required clinical competence skill set, but also the non-technical attributes critical to the role. **Risk – moderate**

Recommendation 18

Work with individual Colleges is undertaken to establish standardised specialty specific selection criteria (this assumes a job specification analysis) at various levels of training, including streamed PGY3-5 positions. **Risk – moderate**

Recommendation 19

For regional and rural positions, consideration is given to allowing selection criteria to reflect an applicant's interest in, commitment to and suitability for rural medical practice. **Risk – moderate**

6 Short-list to interview

A second phase of the culling process, requires a comparative analysis of those applicants who have met the selection criteria in order to determine who should proceed to the next phase of the selection process. From the policy perspective, this further comparative analysis should occur against the selection criteria.

Advice was provided to the reviewer, that this phase presents selection panels with significant challenges given, that many applicants are viewed as having similar qualifications, skills and experience.

The capacity for selection panels to confidently and validly conduct further comparative analysis of applicants against the selection criteria is critical to overall efficiency of the recruitment campaign.

It was noted that there is little information provided in the policy directive in either Module 1 or Module 4 on further comparative analysis and given the nature of this high stakes decision in the context of high volumes, this is seen as a significant issue.

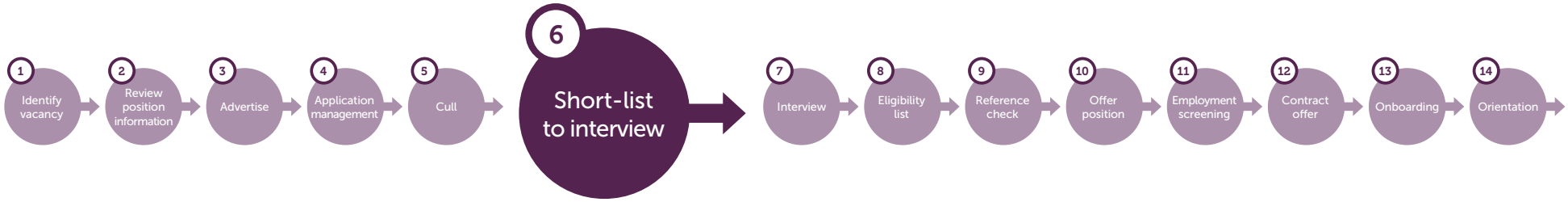
The net result appears to be that large numbers of applicants are proceeding to the interview stage. This is a particular issue for the midgrade levels of junior doctors. There were approximately 11,500 interviews undertaken during the 2015 JMO recruitment campaign across NSW.

Whilst there may be an argument in the interests of equity that applicants are given the opportunity to be interviewed, a review of the literature would suggest that using the traditional interview in isolation is not particularly valid as a selection technique. This is further compounded when interviews are very short in length, but is also problematic in terms of the significant costs in human resource and fiscal terms, being expended not just by panels and administrative staff, but also by the applicants themselves.

Junior doctors are employed to deliver front-line clinical services to patients within NSW. Attending interviews, particularly in geographically dispersed locations across the state, results in large cohorts of junior doctors requiring leave during the interview period and the potential for disruption to clinical service delivery.

Whilst for many junior doctors attending an interview across town may mean no more than a few hours to a half day's absence from the workplace, for others, particularly those working in rural and regional settings, it may mean days away from work during the main interview period.

Given the staffing ratios in rural and regional settings, these are the very places where the absence of even one or two doctors for a day can have a significant impact on clinical service delivery. For doctors attending more than one or two interviews during this period, this issue is exacerbated.



Considerable attention has been paid to the culling (and short-listing) of applicants in the literature, reflecting a common concern, particularly in North America, Canada and the United Kingdom on the validity of processes being used in the selection of applicants for postgraduate medical training programs.

Volume, in the context of high stakes decisions is a key concern. Brothers et al (2007) argues that the more liberal use of a screening system might be anticipated to reduce as much as 80%, the number of unranked applicants interviewed.

Managing the balance between short-listing applicants and preserving equity and fairness is not unique to NSW and is an issue shared by other states/territories within Australia. Some hospitals have trialed novel approaches to the comparative analysis of applicants.

For example, in St Vincent's Hospital Victoria, staff have explored the use of a prescreening web-based video interviews whereby applicants who meet the selection criteria, are sent a link and asked to answer a couple of questions, each requiring a response of a few minutes duration. Members of the selection panel view these videos, score the applicant's response and a short list of candidates to progress to interview is determined.

There is no doubt that conducting interviews with thousands and thousands of applicants across NSW during each recruitment campaign comes at a significant fiscal and human resource cost.

Any measure that supports a more limited number of applicants being interviewed, so long as selection panels and applicants alike can be confident that the process is fair, transparent and valid is likely to be welcomed.

Case example

In Royal Brisbane Hospital, Queensland, the Medical Officer Support Unit uses a detailed scoring sheet to short-list applicants, which has been developed and finessed over several recruitment cycles.

The details of the scoring sheet, including the weighting applied to the various selection criteria, have been agreed and approved by an expert committee and is made readily available to applicants.

Interestingly, once applicants are scored, the top-scoring group proceeds directly to the contract offer stage (without the requirement for interview); the bottom-scoring group are culled and the middle group proceed to interview.

For approximately 60 resident positions, only 25 interviews were conducted from an applicant pool of hundreds of applicants.

By limiting the numbers of interviews, staff believe that they are able to focus their attention on discriminating between the group of applicants that present, from a binary decision perspective (to offer a job or not offer a job) the greatest selection challenge.

7 Interview

The policy directive articulates the expectation that the selection process should include an interview, preferably face-to-face by an appropriately composed selection panel.

For the JMO annual recruitment campaign, the majority of interviews are conducted during a period of several weeks, the exact dates of which are stipulated in an information bulletin published each year.

The composition of the interview panels remains relatively standard across the system with usually three to four panel members, most of whom are senior doctors, but also including an independent. (Panels for the centralised recruitment processes and networked positions are often considerably larger than this. Further detail on this is provided in an earlier section).

The composition of the interview panels generally complies with the policy requirements and having the DAO approve the composition would appear to have resulted in appropriate attention being paid to ensuring balance across the panel, particularly with respect to gender mix and the use of independents, though at times sheer volume and timeframe imperatives place a lot of stress on the system in terms of ensuring panel members' availability.

Some expressed the view, particularly for the more junior positions, that the use of JMO management unit staff as the independent panel member may not fully comply with the spirit of the inclusion of an independent.

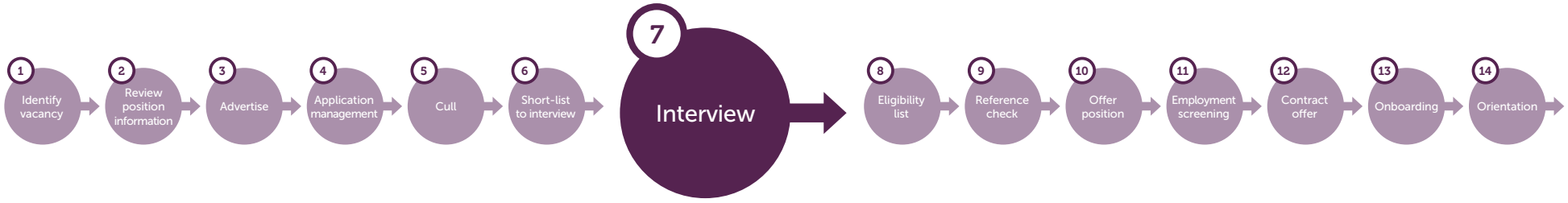
During the interview period for the 2015 clinical year JMO recruitment campaign, over 18,000 interviews were scheduled through the eRecruit system and over 11,500 interviews of junior doctors were actually conducted by interview panels.[5] Even when compared to international examples, these numbers are high and represent a significant human resource burden on the system.

It is difficult to calculate the exact amount of time devoted to selection activities across the system, (particularly with respect to the time spent interviewing). In the most recent JMO recruitment campaign, there were just over 5000 convenors and panel members registered on the eRecruitment system. It is understood that the majority, but not all, of these are senior clinicians.

Even if each of these 5000 registered users spent a *maximum* of four hours per annum on JMO recruitment activities (and the consultation process and surveys would suggest that it is considerably higher than this), this still represents a very significant investment of time.

Historically, in NSW, as has been the case elsewhere, the interview has been used as the mainstay of the selection process in recruiting to junior doctor positions. Over recent years however the use of the traditional interview is being challenged and many programs are exploring other mechanisms of selecting applicants.

5 The discrepancy is explained by the fact in a staggered interview process, a number of potential interviewees will decline interviews if they have already been offered a preferred position.



This shift is reflected in a number of publications, particularly from North America, Canada and the United Kingdom where authors have investigated other modalities of making these high stakes selection decisions, in the context of an expectation of ensuring fairness, equity and transparency for all applicants.

Some authors have explored alternative mechanisms to the traditional interview through using a competency based assessment centre (Randall et al, 2006) and many articles now report on the use of skills stations and other simulated activities being used as part of the selection processes, (Patterson et al 2013, Onyon et al 2009, Gallagher et al 2008, Rao 2007).

Whilst it is clear that selection of trainees into postgraduate medical training programs is the remit of the medical specialty colleges, given the interdependencies between training posts and employment, there is considerable benefit to be gained by the employer working with colleges to improve the selection methods of those junior doctors who ultimately gain employment with NSW Health.

During the review, advice was provided that RACP are undertaking work on selection processes for basic physician training[6]. This has included exploring the potential for adopting some strategies used in the UK such as using multi-mini interviews, situational judgement tests and selection centres.

Although this work is in development, given the large number of basic physician trainees employed within NSW, there may well be some opportunities to explore working collaboratively in supporting more robust selection and recruitment processes for that group.

As reflected in the policy directive, the aim of the interview is not to select the person best at interviewing, but to select the most appropriate person for the role. In bulk recruitment campaigns, this can present particular challenges.

Given the high stakes nature of the decision, if interviews are to be used as the primary mechanism of discrimination, then it is important to make every effort to maximise the reliability of the interview.

6 Source – personal communication with Ms Julia Gustavs, Manager Education Development, Research and Evaluation, RACP January 2015.

Applicants expressed the view that, particularly for positions where scores and sometimes hundreds, of applicants were being interviewed, that it appeared that panel members were not reading their CVs or written responses to the selection criteria. Comments were also received regarding the impact of lots of interviews on the panel.

> ***"My interview took place after hours in the evening, at the end of the day wherein the panel had been interviewing almost continuously since early morning. I can't help but think that they would have been exhausted and over the process by that point."*** *(Applicant)*

A number of comments were also made in relation to the time of interviews with some interviews being scheduled for just 10 minutes. In some applicant's minds at least, the time seems even shorter.

> ***"I was in and out (of the interview) in 5 minutes."*** *(Applicant)*

> ***"The interviews all ask the same questions – it was a waste of time."*** *(Applicant)*

> ***"The team was nice and friendly, but the interview felt so short."*** *(Applicant)*

The timing of interviews being reduced to 10 minutes with the same questions being asked across multiple interview panels, calls to question the reliability of this format being used in high stakes decisions.

Many applicants and others consulted highlighted the size of some panels:

> ***"Being interviewed by 13 consultants is intimidating."*** *(Applicant)*

> ***"Having 14 people on a panel seems a bit like overkill."*** *(Applicant)*

One option might be to explore the use of multi-interviews with smaller-sized panels, rather than a single large panel to improve the validity and robustness of process.

A number of comments were also made with respect to the modality of the interview. The perception from applicants, particularly rural based applicants seeking employment in the metropolitan tertiary facilities, is that if they do not attend an interview face-to-face, they will be at a disadvantage.

A further theme that arose with respect to interviews was the practice of the pre-interview whereby applicants may visit the facility before the interview to tour the department and speak with relevant clinicians. In some programs, there is a perception held by trainees, that if you haven't visited the hospital beforehand, you may as well not bother attending the interview.

> *"There was an expectation to pre-interview prior to applications opening." (Applicant)*

Some applicants went further to suggest that it was actually at the pre-interview that recruitment decisions were made and that the formal interview was simply about meeting policy requirements.

> *"I had a cursory 4 minute interview, as decisions regarding positions are largely made prior to the formal interview. This adds to the lack of transparency of the entire process." (Applicant)*

The use of interviews as the primary mechanism of selecting junior doctors creates a significant impost on the system with questions regarding its reliability and the potential for challenge by unsuccessful applicants. There are clearly opportunities for improving current practices.

Recommendation 20

Strategies are explored with the aim of reducing the total number of interviews being conducted. This will include a range of strategies such as: improved culling and short-listing techniques; increasing positions utilising preference matching; and increasing the number of centralised recruitment panels. **Risk – high**

Recommendation 21

Work with postgraduate medical training providers, including Colleges, is undertaken to explore other methods of assessing applicants in the recruitment process. **Risk – moderate**

8 Eligibility list

Once the selection panel has recommended applicants for appointment, their names are placed on an eligibility list in merit ranked order. Commonly more names than positions to be filled are placed on the list, to risk manage successful applicants declining positions. The eligibility list is then forwarded to the DAO for approval prior to offers being made.

A couple of related issues were highlighted with respect to the eligibility lists during the review.

The first relates to the fact that this is a binary decision point in the process. At the end of the interview period, applicants are either placed in the unsuccessful category or placed in merit ranked order on the eligibility list. There is no third 'on hold' category.

Once an applicant is placed in the unsuccessful category, they cannot be retrieved at a later point in the process during that recruitment round, should a facility reach the end of the eligibility list. This is inefficient for a number of reasons, and particularly for facilities that have issues with recruitment.

Eligibility lists cannot be approved by the DAO until all referee checks have been undertaken. This is a particular problem for those facilities that may be trying to risk manage high decline rates by significant oversubscription to the eligibility list. This frequently holds up the process for preliminary offers.

One approach might be to adapt the policy to allow for a number of eligible applicants against the given FTE plus a couple of extras be able to be forwarded in one group to the DAO (with appropriate validation of referees). This has the potential to markedly streamline the process for JMO Management Units making initial job offers.

Recommendation 22

Consideration is given to the creation of a third category list whereby in addition to the eligibility list for successful applicants, potentially eligible but lower ranked applicants could be placed 'on hold'. **Risk – high**

9 Reference check

The policy directive specifies the requirements for referee checks. In recognition of the burden placed on nominated referees during the JMO recruitment campaign, a number of adaptions have been made over the time and these are articulated in Module 4.

Whilst the adaptations have streamlined some processes and undoubtedly reduced the administrative burden on senior clinicians (nominated referees) and administrative staff, this has arguably come at a cost in the quality of the referee report.

The current process requires the applicant to provide the names of two referees at the time of application, regardless of how many jobs they are applying for. An email is sent to each referee and they are asked to complete a referee template, containing a number of generic questions.

The eRecruit system has a number of built in alerts, requests and notifications that automate much of this process. Referee checks of all those on an eligibility list must be validated by the convenor (often the JMO management unit staff) and uploaded onto the system for approval by the DAO, prior to any offers being made.

The system is configured in such a way once a referee report on a particular applicant is validated and uploaded onto the system it is then available to any of the selection panels of positions that that particular applicant has applied for.

It is noted that recruitment practice has shifted away from consideration of the reference report as part of the selection process to the current model that simply uses the referee report to validate the claims made by the applicant.

Given that the referee report is very generic, yet the positions applied for are not, this calls to question whether the current referee format is even able to achieve the aim of validating the claims made by the applicant, particularly in the written format. This is particularly relevant to junior doctor positions given the variation of job requirements across the range of clinical positions with respect to specialty area; clinical competence; level of supervision required; procedural expertise and so forth.

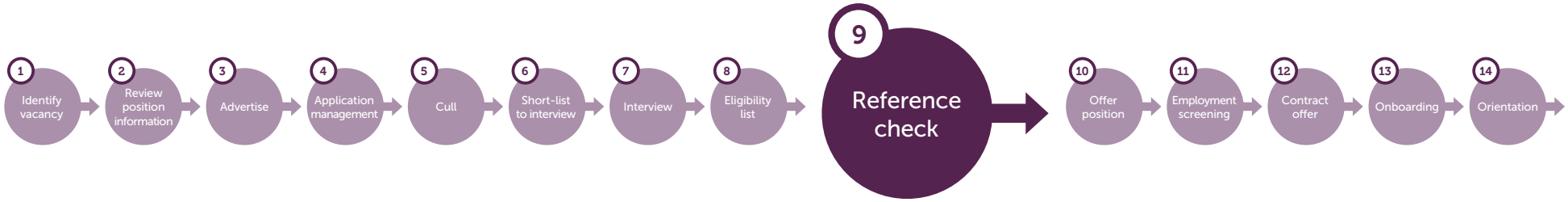
If the referee report is being used as a risk management strategy to circumvent an inappropriate appointment (*"to weed out a bad egg"* as one senior doctor expressed it), in practice, its capacity to do so, is also questionable.

Despite the streamlining of processes, referee reports continue to present a significant administrative burden to the system. Many of those who participated in the consultation process, expressed the view that the generic referee reports simply do not add value to the recruitment process.

A number of applicants raised the issue of not being able to target their referees to particular specialty areas.

The generic template is seen to encourage a tick box approach with very little information being provided in the free text column.

" I don't think the references are very discriminating" *(Senior doctor)*



For those applicants who are allocated through College training programs referee checks are collected by the college but are frequently not shared with the employer or do not comply with the requirements of NSW Health policy. This creates an additional burden, ultimately on the senior medical staff, who have to repeat the process and this was reported as being very frustrating for all concerned.

The exception to this are those training programs where work has been undertaken between the Ministry and the relevant college to align college referee reports so that they comply with the NSW Health Policy.

Given that this appears to be working well within these specialties, it seems surprising that there are relatively few training programs on the list (see text box to the right). There would appear to be great merit in expanding this to other training programs, particularly with respect to achieving a reduced administrative burden on the senior medical staff who complete them.

College training programs that have referee reports approved as complying with NSW Health policy

- Anatomical pathology
- Cardiology
- Gastroenterology
- Ophthalmology
- Rheumatology

Recommendation 23

Work is undertaken with relevant colleges to align referee requirements with NSW Health policy and allow for the sharing of referee reports. This is likely to improve the quality of the referee report, in addition to reducing the administrative load on senior clinicians during the recruitment period. **Risk – high**

10 Offer position

Once the eligibility list containing the names of the preferred applicants in order of merit has been approved by the DAO, offers are sent electronically from the eRecruitment system.

The NSW JMO recruitment campaign is predicated on the use of *exploding offers*. Exploding offers are offers of employment that are made but then retracted if the applicant does not accept the position within a stipulated timeframe (nominally two business days).

The policy clearly articulates the steps to be undertaken by the convenor in the event that this time limit is reached, so in reality it is likely that each applicant is provided more than two business days to respond.

Whilst the policy also stipulates that applicants must not accept more than one position, the reality is that there is currently no electronic barrier to an applicant accepting two or more positions.

Whilst the duplication report provides some capacity to resolve multiple acceptances by a single applicant, it is quite resource intensive (for an already stretched system).

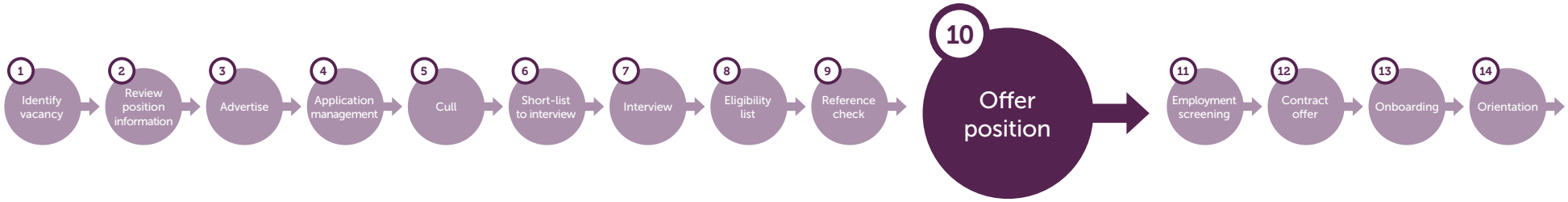
Many expressed the view that once an applicant has accepted a position, they should be committed (and locked in) to that job. Others recognise that applicants should have the opportunity to accept a more senior position should it become available, but it is understood that comes at the price of a downstream cascade impact of vacancies, through the upward filling of (more preferred) positions.

One approach might be to configure the eRecruit system in such a way that requires applicants who may have previously electronically accepted a position, to decline that position before they are able to accept another position.

This would remove the requirement for duplicate reporting and be consistent with the stated policy, although it is acknowledged that this would not cover all positions, as some positions are managed off line and sit outside this process.

The use of staggered recruitment timelines, including offer dates, which seeks to recruit to positions in a hierarchical manner from the advanced training positions to more junior roles has been implemented over the last few years.

For some specialties, this has gone some way to addressing the issue of the downstream impacts, when an applicant has accepted a less preferred position (as a back up) because they are still waiting to hear about a more senior or preferred position which is offered later in the recruitment cycle. It is acknowledged that the timing of college exams can be a factor in this. There is potential to further improve the timing of recruitment lines for some middle grade positions, particularly in the critical care specialties.



Recommendation 24

Further work is undertaken with jurisdictions and colleges to improve alignment of recruitment dates with key training milestones within and across training programs. This implies a hierarchical approach to the advertising and recruitment of positions. **Risk – high**

Recommendation 25

The JMO eRecruit system is configured so that an applicant can only accept one position. In the event that an applicant, having already accepted a position, receives an offer for a more preferred position, the eRecruit system should require the applicant to decline the first position, prior to the applicant being able to accept the second. **Risk – moderate**

11 Employment screening

The provisions for employment screening are often run in parallel with selection activities and from a risk management point of view, are a critical component of the recruitment process.

There is no doubt that all new employees of NSW Health are required to undertaken a 100-point ID check to ensure the various employment screening activities can be undertaken.

The policy stipulates that employment screening should occur whenever an employee is appointed to a new position within the system and that this should take place when a person attends for interview.

Given the nature of junior doctor recruitment, with a bulk recruitment campaign that turns over positions each year, many thousands of these checks are being conducted on junior doctors by administrative staff during the recruitment period, often multiple times on the same applicant.

This is even more startling when one considers that the majority (86% for the 2015 clinical year) of these applicants, are existing NSW Health employees.

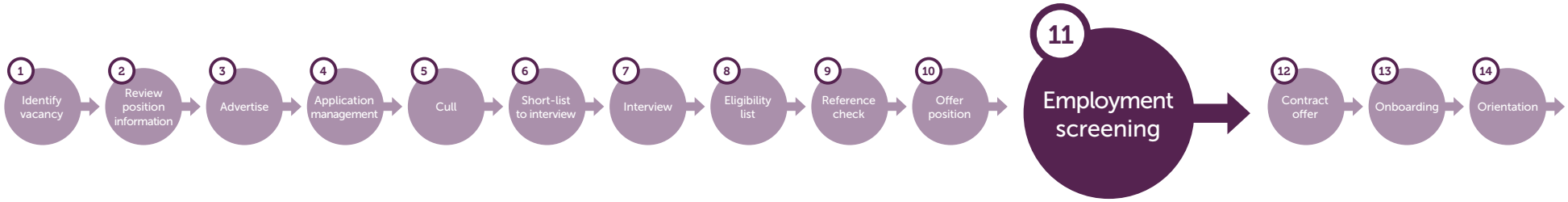
Not only is this administratively inefficient, it also sets up a negative dynamic between junior doctors (who are repeatedly being asked to produce their passport, driver's license and so forth, often within the same recruitment cycle, and even by the same administration staff) with those administrative staff required to undertake these checks.

It is also interesting to note that of the many thousands of 100-point ID checks that were processed during the 2015 recruitment campaign, only approximately 650 requests were forwarded on to CrimTrack for a formal CRC check. Whilst it was not possible to determine the exact number, it is understood that the majority of these would have been for junior doctors who had either had a break in service or were new employees to NSW Health.

The front end of these processes are very manual, requiring JMO management unit staff to photocopy and scan both the consent for CRC in addition to the 100 point check form. Whilst this sounds like a simple enough process for a few doctors, when this is undertaken for hundreds and hundreds of doctors, often within a very short timeframe, it creates a significant administrative burden for the system.

It was also apparent during the review process, that contrary to the policy requirements, some JMO management units continue to photocopy the evidence of the 100-point checks. This practice carries its own risk in terms of identity theft, notwithstanding the additional workload created.

One approach to reducing the administrative burden might be to require applicants to fill in the CRC consent form online and then download a copy to sign, and then upload the signed form (essentially replicating what is required of administrative staff following the 100 point ID checks). The applicant could bring the original signed form to interview for verification at the same time that the 100-point ID check is done.



Recommendation 26

Consideration is given to strategies that will reduce the repeated 100-point checks being undertaken on junior doctors during the same recruitment campaign. **Risk – high**

Recommendation 27

Consideration is given to requiring applicants to upload a signed CRC consent form at the time of submitting the application and subsequently providing the original form for validation when they present for interview. **Risk – moderate**

12 Contract offer

Once an applicant has accepted a position and employment screening has been undertaken, the eRecruit system issues a formal letter of offer with all contractual details that are uploaded from the system. Much of the information included in the formal letter of offer is auto-populated from previously approved input data but nevertheless is manually checked by HealthShare NSW staff.

The dates of the contract are aligned with the dates of the clinical year (articulated in the information bulletin) and vary in duration, usually from a 12 month period to the length of that particular training program (length of training contracts).

The length of the contract provided to junior doctors is an important issue and one where the interface between employee and trainee is most keenly felt. Given the contentious nature of this issue, it is worth reflecting on some of the historical (and to some degree medico-cultural) practices that have developed around junior doctor contracts.

A lot of comments were provided during the consultation process on the *length of training contract*, with a range of views regarding their utility. Historically, junior doctors were issued twelve-month contracts, regardless of where they were placed in the postgraduate medical training continuum.

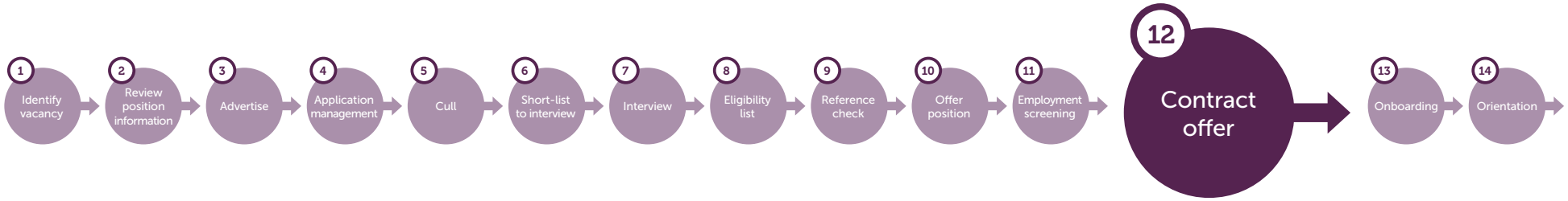
Over time, local health districts (or previous iterations thereof) provided an alternate mechanism to formal recruitment activities via an extension of contract. This was generally undertaken during the annual recruitment campaign to those employees who were engaged in a vocational training program. This effectively reduced the number of positions that had to be formally recruited to during the JMO recruitment campaign.

It is important to note that the limited temporary contract used for junior doctors have enabled an approach whereby doctors could be tested in (and themselves try out) a particular specialty or craft group. This is sometimes referred to by senior clinicians as "try before you buy".

Supporters of extension of training contracts argue that by initially offering a 12 month contract, a department or group of specialists with whom the trainee works, will get a sense of their suitability to that specialty and facility without the need for a formal performance management or other human resource based process to off-load them if there were any emerging clinical or performance issues.

Even with the most appropriate and effective recruitment and selection practices in the world, some trainees will still be selected into training programs and will ultimately be proven not to be suitable for those training programs.

Whilst many trainees may come to this conclusion themselves and voluntarily opt to change training programs, in public sector employment terms, the only option available to forcibly remove someone from a training post is via a performance management pathway.



Many senior clinicians expressed the view that trying to remove an unsuitable trainee on a length of training contract from a training program is potentially fraught with protracted, often legal processes.

The far more effective option in their view was to initially provide a trainee with a 12 month contract, see how they progress, (which might include provision for passing College requirements) and then if deemed suitable, to extend the contract by a further 12 months.

This removes any requirement for performance management in a disciplinary sense whilst still retaining the ability to provide feedback to the trainee on performance from a medical training perspective. Those trainees deemed not suitable for a particular program (or sometimes considered not a good fit for that facility) were not offered a further contract and advised to apply for other jobs.

The extension of training contract thereby allowed departments to simply repeatedly renew a contract for the period of training, rather than requiring trainees to reapply and be re-interviewed, (some would argue in a somewhat tokenistic fashion).

There are two potential issues with extension of training contracts. The first is that someone who has essentially applied for a 12-month position could be incrementally promoted through a training program without further merit selection processes. In other words, if you were in, you had an advantage over other applicants.

The second is that conversely, extension of training contracts potentially support poor performance management practice by not requiring definitive and transparent management of emerging issues but instead offer departments the alternative of simply not extending the contract of a poorly performing trainee. In this regard, poorly performing trainees were frequently passed onto other facilities.

Length of training contracts replaced the use of extension of contracts, several years ago. Those in support of length of training contracts argue that they provide a fairer mechanism whereby trainees are provided opportunities to be selected to training programs based on merit.

The introduction of length of training contracts was an attempt to address some of the issues identified above in terms of equitable access to training programs. In many respects, it mirrors the UK system described in the text box opposite.

Case example – Recruitment of junior doctors within the UK

Whilst there are some significant differences between postgraduate medical training within the UK and that of NSW, junior doctors engaged in postgraduate training are employed within the NHS and like, NSW junior doctors, have both clinical service and training roles.

There have been a number of significant reforms within the UK with respect to postgraduate medical training as the UK responds to increasing demand, increasing specialisation and increasing numbers of medical graduates. Their issues are common to NSW – including geographical and specialty maldistribution.

Training programs within the UK are divided into those that are either run-through or uncoupled. These are specialty specific, and are determined according to key training program milestones, such as barrier exams.

Uncoupled programs have a core or basic training component and some form of assessment before the trainee is ready to progress to the next stage of training, such as physician training.

Run through programs (such as Emergency Medicine, Obstetrics and Gynaecology) are structured in such a way that the trainee is recruited for the duration of the training program.

Once selected onto a training program, trainees are given a contract that is aligned with the length of the training program.

In order to address the issues commonly identified as being barriers to providing trainees with length of training contracts, Health Education England (and previous reiterations of) in collaboration with key stakeholders have developed sophisticated tracking and performance monitoring processes for trainees. The policies and provisions for specialty training are published in *The Gold Guide*.

Length of training contracts have been variably implemented by specialties and LHDs. Many of those consulted expressed concerns regarding managing trainees who were found not suitable for a particular specialty or facility as the main reason why they did not want to implement length of training contracts. The resistance to full implementation of length of training contracts across the system appears to primarily derive from this concern.

Others consulted expressed a more optimistic view and agreed that length of training contracts had resulted in a reduction in the administrative burden of recruitment.

It is clear that length of training contracts are an important initiative and where they have been introduced have decreased the administrative burden of recruitment whilst at the same time, providing trainees with more certainty with respect to their employment.

Length of training contracts are an important initiative and should be extended to include as many training programs as possible. This is likely to very significantly reduce the burden of administration and human resource and fiscal costs of recruitment.

In order to achieve increased support of length of training contracts, particularly by senior clinicians, some fundamental factors need to be in place:

1. A clearer understanding of the training pipeline, in terms of numbers and clinical training requirements. This would include identification of training positions as distinct from short-term service positions. It is acknowledged that in many cases, short-term service positions may still offer appropriate clinical experience and preparation for entry to specialty training.
2. Capacity to track trainees across the system – in the UK, each trainee is provided with a unique number which follows them and thereby allows easier transfer across borders and in some cases across training programs.
3. Robust processes to manage trainees who are found not suitable for the specialty program or do not progress – this needs to be contextualised to both the profession and postgraduate medical education.

Recommendation 28

Length of training contracts should be pursued for as many training programs as possible. (This would substantially reduce the number of positions requiring advertising each year). **Risk – high**

Recommendation 29

Work is undertaken with LHDs and Colleges to identify the number of available training positions (pathways), including the prerequisite clinical experience and entry points (for both run-through and uncoupled training programs). **Risk – high**

Recommendation 30

Work is undertaken with LHDs and Colleges to explore the most effective mechanisms of tracking trainees as they progress through the training pipeline on a length of training contract. **Risk – moderate**

Recommendation 31

Work is undertaken in collaboration with Colleges to strengthen performance management frameworks for effectively managing underperforming trainees within the employment context. **Risk – moderate**

13 Onboarding

Once a successful applicant has been appointed, a number of processes and activities in preparation for commencement of employment are required.

Onboarding activities are a crucial part of the recruitment process and may include a number of requirements, depicted in the text box to the right. They are designed to assist the seamless and efficient transition of the junior doctor to the workplace. The JMO Management Units in collaboration with HealthShare NSW and LHD Human Resource Departments are responsible for managing the majority of the onboarding activities.

These activities are usually undertaken during the period between October and the commencement of the clinical year, in early February.

The annual closure of many administrative units over the late December – January holiday period, in addition to the leave patterns of staff, mean that there is often further compression of the timescale in which these activities have to be undertaken.

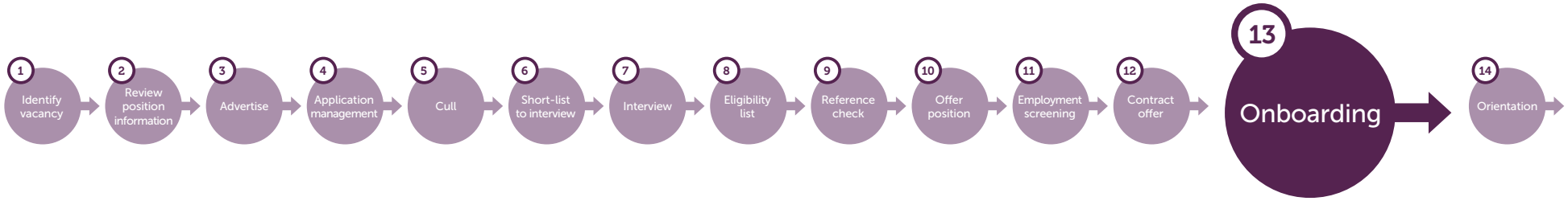
Whilst the onboarding requirements are generally straightforward, the high number of junior doctors who have to be processed drives the volume of work.

Although onboarding activities were not a focus of the review, some key points are highlighted. The efficient completion of onboarding activities prior to the junior doctor's commencement of employment is particularly crucial for junior doctors who traditionally pick up a full time clinical load from the first day of work.

Delays in the efficient processing of many of these elements can have the potential to cause disruption to clinical service delivery.

Onboarding requirements undertaken for junior doctors prior to commencement of employment

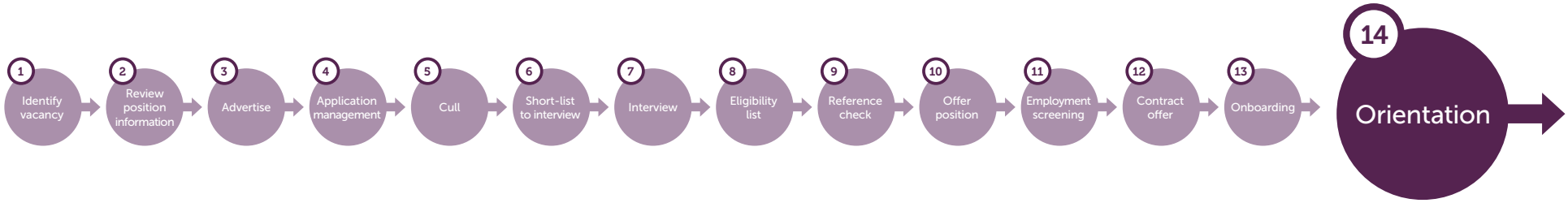
- Immunisation checks and any follow up of relevant matters
- Submission of paperwork, including ATO requirements
- Setting up personnel file
- Getting person on payroll
- Arranging computer and internet access
- In some cases, requiring the junior doctor to undertake some pre-employment orientation activities
- Seeking leave preferences, particularly if in first six months of year (the majority of junior doctors come with leave balances)
- Arranging rosters
- Undertaking term allocations, including any rotations to rural/regional facilities which may require travel and accommodation



14 Orientation

Like onboarding, orientation activities are a significant component (and final stage) of the recruitment and selection process and done effectively, support a seamless transition to the workplace.

Whilst included in the recruitment process map for completeness, a consideration of orientation activities were beyond the scope of this review.



Final comment

The NSW statewide JMO recruitment campaign is an immensely complex and resource intensive undertaking. This review has highlighted a number of key improvements implemented over the last few years, in addition to identifying emergent risks, particularly in the context of a tightening job market.

As postgraduate medical training pipelines fill, increasing competition for junior doctor positions within the state will continue to escalate.

Many of the recommendations made within this report call for collaborative efforts between key internal and external stakeholders in order to proactively and effectively manage the emergent risks, thereby ensuring the sustainability and continued effective operation of the JMO recruitment strategy for the future.

Acknowledgments

I would like to gratefully acknowledge the many people who participated in this review. To those individuals who participated in the phase one consultation process, through either interviews or focus groups, I am very appreciative of your insights and contributions to the review process.

I would also like to express my gratitude to the NSW facilities that agreed to host site visits, (particularly the JMO management units of those facilities), in addition to the staff at HealthShare NSW, as well as interstate organisations for their willingness to share information about their JMO recruitment systems, processes and challenges.

To the members of the Statewide JMO Recruitment Strategy Project Reference Group who provided oversight of the review process, thank you for your support and advice.

Finally, I would like to thank both Gareth Boylan and Merielee Desepida for the significant support and assistance provided to me for the duration of the review.

JB

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