BMA RESPONSE

British Medical Association response to the Shape of Training Review report

March 2014

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BMA

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1. Introduction

1.1. The British Medical Association (BMA) is an independent trade union and voluntary professional association which represents doctors from all branches of medicine over the UK. It has a total membership of over 152,000.

1. 2. In a world where the needs of patients are changing, we must regularly review the way that we train doctors. And, where necessary, we must make changes to existing structures. The Shape of Training report makes a valuable contribution to the debate about the future of postgraduate medical training and we support many of its recommendations. However, we do have concerns about how some of the more fundamental changes proposed by the report will work in practice – especially those which would effectively shorten the length of training and redefine the meaning of certification. Our concerns are detailed in this paper together with our views on the report's more minor recommendations, many of which we support.

2. Changing the formal training structure

2.1. We are pleased the Shape report recognises that "the needs of patients in the UK are changing fast" and that we need "a better balance between doctors who are trained to provide care across a general specialty area, and those prepared to deliver more specialised care."

2.2. We welcome the broad thrust of the report and its recommended move towards more broad based training. However, we cannot support the development of a broad based training scheme that is delivered through shorter 4-6 year programmes. The report argues that doctors who are awarded a Certificate of Specialty Training (CST) must be trained to "the same level of competence" as a current CCT holder. But it makes no attempt to explain how doctors can be trained to this skill level in a shorter training programme which has, at the same time, been expanded to include more generalist training.

2.3. There is clear evidence to show the value that a fully trained consultant brings. In 'The Benefits of Consultant Delivered Care'[1], the Academy of Medical Royal Colleges observed that consultants have "the breadth, depth and length of experience not just to recognise diagnoses, take action, investigate appropriately and initiate treatments, but also to acknowledge the unusual, unexpected and unfamiliar. They make rapid and appropriate decisions that benefit patient care." This is supported by evidence from the 2012 Hospital Guide[2] which demonstrates that mortality rates drop when there are more senior doctors on site.

2.4. We recognise, and appreciate, that there is no appetite among the report's authors to produce a sub-consultant grade doctor. However, regardless of intention, there is a real risk that a cohort of doctors who are less well trained than the consultants of today will be produced. Post-CST 'credentials', which will consist of specialty competences currently gained pre-CCT, will only be available according to local population need. This could create a workforce where only a small number of doctors will be highly trained specialists on a reactionary basis.

2.5. Instead of training doctors to CST level, we believe that patient care in the NHS should be led by highly trained and highly skilled consultants who have obtained a CCT. By investing properly in their training the NHS will benefit from doctors who can deliver high quality, safe, and cost effective patient care. Training should place more emphasis on the development of generalist skills, but we should never seek to train a workforce that is less skilled than the current workforce.

3. Moving the point of GMC registration to the end of medical school

3.1. The report argues that current governance arrangements for the F1 year are unsatisfactory – medical schools' ability to supervise F1 doctors is limited and employers find it difficult to manage fitness to practise concerns. It concludes that moving the point of registration to the end of medical school would address this problem, provided that measures are put in place to ensure that "graduates are fit to practise at the standard of a fully registered doctor at the end of medical school", and notes that legislative change may be required. This is an ambitious goal. But, in the absence of a linked recommendation to extend the length of medical school programmes, it can only be realised by cramming the training and clinical experience that the F1 year currently provides into an already comprehensive undergraduate curriculum. We are not convinced it is possible to produce doctors who are fit to practise under these conditions.

3.2. Moving the point of registration will also have broader workforce implications. It will increase competition for jobs in the UK by opening up the Foundation Programme to qualified doctors from 16 additional EEA member states. Bringing forward the point of registration will nominally leave those UK trained doctors who are unable to secure a place in the Foundation Programme qualified to compete on a global medical market. But, in reality many will struggle to find employment abroad – many will not have the language skills to compete in the EU market, and many others will struggle to get visas to work in Anglophone countries outside the EU. Each of these doctors lost to the UK workforce represents a loss of the £269,000[3] invested in their education.

3.3. We do not believe that embarking on a major programme of changing legislation and curricula is the best way to solve what is, at its heart, a straightforward problem of governance. Instead, we believe a simpler, and more pragmatic, solution must be found – perhaps by giving medical schools or Local Education and Training Boards (LETBs) overall responsibility for the entire foundation programme.

3.4. We are aware that moving the point of registration is one of a number of options that Health Education England (HEE) are considering as a part of their attempt to address Foundation Programme oversubscription. We have expressed similar reservations to HEE, and continue to work with them to develop a solution.

4. Other issues

4.1. Broadly, the BMA welcomes the report's remaining recommendations, although we do believe that most of them could be achieved within the current training framework. A few of these are discussed in more detail below.

4.2. **Greater involvement of patients in educating and training doctors.** Patients have a unique perspective on their care. Balanced against the views of expert trainers and educators, patients can help to train doctors who have a holistic understanding of the whole patient and their needs, not just the condition being treated. The BMA has long recognised the vital role that patients play in educating and training doctors, and our recommendations for change are outlined in more detail in the 2008 report 'Role of the patient in medical education'[4].

4.3. **Clear advice to potential and current medical students about what they should expect from a medical career.** Anyone choosing a career in medicine today will invest years of their lives in training – at medical school and beyond. Although no-one can know exactly what the NHS will look like in the coming decades, if we expect someone to make a commitment of that scale we must commit to providing them with a clear realistic assessment of the career that awaits them. To help widen access to medicine, GCSE and A-level (or equivalent) students should be given information and guidance about the level of financial support that is available to them.

4.4. **Academic training.** We would welcome greater flexibility in the clinical academic training pathway, particularly if it makes entry into academic training easier and facilitates entry at different points in a doctor's career. However we believe the overall format of the current integrated academic pathways work well and they should be protected as far as possible to afford trainees job security.

4.5. **Ensuring training takes place in high quality placements, over a longer period of time, with progression according to competencies gained rather than time served.** More time spent in individual placements will enable trainees to consolidate skills, develop their confidence, and integrate more fully into multi-professional teams. Placing more emphasis on capabilities and competencies gained will help to ensure that trainees progress through training at a safe pace, and improve patient confidence in the service.

4.6. **A review into the barriers of development for SAS grades.** We welcome this review as for some years we have been arguing that the current approach to development is too rigid.

4.7. **Developing the 'out of programme' year.** Incorporating the out of programme year into training programmes will encourage the development of a well rounded, informed and innovative workforce.

References

1 The Benefits of Consultant Delivered Care, Academy of Medical Royal Colleges, January 2012: **http://www.aomrc.org.uk/about-us/news/item/benefits-of-consultant-delivered-care.html** (accessed February 2014)

2 Dr Foster Hospital Guide 2013, Dr Foster Intelligence, December 2012: **http://download.drfosterintelligence.co.uk/Hospital_Guide_2012.pdf** (accessed February 2014)

3 Unit Costs of Health and Social Care 2012, Personal Social Services Research Unit, 2012: **http://www.pssru.ac.uk/archive/pdf/uc/uc2012/full-with-covers.pdf** (accessed February 2014)

4 The Role of the Patient in Medical Education, British Medical Association, 2008: **http://bma.org.uk/developing-your-career/medical-student/the-role-of-the-doctor/role-of-the-patient** (accessed February 2014)