Future doctors, safeguarding our NHS
BMA MSC UK priorities

June 2015
Foreword

The NHS is already admired around the world for its equitable, cost effective and leading edge provision of high quality care. Medical students are the future of our NHS, current care-providers and soon to be leaders of the UK health service and we are determined to safeguard this service for patients and the public.

The BMA’s medical students committee has summarised our five key priorities for the year ahead. We believe that by working together with other stakeholders we can help provide solutions to some of the challenges that we face, to support our future doctors, future patients and future NHS. This document draws on existing policy as well as the experiences and views shared by many of our committee members and our wider membership. We hope it will be useful for policy makers and other stakeholders to help explain our views and to provide a springboard for action.

Our vision is that with adequate support and development, and with a more constant stable career path, future doctors will make an important contribution to a sustainable NHS.

We would like to hear your views about the important issues we have raised. Together we can ensure that the doctors of the future are enabled to provide the care and support that our patients deserve.

Harrison Carter
Co-chair
BMA UK medical students committee

Charlie Bell
Co-chair
BMA UK medical students committee
Our top five priorities

1. Widen participation in medicine and improve financial support for students.

2. Consider options to end oversubscription to the foundation programme, to guarantee placements for eligible medical students and ensure wider policies (such as the cap on overseas students) remain in place in order to provide the necessary infrastructure to reduce oversubscription.

3. Ensure a consistent and evidenced based approach to assessment of medical students by ensuring consistency in delivery of the prescribing safety assessment and resisting unnecessary change while embracing current strengths such as the diversity of our current medical schools’ curricula.

4. Provide a period of stability and consistency for medical training and ensure that further elements of the EPM (Educational Performance Measure) are not eroded.

5. Improve the working conditions of doctors in training by ensuring safe working hours, fair and transparent pay, high quality training and rotas, and a contract that respects the right to a life outside work.
There are 40,625 medical students currently studying in the UK.

The BMA and the BMA MSC

The BMA (British Medical Association) is an apolitical professional association representing doctors and medical students from all branches of medicine all over the UK, supporting them to deliver the highest standards of patient care. We have a membership of over 154,000, which continues to grow every year.

There are 40,625 medical students currently studying in the UK. The MSC (medical students committee) is the BMA branch-of-practice committee that represents medical students across the UK. MSC representatives are elected from each UK medical school to sit on the committee for one year. BMA membership amongst these students is high from all 33 UK medical schools.

2015 MSC priorities

1. Finance – widening participation and improving financial support.

Widening participation – what is the current situation?
With such demanding entry criteria, it is important that candidates to medical schools are selected in the fairest way possible. Concerns have been raised that some students, despite having the necessary aptitude to study medicine, are being excluded from this career pathway and that this is to the detriment of the future medical profession. Just two-fifths of today’s doctors attended non-selective state schools, while a third were privately educated.

As the UK demographics change and the aspirations for our health service increase, we need to ensure that medical schools select students based on merit. The Selection Literature Review, commissioned by the GMC (General Medical Council) and published in November 2012, highlighted the fact that UK medical schools use a variety of methods to select their students and while there are very good reasons for this diversity of approach, there is also a need to ensure that selection decisions are consistent and that all universities prioritise widening access. It is only by selecting the best applicants, in the fairest way, that we will continue to produce world-class doctors. We have a duty to ensure that our NHS remains the envy of the world, continuing to produce the highest quality of patient care.

The role of ‘Selecting for Excellence’
Through widening participation initiatives, medical schools can encourage those with the potential to study medicine to regard it as a viable option irrespective of their socio-economic circumstances. Selecting for Excellence is a project initiated by the Medical Schools Council in March 2013, which scrutinises the issue of selection to medicine with particular focus on widening participation. Selecting for Excellence has spent time considering ways of implementing recommendations from important reports relevant to widening participation and medical school selection, such as the GMC’s Selection Literature Review, Alan Milburn’s Fair Access to the Professional Careers: a Progress Report and the Shape of Training Review. The BMA MSC are represented on the group and fully support the recommendations contained in the final report.

Our recommendation to widen participation
Progress all the proposals contained in the Selecting for Excellence Report which was published in December 2014. Medical schools and policy setters should share understanding and insight to help inform effective practice.

1 As at the start of 2014 – The State of Medical Education and Practice in the UK:2014 (GMC, October 2014)
2 Cabinet Office (March 2014), Fair access to professional careers: a progress report
7 http://www.shapeoftraining.co.uk/home.asp
Costs, bursaries and other allowances – what’s the current situation?

Students studying medicine are more likely to have much higher levels of debt than those students studying other subjects. This is because:

- a medical degree takes five (or sometimes six) years to complete – longer than most undergraduate courses which usually take three years
- for most degrees the academic year is 30 weeks long, but for a medical degree it can be up to 45 weeks. This extra-long academic year means more debt is accumulated and there is less chance for medical students to work in their holidays
- medical courses tend to have expensive course equipment and materials.

Living costs and tuition fees in the first four years of study are governed by the student finance companies. Students may apply for a tuition fee loan for course fees and a maintenance loan for living costs. Medical students from their fifth year of study onwards may qualify for the NHS Bursary Scheme. The NHS Business Services Authority award and pay bursaries to students on pre-registration health professional training courses according to the NHS Bursary Scheme9 as published by the Department of Health (DH). This scheme awards contributions towards tuition fees as well as maintenance awards to assist students with the cost of attending their course. There is some national deviation across the UK (see box below).

In **Northern Ireland**, this scheme is known as Financial Support Arrangement for Allied Health Professional Students and Medical Dental Students.

The (NHS) **Wales** Student Awards Services implements the NHS Wales Bursary Scheme for Welsh domiciled medical and dental students within the UK.

Financial help for Scottish domiciled students is available from the Student Awards Agency for **Scotland** (SAAS).

This means that from the fifth year of medical studies (including any intercalated year), the majority of medical students10 receive (upon application) £3495 towards the cost of their tuition fees. Some students also receive a means tested bursary for living costs. Students who are eligible for the NHS bursary scheme may still apply to student finance bodies, however students receive a lesser maintenance loan if they are in receipt of a student finance bursary for living costs.

Qualifying medical students in England, Northern Ireland and Wales are entitled to receive an NHS bursary. Upon application by the student the bursary is paid directly to the medical school to pay for tuition fees. The NHS bursary is a vital part of widening participation work, reducing some of the financial strain caused by the longer undergraduate course. NHS bursaries are also vitally important to graduate entry medical students, a majority of whom commence medical school with substantial debt from previous degrees and other commitments.

The level of living cost support available to students via an NHS bursary varies depending on whether a student started their course on or after September 2012, whether they are domiciled at their parental home, the length of their academic year, parental income and by which country of the UK they are from.

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10 Northern Irish graduates on five year medical courses are ineligible for this funding
Scottish medical students studying in Scotland
Scottish domiciled students don’t have to pay tuition fees but can claim financial assistance, in the form of a loan or a variety of bursaries from SAAS, to cover living costs. The Scottish Government also provides Scottish Universities with monies for a Discretionary Fund, to help students who are having financial difficulties, and a Childcare Fund, to help toward the cost of childminders, after school clubs, day care, sitter services and providers of preschool and education.

Other support for medical students
Another important allowance that supports the widening participation agenda is the Disabled Students Allowance which provides additional support in England for disabled students. There are currently plans to amend this scheme in England and we ask stakeholders to work with us to ensure that any changes do not negatively impact on this important support. There is an equivalent allowance in Scotland and Wales but this is not currently under review.

Other support available for qualifying students include dependants, parent learning, childcare and disabled allowances.

What are the issues?
The BMA is conscious that once students are in years where they are able to apply for NHS bursary funding, some students receive less funding due to different means testing criteria under the NHS bursary scheme. The medical students committee is also conscious that in the final year of studies the maintenance loan from student finance bodies is reduced.

There are sometimes students who are unable to apply for these bursaries due to complicating factors (in Northern Ireland this includes graduate medical students on five year medical degrees) and we ask the Business Services Authority (and national equivalents) to work with us to ensure the fairest possible system.

High fees and increases in the cost of living have made medicine a less attractive option for many students. We are particularly concerned that those from lower social-economic groups and graduate entrants are those most likely to be deterred by finance.

Our recommendations on financial support for students:
Financial assistance across the UK must be maintained and improved to support widening participation. In England we would expect that the NHS bursary scheme must be maintained to ensure that it benefits those who need financial assistance, that access is simplified and that every effort is made to ensure the system is fair and flexible. Funding pressures must not negatively impact on this or other valuable support (such as the Disabled Students Allowance) which are an essential part of UK medical training.

11 Calculations on predicted levels of student debt from the BMA’s health and policy economic research unit, based on findings from the BMA’s student finance surveys.
12 UKFPO (October 2014), FP 2015 Oversubscription Confirmed
2. Transition – foundation programme oversubscription and medical school overseas cap.

What is the current situation with regards to oversubscription?
Graduate doctors, upon completion of an undergraduate medical degree (typically lasting 5 to 6 years), must complete the FP (2-year foundation programme) in order to achieve full GMC registration which is required to practise as a doctor. The FP is designed to build on the knowledge and skills gained during undergraduate training.

In 2015 the number of UK medical students predicted to graduate again exceeds the number of FP places starting in August 2015. The foundation programme is oversubscribed by a record 399 applicants – who have now been placed on a reserve list for their first jobs. This is the fifth year that the programme has been oversubscribed, but it is the first time the reserve list has been so high.

Oversubscription has a huge psychological impact on final year students who face an anxious period of increased stress as they await news on whether they will receive a place on the foundation programme and, if so, where it will be. It could also mean that those on partly-publicly-funded medical student places may not end up contributing to the medical workforce in the UK. As well as being a huge waste of talent this is a real irony when there are calls by the Government to increase the GP workforce and to deliver a ‘7-day NHS’.

Our priority for the FP
A workable long-term solution to foundation programme oversubscription is needed and we believe that every effort must be made to ensure all eligible UK medical students receive a foundation programme place.

The overseas cap
There are currently approximately 3,000 non-EEA students studying clinical medicine in the UK. International (non-EEA) admissions to UK medical schools are subject via the HEFCE (Higher Education Funding Council) to a Department of Health cap of 7.5 per cent of total admissions. The Department of Health has recently considered a proposal to lift this cap.

We are concerned that this would further exacerbate the oversubscription problem, leading to overcrowding on placements, increased unemployment of graduates of UK medical schools and we need to be mindful of ensuring value for money for UK taxpayers.

The BMA believes in the importance of attracting the best to UK medical schools but any change to intake should not be taken with the sole aim of driving up revenue for universities. The purpose of the cap is to manage NHS workforce supply and demand and to prevent a situation where public funding of medical education is spent on training and developing a large body of international students who may then leave the NHS and return fully trained to their countries of origin. The BMA fully supports this aim and current position and we have not heard any plausible arguments for lifting the cap from the Department of Health and are unsure of the motivation behind the proposal. We do not believe that many universities have capacity to take on extra students.

We need to ensure security of supply of doctors for UK healthcare, retain the confidence of the public and taxpayers in the system and protect taxpayer investment in students of UK medical schools. The medical student intake must be controlled and reviewed regularly in line with wider workforce planning.

Our recommendation for the overseas cap
The overseas cap should remain in place – with so much else that would be impacted upon, at the very least nothing should be changed until a full review can be undertaken.

13 Taxpayers fund the related undergraduate placement tariff at £38,430 per student and Foundation Programme costs (approximately £28k pa per trainee)
Consider options to end oversubscription to the foundation programme, to guarantee placements for eligible medical students and ensure wider policies (such as the cap on overseas students) remain in place in order to provide the necessary infrastructure to reduce oversubscription.

Our priorities.
Widen participation in medicine and maintain and improve financial support for students

Our priorities
3. Assessments – PSA and National Exam

What is the Prescribing Safety Assessment?
The PSA (Prescribing Safety Assessment), developed by the British Pharmacological Society and Medical Schools Council is an assessment that will allow final year medical students to demonstrate that they have the necessary knowledge, skills and judgement (in relation to the safe and effective use of medicines) to begin their work as junior prescribers in NHS hospitals.

What are our concerns?
Although we support the sentiment of the PSA to improve prescribing skills and patient safety within the Foundation Programme, we are concerned that assessment is not being used in a standardised and universal way. From 2015, we understand that only nine schools will be using the assessment summatively while the remaining schools will use the assessment formatively.15 Passing the PSA will be a requirement for graduation in the few schools that have elected to include this in their final examinations. The MSC strongly believe that a consistent approach must be adopted by all schools.

Additionally, we are concerned that communication about the assessment is not consistent across all medical schools. The MSC will continue to campaign for regular communications to medical students to be issued centrally by the developers of the PSA. Furthermore, the MSC firmly believes that the status of the PSA has to be clarified by NHS employers and communicated to all relevant stakeholders.

Our recommendation for assessment
We call for a consistent approach to the PSA combined with regular and timely communication. The priority must be patient safety and consistency of approach.

What's the current situation regarding a national exam for medical students?
The GMC has proposed a single national licensing examination marking the first step to a unified ‘passport to practise’ for doctors wishing to practise in the UK.16

The MSC remains unconvinced of the benefits of a new national exam which we fear would stifle diversity and will not reflect the different learning approaches taken by students. Additionally there is a real danger that the introduction of a national exam would become an unnecessary duplication of the prescribing safety assessment (PSA), situational judgement test (SJT) and the medical school final exams and merely add a further ‘hurdle’ for students who are already subject to these rigorous examinations and assessments. It is unclear why there are already two current national assessments (PSA and SJT) lacking a solid evidence base and yet another exam is being considered. The MSC will continue to engage with the GMC to highlight all the likely issues that will arise from the introduction of such a high stakes exam.

Our views on national exam proposals:
We are concerned by proposals for a national licensing exam and would instead recommend making better use of clinical placements, student assistantship and shadowing opportunities. These could be developed into a structured process where students get exposure to experiential learning across a range of specialties. We will continue to engage with the GMC on this issue.

15 According to the PSA stakeholder group
16 General Medical Council (September 2014), GMC gives green light to ‘passport to practise’
4. Stability – a foundation programme that’s fit for purpose.

What’s the current situation?
In the last few years, the selection criteria for the foundation programme has undergone a complete overhaul. Most recently, the educational achievements section of the foundation programme application form has been subject to a series of major changes. Conference presentations and prizes were removed so they would no longer count in the applications for the mainstream foundation programme. The MSC firmly believes that it is unacceptable for students to no longer be able to claim points for presentations and prizes, when they are only trying to strive for excellence. Students should be encouraged to develop diverse skills and their efforts should be rewarded in a consistent manner.

What do MSC propose?
We call for a period of stability and consistency and call on all relevant organisations to ensure that further elements of the EPM (Educational Performance Measure) are not eroded.

5. Workforce – junior doctor contracts and Shape of Training.

What’s the current situation regarding contracts for doctors in training?
As future doctors in training, medical students closely followed the progress of contract negotiations led by our colleagues in the BMA JDC last year. After a year of negotiations, unreasonable demands from the Government meant that it was impossible to reach agreement on key issues and negotiations on a new contract for doctors in training in the UK stalled. The Government subsequently asked the independent DDRB (Doctors and Dentists Review Body) to consider all evidence relating to the talks and make recommendations for doctors in July 2015.

Future doctors in training have fully supported JDC in their negotiations and had hoped for safe working hours, fair and transparent pay, high quality training and rotas, and a contract that respects the right to a life outside work. It is important to ensure that doctors have a secure working environment in which to put patients at the centre of their practice.

What do we recommend for junior contracts?
We call for the Government/s to actively engage with the BMA to develop a contract for junior doctors that is focused on patient safety, improves the working life of doctors in training, is simpler and easier to understand and offers fair and transparent reward for the work done. Junior doctors are the future of the NHS.

What’s the current situation with regard to the future of training?
The Shape of Training was an independent review into whether changes are required in postgraduate medical training to ensure it continues to meet the needs of patients and health services in the future. The Shape of Training report made 19 recommendations for change. The BMA supports some of the report’s recommendations, such as more flexible training and improving careers advice for medical students, but there are a number that cause concern.

17 General Medical Council (October 2013), Shape of Training. Ensuring the future of excellent patient care.
18 British Medical Association (March 2014), Response to Shape of Training review.
What are our concerns?
In February 2013 the BMA responded to the review’s call for evidence and ideas, after asking for views from our members. While we welcome the broad thrust of the report and its move toward broad-based training, our two areas of concern – around the CST (Certificate of Specialty Training) programme and the point of registration with the GMC – remain.

CST programme
The BMA does not support the development of a broad based training scheme that is delivered through shorter four to six-year programmes. The Shape of Training report argues that doctors who are awarded a CST must be trained to ‘the same level of competence’ as a current Certificate of Completion of Training (CCT) holder. 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.

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. An increasing number of patients would therefore be cared for by doctors who are not as well trained as today’s consultants.

There is a real risk that a cohort of trained doctors who are less well trained than the consultants of today will be produced. 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 or equivalent.

Point of GMC registration
The report recommends moving the point at which doctors are fully registered with the GMC from the end of the first year of the Foundation Programme to the end of medical school. However, unless the length of medical school programmes were extended, this would result in the cramming of training and clinical experience currently provided by the first year of the FP into the already highly saturated undergraduate curriculum. The BMA is not convinced it is possible to produce doctors who are fit to practise under these conditions.

We are also concerned about the workforce implications of this recommendation. It will increase competition to the FP by lifting the restrictions on doctors applying from an additional 16 EEA member states. Currently medical graduates from these 16 states are excluded from applying for GMC provisional registration. Excluding foundation year 1 from the minimum time requirement for full registration would mean four-year courses would no longer comply with European law. This change would open the programme to applicants from across the EEA, increasing the displacement and potential unemployment of UK medical graduates.

BMA vision
The need for reform is clear. In order to constructively add to the debate the BMA will be publishing views on pre and post qualification medical training and development. ‘Pre and Post Qualification Training and Development of Doctors: A British Medical Association Vision’ is structured around a series of principles that we think must underpin the training and development of doctors. We urge all concerned with training to support the principles contained in this document as essential to all future reform. With these principles universally acknowledged and accepted, we can future proof the medical profession as a rewarding, inspiring career that will care for patients to the best of its ability through the challenging times ahead.

What would we like to see happen for training?
We call on policy makers to work with the BMA across the four nations, to take forward our vision in order to positively support patient care and ensure that the NHS continues to be led by doctors appropriately trained to the current high level of skills and expertise.
Improve the working conditions of doctors in training by ensuring safe working hours, fair and transparent pay, high quality training and rotas, and a contract that respects the right to a life outside work.

Our priorities