NHS Future Forum
Education and Training: how to develop the healthcare workforce to deliver world-class healthcare – BMA response

The BMA is an independent trade union and voluntary professional association, which represents doctors and medical students from all branches of medicine all over the UK. We have a membership of 149,000 worldwide. We promote the medical and allied sciences, seek to maintain the honour and interests of the medical profession and promote the achievement of high quality healthcare.

The BMA recognises that medical education and training in the UK did not develop according to a pre-determined plan. Rather it evolved piecemeal over a number of years and incorporated a number of formal and informal and explicit and implicit elements. The system has developed progressively, resulting in highly complex interactions between different structures and organisations. These interconnections may not be inherently obvious and could be inadvertently damaged by ill-thought-out changes, however well intentioned, leading to unanticipated disruptions. The BMA believes that whilst improvements could be made to the current system of medical education and training, the current structure broadly works and is not in need of radical reform. However, the proposals in the Health and Social Care Bill and the Department of Health’s consultation Liberating the NHS: Developing the Healthcare Workforce mean that current structures for education and training face major change to fit in with the Government’s broader reforms.

We believe that reform of medical education and postgraduate training should be based on a conservative evidence based approach. Any changes need to improve on the current system. We believe that changing too radically the system that is currently in place would result in an inconsistent, over-localised approach to education, training and workforce planning, driven by the short term needs of employers rather than the maintenance of high standards in education and training which are fundamental to high quality patient care.

Below is our response to the specific questions currently being asked by the NHS Future Forum on education and training. Further detail on the BMA’s position regarding structures, governance and funding can be found in the attached document Improving Post-Graduate Medical Education and Training – BMA proposed solutions.

1. How can we ensure that education and training in the new system is flexible and fit-for-purpose for the new way that care is delivered and enables training beyond the job, for example stimulating a culture of continuing professional development or academic and research development?

In order to allow flexibility within the new system and the proposed multi-professional approach, there should be recognition of the specific needs of medical education and training, compared to those of other healthcare professionals. There is a need to create a cadre of people with the necessary breadth and depth of knowledge, the ability to manage uncertainty, the ability to lead teams and the capacity to take crucial decisions and be held accountable for them. Doctors are, in these ways, different from other healthcare professionals and have characteristics that should be valued. Their education and training therefore requires distinct consideration.

National oversight is vital in ensuring that the delivery of education and training supports the requirements of the GMC’s Good Medical Practice. We believe that this responsibility should lie with Health Education England (HEE). HEE should have strategic overview and a clear remit to centrally oversee postgraduate education and training at a national level, with quality assurance of medical training performed by the GMC as it currently is. National oversight will ensure the delivery of consistent standards of education and training, as well as equal opportunities for continuing professional, academic and research development. These should be compulsory for any provider of education and training and
agreed through contractual arrangements. HEE should have sufficient power and resources to mitigate a provider’s failure to meet these standards.

HEE should also be accountable for national healthcare workforce planning. Based on this planning, and an iterative process that includes input from employers, recruitment numbers should be set nationally across the whole workforce. Medical students and doctors in training should be supplied with information about competition ratios and service needs, so they can make informed career choices.

To deliver flexibility and respond to local needs, including the differences in sizes of healthcare providers we recognise the requirement for sub-national oversight and planning as well. We believe that Postgraduate Deaneries are currently fulfilling this role and deliver effectively continuing professional development and educational opportunities for doctors. Even within the new proposed structure, we believe that Postgraduate Deaneries will continue to be the most effective way to provide this function. They should be maintained in the long term as integrated organisations fulfilling all their current functions. This should be within a cohesive and integrated unit, perhaps independently within another organisation such as Local Education Training Boards (LETBs).

We believe medical training should be seamless, from undergraduate education to postgraduate level within the Foundation Programme. This should continue through to specialty training (preferably run-through training) and continuing professional development (CPD).

We are concerned about the direction of travel of the current ‘Shape of Training’ projects being undertaken in England and Scotland, and the project’s recent proposal of further ‘break points’ within training. Workforce plans must also take account of the large number of doctors working in the NHS now in non-training, non-consultant roles in hospitals, who currently provide a great deal of service but do not necessarily receive much professional development. Workforce plans should take into account the aspirations of these doctors and how training opportunities could be provided in order to assist the delivery of the workforce intention of a consultant delivered service, as well as how to ensure the current high level of service is consistently maintained and further improved.

Training should motivate and empower all doctors to develop a CPD portfolio of activities that encompasses skills, knowledge, research capability and initiative, albeit in varying proportions; and this continued development applies throughout their working life.

There should be a distinction between postgraduate medical training and education, the latter being a more participatory process of personal and incremental development. Although most doctors do pursue educational objectives, the benefits of education as an addition to training are not always recognised. We would also appreciate confirmation that SAS career development funding will be ring-fenced and recurrent.

2. How can we ensure the right balance of responsibilities and accountability and line of sight throughout the new system (for example, Health Education England and the provider-led networks, employers / professions / education sector, whole workforce) including for research training?

Overall responsibility for education and training should lie with HEE, which should have a clear remit to centrally oversee postgraduate education and training. HEE should set national principles, guidelines and standards, delegating, as appropriate, to the relevant professional programme board.

The activities and decisions of HEE should be published quarterly, in order to increase transparency and awareness of its role. HEE should have an independently appointed Executive Board, along with a duty to provide an annual report to Parliament to ensure sufficient accountability. In order for HEE to run effectively, strong representation from all of the professions it hopes to oversee will be needed on its Programme Boards. Where pan- or inter-professional issues need specific discussion, a Multi-professional Board could sit alongside the other professional programme boards and provide a forum for these issues to be aired and for a consensus to be developed.
Whilst having a close relationship with HEE, the Medical Programme Board (MPB) must continue in its current role of delegated authority for MPB to handle operational, policy and technical issues in detail. HEE should take a more strategic (and multi-professional) view. In addition to making national policy decisions within its purview, the MPB should address issues related to medical education and training that occur both locally and nationally. MPB should oversee the educational issues and problems that are identified sub-nationally from time to time by the GMC, Royal Colleges, LETBs and Postgraduate Deaneries.

We acknowledge that nationally set standards, principles and guidelines need to be implemented sub-nationally. Employers should have the opportunity to influence the shape of the medical workforce both locally and nationally and to have a say in the types of doctors produced through the training programmes of each specialty. We therefore support the development of a multi-professional, whole-systems approach, with employers being represented on MPB and LETBs. However, Postgraduate Deaneries should retain their current responsibilities and continue to carry out the following functions independently:

- allocate trainee doctors to specific posts within specialty training programmes according to educational need and the quality of the training posts;
- commission postgraduate training for doctors (including Public Health Registrars) through work-based placements, according to broad national workforce plans and with specific regional workforce insight, which is in turn fed back to the centre;
- commission postgraduate education for doctors and, to a lesser extent, provide it;
- assure and manage the quality of training and education for junior doctors;
- monitor and record the training and educational progress of junior doctors and, if necessary, provide remedial training and support;
- provide pastoral and professional support and careers guidance for junior doctors;
- provide the necessary support for non-medical public health specialty trainees;
- liaise with those commissioning and providing training for other healthcare professionals and enable appropriate cross disciplinary working.

Our preferred long-term solution for Postgraduate Deaneries is that they are housed independently under the auspices of Health Education England (HEE), or independently within LETBs (although this arrangement will need strict safeguards to ensure their independence of action).

To maintain accountability and line of sight for public health training, the delivery and management of training in this specialty should be kept within the NHS family and under the auspices of the Postgraduate Deaneries. To separate this out risks de-professionalisation of the public health workforce, and a decline in the standards of medical public health provision in all three branches of public health practice.

We believe that the Multi-Professional Education and Training (MPET) levy should be protected and only used for the effective delivery of medical education and training, rather than being top sliced by employers and used for service delivery. Furthermore, only posts approved for training by the GMC should receive MADEL/SIFT funding. These reforms should be utilised as an opportunity to increase the transparency of MPET funding, and we believe that it would be beneficial to delay the MPET review until there is a clearer picture of how medical education and training delivery will be structured following the reforms.

We suggest that MPB should take responsibility for the medical postgraduate education and training component (MADEL) of the MPET budget as soon after HEE has been established in shadow form as is feasible. Once agreed, funding should be allocated directly to each Postgraduate Deanery, and the future allocation of funding to providers should be related to the quality of training provided. A post which meets the basic quality requirements should be funded 100%. If the quality falls below an agreed standard, the funding should be reduced commensurately. However, this reduction in funding should be graduated to avoid risks to service provision while allowing degrees of financial penalty for poor quality training. The quality assurance process should be delivered by the Postgraduate Deanery and General Medical Council (GMC). The GMC should continue to have the authority to remove approval for training altogether.
3. How do we best ensure an effective partnership with health, education and research at a local level?

As previously stated, we support the development of a multi-professional, whole systems approach to healthcare education and training delivery at a sub-national level, with national standards being set and enforced centrally by HEE and quality assured by the appropriate healthcare professional regulators. We believe this whole systems approach and effective partnership can be provided through representation and engagement via LETBs. Stakeholders should be involved in ensuring an appropriate supply of a highly skilled and trained workforce to provide high quality service now and in the future. The stakeholders involved in this partnership should include NHS service providers, representatives of trainees and trainers, Higher Education Institutions (HEIs), Medical Schools, Health Innovation and Education Clusters (HIECs), Academic Health Science Centres, local research networks, local authorities and professional advisory groups.

We believe that the current model of collaboration for health and education between universities, postgraduate Deanelies and employers largely works. However, for research, there needs to be greater collaboration between employers. This should improve data collection, improve research material exchange, and ensure meaningful results are achieved. This should be organised centrally, at a national level in order to generate world-class research results. The role of the doctor in education is an important one, and all doctors should be given the opportunity to learn about research and education and to undertake research at any point in their career. The active involvement of HEIs and/or local Academic Health Science Centres, as described above will help to achieve this.

4. How can we ensure appropriate and effective patient and public engagement in the new system?

The public (along with other stakeholders such as workforce representatives and employers) should also be consulted on the strategic plans for the whole healthcare workforce, as produced by the Centre for Workforce Intelligence (CFWI) and LETBs.

At a national level the public and patients should continue to be engaged in curriculum development, through the GMC and the Medical Royal Colleges, following the existing GMC guidance. In addition, all Medical Royal Colleges are currently encouraging patient involvement in their committee and regulatory structures, which we support (and do ourselves). Sub-Nationally, patient and public engagement in medical education and training should continue through representation on Postgraduate Deanery Specialty School Boards.

5. How can we improve information on the quality of education and training?

In order to maintain quality, employers should be required to provide protected time for all doctors to undertake both medical education and training. This time should not be jeopardised by the needs of service delivery in the short term, as this compromises the long term provision of a trained workforce. Currently, the quality of education and training provided is variable across the country, and we believe this would be exacerbated if there is too much focus on local arrangements and employer input. We believe that strengthening the relationship between quality assurance processes and the allocation of funding would help improve quality and would provide a counterbalance to the short-term pull of service-delivery targets and funding.

In order to link funding and quality, there is a need for accurate information on the quality of education and training. Visits and quality assurance reports produced by Foundation Schools, Deaneries and the GMC should continue and should be used to guide the number of posts and the amount of funding for each hospital. Future allocation of funding should be based, in part, on the quality of training provided, as specified above. The GMC should continue to regulate and independently quality assure both postgraduate and undergraduate training, and should continue to have the authority to grant or remove approval for training.
The process for gathering direct feedback from doctors (both trainees and trainers) within training programmes should also be improved through the GMC’s annual national training surveys. There should also be on-going engagement with stakeholders to ensure that this survey is up to date and fit for purpose. A similar survey should also be developed for undergraduate medical education, which could cover a number of broad domains, such as: facilities, organisation, delivery of scheduled teaching, opportunities for learning and clinical experience, availability of support, assessment and overall rating.

Education and training are linked, but separate. Separate data on their quality should be gathered in order to make the required improvements. We would also stress the importance of allowing professionals input into defining what type of data is needed and updating this as required.

The information provided by the CfWI regarding workforce can be improved by CfWI collecting data in conjunction with HEE, Programme Boards, the BMA, Postgraduate Deaneries and individual local providers. This should ensure that its recommendations are based on the best possible data at various levels and are able to be implemented nationally and locally.

6. How can we improve information on the quality of education and training and what should be the roles and accountabilities of the key players in this?

As mentioned above, the GMC should continue to quality assure both undergraduate and postgraduate medical education and training. HEE should have a strong relationship with all the healthcare regulators and should be held accountable to ensure that quality assurance processes are being appropriately undertaken.

At a local level, employers should be required to collect and share quality data and be held accountable to Postgraduate Deaneries for the funding provided for education and training. Clear and transparent arrangements are needed to allow Deaneries/HEE to demonstrate that this funding has flowed according to quality and to educational need. This will also strengthen the ability of the Deanery to act impartially and without undue influence from employers (especially if they are housed within LETBs). Information on quality may need to be shared between regulators, with due regard for individuals’ data protection rights, to allow areas of strength and weakness to be identified.

Employers must have a responsibility for facilitating all aspects of education and training, and for the collecting and recording of information on the education and training activities of their medical staff. They must also be responsible for sharing that information with individual doctors, the postgraduate deanship, those responsible for monitoring CPD and also with wider stakeholder groups and patients/public as required.