Aspiring to Excellence

Findings and Recommendations of the

Independent Inquiry into MMC

Response by

The Association of Surgeons in Training

1 Key messages

1.1 A representative body for the medical profession should be formed that can present a coherent, over-arching opinion with a membership that is capable of representing the views of trainees and fully trained doctors in all specialties.

1.2 Future policy decisions on medical training must only be made after full and frank consultation with this representative body for the medical profession.

1.3 The Tooke Inquiry must not act as a vehicle for the introduction by stealth of changes to the post-CCT workforce. ASiT is particularly concerned about the recommended split into Consultants and Specialists, which will be seen as the creation of a sub-consultant grade. These significant changes require full and transparent debate in their own right urgently.

1.4 High quality workforce planning is essential to any future policy making on medical training and includes a reassessment of the number of places available at medical schools. The concept of an over-production of specialists with a view to playing off market forces is unacceptable and will result in significant consultant unemployment. Training an excess number of specialists is a waste of public money which must not be tolerated.

1.5 Trainees caught in the "bulge" should be provided with career guidance and the opportunity to re-train if they are unsuccessful in progressing in their chosen specialty within a realistic timeframe.

1.6 Trusts must build resources and funding for medical training into their budgets, and greater control is required on the use (and abuse) of these monies.

1.7 PMETB and the GMC should be assimilated promptly hence ending the overlap in regulation and representation of trainees, with rationalisation of funding issues.

1.8 Demonstrable excellence, rather than competence should form the basis for selection into postgraduate medical training. Methods used for selection must be proven to be reliable and valid. A structured CV and formal interview are essential. Individual regions should have a flexibility to tailor short-listing and appointment criteria to local requirements.

1.9 FTSTA posts should be time-limited in their existence and not become the potential source of a second "lost tribe".

1.10 ST1 is too early to select into run-through training. Flexibility to move between different disciplines during core specialty training (ST1/2 level) should be available.

1.11 CCT holders should have a reasonable expectation of being appointed to a substantive consultant post and must not be forced into NCCG or Trust Registrar roles.

1.12 Post-CCT training should be time limited and undertaken only in sub-specialties where a specific requirement exists. Such posts must be educationally approved and subject to proper quality assurance. The availability of these training posts must accurately reflect workforce-planning requirements.

2 Introduction

2.1 The Association of Surgeons in Training (ASiT) welcomes the opportunity to submit evidence to the Modernising Medical Careers (MMC) Inquiry, with particular reference to trainees in surgical specialties.

2.2 ASiT represents trainees from all surgical specialties and with over 2200 members is one of the largest specialty trainee organisations in the UK. The opinions expressed in this document have been gathered from members and agreed by the ASiT Council. A consensus has been sought from the relevant surgical specialty trainee organisations.

3 Response to recommendations

3.1 Clarification of policy objectives

3.1.1 Recommendation 1

ASiT supports this recommendation. The Inquiry rightly highlights the subversion of the original principles of MMC during the development and implementation of policy. Over-arching principles are vital, encapsulating the essence of the project and setting direction. We agree these should be re-examined and refined. However, it is in the translation of principles to policy objectives that success depends, a process that has been found wanting during the development of MMC.

3.1.2 Recommendation 2

Comments on evidence are welcome. The basis on which many decisions were taken during the development of MMC is still unclear to us. Policy documents must be explicit in this regard.

3.1.3 Recommendation 3 – 4

ASiT supports these recommendations. Consultation is only useful if policy makers remain open-minded during the process and are willing to act on the consensus opinion received. Consultations should present stakeholders with real options and policy makers made firmly accountable for subsequent decisions taken in apparent contradiction to responses received.

3.2 The role of the doctor

3.2.1 Recommendation 5

ASiT supports this recommendation which highlights the long-standing issue at the heart of the problems associated with MMC: how can medical training be redesigned when the ultimate goal of that training remains unclear? In recent years there has been a failure to accept the relationship between service and training. Surgical training in particular is more often than not delivered entirely through the provision of service (see 3.6). The certificate of completion of training (CCT) represents the standard at which an individual is deemed suitable for appointment to the consultant grade and it is imperative that this level of competence is maintained. *The NHS Plan (2000)* describes

a commitment to a consultant-delivered service and any deviation from this assurance must be fully justified by the DH. A surgeon in training should expect to become a consultant and although this has never been guaranteed, most did. We have yet to hear any argument that supports splitting the consultant grade into two separate grades: specialist and consultant (page 99 diagram). What would be the benefit of doing this? Of course there are many "levels" within the current consultant grade but what would define a specialist from the consultant? How would all current consultants relate to these two new grades? If the new specialist grade were to form part of the Inquiry recommendations, we would hope that the text on the Inquiry report includes more details as to the thinking behind this proposal.

3.3 Policy development and governance

3.3.1 Recommendation 6 – 10

ASiT supports these recommendations. It is stating the obvious to say that robust policy development is the essential foundation on which change is built, yet this has clearly been deficient throughout the process of MMC. It is essential that there is a collaborative approach to policy making between the profession and the government. Consultation by the DH must be more than paying lip service, while the profession must play its part and re-examine representational structures and how these could be made more effective. It is also important that timeframes for policy development and implementation are realistic; at least some of the problems associated with the introduction of MMC could have been mitigated but for the pressures resulting from the incredibly short timescales in which changes were required to be made.

3.4 Workforce planning

3.4.1 ASiT welcomes the importance that the Inquiry has focused on medical workforce planning, an area seemingly neglected over the last few years, although we do accept the complexity of this task. Policies with the objective of self-sufficiency in relation to doctor supply have been shortsighted with regards to the benefit that the UK gains from a more diverse, international stock and the impact of an expanding EEA.

3.4.2 The old SHO 'lost tribe' are fast becoming the new FTSTA 'lost tribe' and forcing these doctors into NCCG posts is an unacceptable outcome for most.

3.4.3 We have tried to highlight the problems created by over-specialised training programmes and the inflexibility in career pathways that has been created by MMC and are pleased to see this being addressed. We particularly sympathise with the respondent quoted by the Inquiry who gave up their training post in order to spend a year working in Zambia. We support the view that the UK medical training system should be encouraging such ventures, with the long-sighted aim of improving the quality of our workforce. Equally we agree that the situation in regards to Academic Medicine needs urgent attention. MMC has been seen to ignore and actively discourage this career path, but we believe that academia must remain the backbone of our training system and clinical service.

3.4.4 Recommendation 11

We agree that the DH must review their policies on self-sufficiency and open borders/over production. Implicit in this is the appreciation of the importance of foreign nationals in our workforce over the last fifty years and the benefits that many of these doctors still bring to the NHS. We would also encourage the DH to revisit the number of places available for medical students at universities, as we believe too many doctors are currently training in the UK.

3.4.5 Recommendation 12

While accepting that this is a complicated and specialist area, we broadly agree with the proposed arrangements for workforce planning. We would particularly emphasise

the importance of involving senior doctors in process to advice on potential future changes in healthcare practice and the impact that this will have on workforce requirements.

3.4.6 Recommendation 13 – 14

ASiT agrees with these recommendations.

3.4.7 Recommendation 15

Policies on how to handle the transitional bulge do need to be developed as a matter of urgency. Surely it is now inevitable that a large number of these doctors are going to be disappointed by the outcome, so the provision of career guidance and perhaps retraining for these individuals must be included in these policies.

3.4.8 Recommendation 16

We believe that there should be sufficient capacity in the specialist training systems to accommodate all doctors successfully completing their foundation training. Any other outcome would represent a waste of tax payers' money. As mentioned (3.4.4), if we are producing excess medical graduates through our universities then we should reduce the number of places available on these courses.

3.4.9 Recommendation 17

ASiT agrees with this recommendation and believes career guidance from an early stage to be a vital part of the process.

3.5 Medical professional engagement

3.5.1 Recommendation 18

ASiT supports the proposal that the medical profession should have an organisation that can present a coherent consensus opinion on matters affecting the profession. However, policy-makers must recognise that the structure of the medical profession is complex one solution will not fit all. Flexibility in policy must exist to allow for differences in individual specialities. The MTAS application form is a good example of

how one generalised form was not suitable for all medical specialities.

3.5.2 Recommendation 19

ASiT agrees that opportunities should be created in postgraduate training for those wishing to pursue an interest in clinical management to undertake appropriate training. However, developing the management skills of clinicians is essential to the smooth-running of NHS Trusts and training should be publicly funded, not paid for out of the clinician's own pocket. It is hoped that clinical representation at a managerial level will help non-clinical managers better understand the balance required between clinical priority and financial or target driven expediency.

3.5.3 Recommendation 20

ASiT agrees that trainees should be better represented in the management structures of Trusts. Trusts (and ISCPs) should have contractual obligations to balance training requirements with service provision. Trainees recognise that service provision often provides valuable training opportunities and have no wish to rid themselves of this commitment. In addition, when designing Consultant contracts Trusts must allocate time, resources and appropriate financial remuneration for Consultants who undertake a training role if future generations are to receive optimal medical training.

3.6 The commissioning and management of postgraduate medical education and training

3.6.1 ASiT is significantly concerned regarding the current and future funding of postgraduate medical education and training. The erosion of training budgets in many areas through devolution of responsibility to the Strategic Health Authorities (SHAs) and subsequent use of training budgets to offset deficits created in service delivery, has left many trainees suffering with no budget to support training in those areas.

3.6.2 ASiT remains concerned that in the setting of pressure to meet service targets that training will continue to suffer unless there is appropriate incentivisation for Trusts to participate in training delivery. We believe that deficiencies in the current funding of this process, and the resulting problems with manpower, make it impossible to

maintain excellent training delivery in the current climate. In surgery, these problems are compounded more than some specialties with frequent attacks on waiting list targets and the evolvement of Independent Sector Treatment Centres.

3.6.3 The complexity of the current arrangements and number of bodies involved in the administration, commissioning, and delivery of postgraduate medical education and training makes effective co-ordination of the training process unclear and cumbersome. We believe that clarity of responsibilities and authority for the process must be achieved as a matter of urgency.

3.6.4 ASiT believe that more formal links between higher education authorities and the Postgraduate Schools of Surgery may be beneficial for improving postgraduate medical education. Collaboration to ensure sound educational principles, and delivery of evidenced based teaching can only serve to strengthen postgraduate surgical education.

3.6.5 Recommendation 21

ASiT strongly supports any initiative that provides leadership and accountability within the Department of Health for ensuring that Education and Training are appropriately managed.

3.6.6 Recommendation 22

ASiT strongly supports this recommendation and in particular the formal review of compliance of Service Level Agreements relating to commissioning training.

3.6.7 Recommendation 23

ASiT strongly supports this recommendation and would like to see novel funding methods introduced for craft based specialties to ensure adequate delivery of procedural based training.

3.6.8 Recommendation 24

ASiT supports this recommendation.

3.6.9 Recommendation 25

ASiT supports this recommendation and in particular the potential benefit that may be derived from educationally sound higher level education and training.

3.6.10 Recommendation 26

ASiT feels that this is outside of our remit to comment on the Foundation training management, and further information on this is required prior to being able to take a firm position.

3.6.11 Recommendation 27

ASiT strongly supports this recommendation and feels that the importance of this recommendation may be more beneficial in protecting and enhancing training than many of the other suggestions. We would urge that this is taken forward as quickly as possible.

3.6.12 Recommendation 28 – 29

ASiT strongly supports these recommendations.

3.7 Streamlining regulation

3.7.1 Recommendation 30

ASiT fully supports assimilation of PMETB with GMC. We have long called for rationalisation of the organisations regulating and representing doctors. The arguments offered in support of GMC providing an overarching role are robust, particularly the need to integrate the three periods of medical education: undergraduate, postgraduate and CPD. PMETB is a costly organisation funded largely by trainees; we hope integration with GMC would result in these costs being spread across the profession as a whole.

3.8 The structure of postgraduate medical training

3.8.1 Foundation Training (5.8.1)

ASiT supports the notion that UK medical graduates should be assured an opportunity to undertake an FY1 job in order to complete full registration. ASiT remains

concerned that workforce planning issues continue to be ignored with the ongoing expansion of medical student numbers however.

3.8.2 Selection into Specialty Training (5.8.2)

ASiT whole-heartedly supports the finding that MTAS had significant shortcomings and has long emphasised the importance of demonstrable excellence, rather than competence, as a key attribute to selection of surgical trainees.

3.8.3 Specialty Training (5.8.3)

ASiT agrees that ST1 is too early to select to run-through training and this disadvantages individual trainees who may wish to reconsider their chosen career paths, both within and between core specialties. ASiT has long argued that the inevitably increased burden on trainers must be adequately resourced in terms of both finance and time. It is clear that not all consultant surgeons will posses the key attributes required to be an effective trainer, and those that do must be formally supported in their endeavours.

3.8.4 FTSTAs (5.8.4)

FTSTA appointments were always planned as a temporary stop-gap and, pending demonstration of the required competencies, steps should be taken to transfer as many of these posts to run-through training as possible, where vacancies exist at ST3 level or above.

3.8.5 NCCGs (5.8.5)

Whilst recognising that the NCCG holds certain attractions to some, in terms of level of responsibility and flexibility of working, ASiT feels strongly that CCT holders should not be "forced" into such posts and that they should not be used to introduce a formal "sub-consultant grade by stealth". It should remain the fact that all CCT holders should be eligible for, and have a reasonable expectation of being appointed to an appropriate substantive consultant post.

3.8.6 Post-CCT Careers (5.8.6)

As ASiT believes that all doctors attaining a CCT in their chosen specialty should be eligible for consultant appointment we would argue that any "enhanced roles for specialists" should form part of the core PMETB curriculum for that specialty. ASiT recognises a role for post-CCT training for some highly specialised fields, but feel that such posts must be time-limited and educationally approved to provide specific training goals, rather than simple service provision. Such post-CCT training may need to be organised at a National level for small sub-specialty groups, and availability of posts must be accurately matched to workforce planning.

3.8.7 Clinical Academic Careers (5.8.7)

ASiT supports the implication that entry to and exit from academic training and careers should be more flexible. We would maintain however, that many NHS institutions offer excellent opportunities for the practice of academic surgery and that surgeons, as a group, have a clear track record of producing high quality academic and research activities.

3.8.8 General Practice (5.8.8)

No comment.

3.8.9 Regional Specific Issues (5.8.9)

ASiT recognise that some smaller surgical specialties may require the formation of National Training Networks in order to provide the best possible training experience.

3.8.10 Recommendation 31 – 32

ASiT supports these recommendations

3.8.11 Recommendation 33

ASiT supports the incorporation of FY2 into core specialty training and wish to see greater flexibility by trainees being able to move between specialties following this year.

3.8.12 Recommendation 34

ASiT strongly believes that selection into run-through training following only 1 year of core specialty experience is too early for any specialty and that such arrangements would substantially disadvantage trainees who wish to move between specialties. We do however fully support the plan to recruit initially to a fixed three year core training programme.

3.8.13 Recommendation 35

ASiT supports this recommendation, but feel that it should also possible for trainees in non-hybrid programmes to have the flexibility to change specialty should the need arise.

3.8.14 Recommendation 36

ASiT supports the recommendation for a standardised assessment, but feels that individual regions should be able to maintain some degree of freedom in devising their own short-listing and appointment criteria.

3.8.15 Recommendation 37

ASiT recognises that not all trainees will progress to the grade of consultant and that, for a very few, a position as a trust registrar may be appropriate as a temporary measure if planning to enter a NCCG post. We feel strongly that CCT holders should expect to be appointed to a substantive consultant post, a NCCG post or to time limited higher sub-specialty training. Appointment of fully trained surgeons (CCT holders) to Trust Registrar posts would be wholly unacceptable.

3.8.16 Recommendation 38

ASiT envisages only a very limited role for Trust Registrar appointments and regardless of the degree of "destigmatisation" of the post, the introduction of long-term service posts (other than consultants or NCCG specialists) should be avoided.

3.8.17 Recommendation 39

ASiT wholeheartedly support the increased flexibility that this recommendation would

bring and would ask that PMETB consider a more accessible system for the accreditation of overseas and out of programme experience (OOPE), towards a CCT.

3.8.18 Recommendation 40

ASiT supports the introduction of any means of improving objective selection to surgical training, provided that such methods have been robustly proven to be both reliable and valid. We agree that a structured CV and formal interview process are essential to a fair selection process.

A difference in opinion exists within the ASiT Council as to whether the application process should be limited, both in terms of time and number of Units of Application (UOAs). It s felt by some that such a system may disadvantage those who wish to interrupt their training for whatever reason. Perhaps an allocated limit on the number (rather than timing) of applications would be a reasonable approach to avoid trainees getting "stuck" at any given level.

3.8.19 Recommendation 41

ASiT feels that if educational or management skills are felt to be necessary to work in independent consultant practice, that such training should form part of the prescribed PMETB curriculum for that specialty and, as a result, should be available to all trainees.

3.8.20 Recommendation 42

ASiT supports this recommendation.

3.8.21 Recommendation 43

ASiT agrees that a period of further training, beyond that required for the award of a CCT, may be required for certain sub-specialty practice. Such a process should however, be time-limited, educationally approved and focussed to the acquisition of pre-determined specialist skills or attributes. We feel that the burden of further examinations following this period of training should be minimal and that a work-based professional assessment could be the most appropriate mechanism. Entry to such sub-specialty training should be very closely linked to the prospect of substantive

appointment and workforce planning.

3.8.22 Recommendation 44

Clinical academics should be appointed purely on their ability to display the required clinical and academic attributes required for the specific consultant role. The implication that academics may need a less broad skill base in their given sub-specialty is to be avoided and they should be clinically skilled to the same level as their equivalent non-academic colleagues. Academic skills required by a specific appointment should be as explicitly stated as clinical requirements.

3.8.23 Recommendation 45

No comment.

4 Conclusions

ASiT very much welcome the independent inquiry into the MMC process and congratulate Sir John Tooke and his team on their hard work and achievement. We feel that the current recommendations would provide some great improvement over the present arrangements, however several areas have been identified which we feel, require further resolution. We are grateful for the opportunity to respond to the initial findings and recommendations and hope that the Inquiry team will address the issues raised in this document.

5 Contact

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