# Modernising Medical Careers: effect on NHS service delivery

*Chris Clough*

***Modernising Medical Careers will be introduced from August 2005 and will significantly change the system of education and training for doctors in the UK. The impact of these changes on NHS service delivery needs to be fully understood and is discussed in this article.***

The Chief Medical Officer's (CMO) response to the continuing training problems of senior house officers (SHO) ('the lost tribe'), called *Unfinished Business* (Chief Medical Officer, 2002), was the logical successor to the 'Calmanization' of the higher training grades of registrars and senior registrars. Calman merged the previous grades of registrar and senior registrar, and gave structure to higher medical training, emphasizing the need for supervision and yearly assessment (Department of Health, 1993). The CMO's perception was that SHO training needed similar attention. Although many SHO posts had been brought into training schemes specific for college requirements, many remained outside programmes as solo posts, and most lacked appropriate supervision and assessment. Many SHO posts are predominantly service-based and are essential to the running of most hospital trusts. SHOs move from post to post without any recognition for what they have done and without reassurance that their experience would necessarily qualify them for appropriate higher training.

**TABLE 1.**
**Aims and objectives of foundation training**

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|---|
| To produce doctors who are able to assess and manage the acutely-ill patient |
| To expose doctors in training to sub-specialties not usually encountered in clinical training (to understand them better, with the aim of improving recruitment) |
| To expose all doctors in training to primary care to imporve understanding of the patient's pathway to good care |
| To develop effective team-working with other health professionals. |

Modernising Medical Careers (MMC) was the response to this problem and to the perception that doctors going into specialist training and general practitioner (GP) training lacked skills in recognition and management of the acutely-ill patient. This problem was recognized on the wards of accident and emergency receiving rooms where generalists were needed to diagnose and resuscitate acutely-ill patients, be they medical, surgical or psychiatrically ill. In light of this, MMC has two separate, but related, drivers:

- The need for additional training following the preregistration year (foundation training)
- The need to create shortened, run-through (i.e. a single training grade) specialist training, merging, where possible, basic training programmes with higher training.

The aims and objectives of foundation programmes to develop foundation training are now clear (*Table 1*), and the preparatory steps for implementation of foundation programmes from August 2005 are taking place in deaneries. In contrast, the next steps from 2007, when the first foundation trainees emerge for onward basic training, have not been agreed; although the royal colleges have all submitted their preferred plans to the MMC directorate at the Department of Health.

Plans for MMC have caused concern among NHS trust chief executives. In a climate of performance targets and financial uncertainty they are worried that MMC plans have not been sufficiently thought through and shared with managers of the service. SHOs make a substantial contribution to the running of NHS hospitals and the proposed changes raise a number of questions. Will the replacements for SHOs do the

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same job? Do the requirements for education and supervision place a further burden on the overstretched consultant workforce? Are there any other hidden resource implications?

## FOUNDATION PROGRAMMES – PHASE ONE

Foundation programmes will be supervised by foundation schools. These will require resources to set them up (*Table 2*). Most usually, the programme director will be a consultant. Therefore, those sessions worked (1–2 programmed activities) will need to be recognized within their contract. Within trusts there will need to be an administrative structure with trainee programme directors (TPD), a foundation programme administrator and, importantly, educational supervisors (most usually consultants). Consultants will need time reserved within their job plans for educational supervision. The move to a time-based consultant contract, painful though that was, means that the NHS can no longer expect its consultant workforce to take on more duties without recognition. This means that time devoted to supervision needs to be properly accounted for within job plans and that trusts are appropriately remunerated to enable them to take on more consultants if service time is lost.

Costing exercises are taking place to enable workforce development confederations along with the deaneries to better understand the costs of foundation training as part of MMC implementation. Workforce development confederations are bodies within strategic health authorities responsible for the training of all health-service workers. They hold training budgets for doctors, previously known as the medical and dental education levy.

It will be difficult for trusts and deaneries to proceed without agreement of funding. In a climate where NHS trusts are expected to compete for value-for-money provision with private contractors, the additional cost of training doctors in trusts needs to be properly allocated. Alternatively, a training levy needs to be placed on private hospitals to recognize that they have the benefit of using NHS staff without any of the costs of training them.

A further problem that has emerged is the funding of primary-care allocations. The Health Minister, John Hutton, has indicated that all foundation trainees should be exposed to primary care. The assumption was that this would normally be a 3–4 month attachment in general practice. Other primary care experiences are possible, however, e.g. public health and community paediatrics. The cost of including primary care in foundation programmes has been estimated: it is substantial and central funding will be required, although this has yet to be agreed and so presently this programme is on hold.

**TABLE 2.**
**Costs of Foundation Programme**

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|---|---|
| Foundation school | Office space and overheads<br>One administrator and secretarial support<br>Director time |
| Trusts | Trust programme director (1– 2 sessions' consultant time)<br>Secretarial support<br>Office overheads<br>One consultant per five trainees |
| Primary care placements | Support to general practitioner practices<br>General practitioner trainer's time<br>Additional senior house officer posts for 4 month placements |

## FOUNDATION TRAINEES

The main concern for trust chief executives was the threat that existing SHO posts would be removed from service to create foundation posts. SHOs make a substantial contribution to the running of NHS hospitals, a large burden of the out-of-hours care of patients and emergency provision has fallen to them. Chief executives are concerned that transferring these posts into training posts would significantly affect service provision.

Postgraduate deans are responsible for the identification of appropriate SHO posts which could be transferred into foundation programmes. These have come from a broad spectrum of specialties, but most of them from medicine and surgery.

Pilot studies of the introduction of foundation trainees at the London Deanery are reassuring. Where foundation trainees have replaced traditional SHOs, there has not been a significant impact on service. Second-year foundation trainees, coming direct from existing pre-registration house officer (PRHO) posts, are likely to be less senior (and therefore less experienced) than the usual SHO. Feedback from consultants indicates that foundation trainees are of a high calibre, enthusiastic and capable of doing the job. Other fears were that the additional training requirement of foundation trainees would take them away from their work. The emphasis in the pilots has been on 'work-place' training. The additional requirement for monthly multiprofessional seminars away from the wards requires release from ward duties, but can be accommodated within present study-leave allocation. It is estimated that 15 days' training is required yearly;

presently SHOs are allowed 30 days per year. As a consequence, it seems reasonable to spend 50% of the allocation on foundation training.

## BENEFITS FOR THE NHS

The creation of foundation programmes moves the responsibility for post-registration postgraduate training away from the medical schools, previously responsible for preparing PRHOs for the NHS. Although the initial concerns about the introduction of the foundation programme will be logistical, there will be an opportunity to train doctors early in their careers and ensure they are 'fit for purpose'. The past experience of NHS hospitals has been mixed, with PRHOs needing close supervision and SHOs not always clear about the requirements of clinical governance. Hospital surveys repeatedly demonstrate errors in drug prescription and poor understanding of infection control (e.g. hand washing) and occupational health (e.g. poor reporting of needlestick injuries). The competencies of foundation training have emphasized the management of the acutely-ill patient, but there is an opportunity for the NHS to develop those skills necessary to be a safe, competent doctor in the NHS. Additionally, doctors entering the NHS need to understand the values and expectations of the NHS and public, and, in return, be respected as a valued employee.

## PHASE TWO

Many questions will be answered by the MMC Board over the coming months so that plans can be developed and costed quickly and put in place by 2007 for the first cohort of foundation trainees who started in 2005. It is not yet known what percentage of residual SHOs will convert to basic training programmes, and what will happen to the rest of the SHO posts, e.g. whether they will convert to trust doctor posts.

It is the expectation of the MMC Board that the royal colleges will develop plans for developing focused shortened specialty training with the potential of run-through (i.e. a single training grade) into higher specialty training. The key question will be how selection into speciality training is conducted. National matching programmes have been suggested which pose significant logistical problems. If fair and open processes are not developed, trainees in popular specialties may compete as formerly, acquiring additional research or other credentials to become more attractive applicants. It is generally accepted that a period of unstructured research is not a requirement for good training, although many specialties still expect it.

The impact of MMC on medical research has not been fully evaluated. The request by medical schools for identified academic pathways in MMC will not necessarily address the shortfall in medical research manpower likely to emerge from implementation of MMC.

While it is too early to fully understand the resource implications of MMC phase two, the experience of phase one will be helpful. Again it is likely that existing SHO posts will transfer into MMC and be expected to perform the same service work, and there will be requirements for structured supervision and assessment. Thus the main resource implication will be the indirect cost of consultant time. Deaneries will need to put structures and systems in place to admit trainees into basic programmes, and carry out and record assessments and outcomes. These will have additional costs and may present substantial logistic problems.

## CONCLUSIONS

Resources are required to deliver part one of MMC, mostly to replace consultant time devoted to running programmes and assessment of foundation trainees. The impact on service delivery can be minimized by moving existing SHO posts into equivalent training posts and using existing funded study leave. Phase two of MMC needs to be agreed quickly to enable a proper assessment and agreement of resources required to implement it by 2007. HM

*Conflict of interest: Dr Chris Clough is employed part-time by Southeast London Strategic Health Authority and is Medical Director Designate of the Joint Committee of Higher Medical Training.*


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### KEY POINTS

- Modernising Medical Careers (MMC) will have a significant impact on the training of doctors.
- Phase one, introduced in August 2005, will produce better trained generalists with skills better adapted to the needs of the NHS.
- Phase two will create more focussed training and the potential for run-through training to consultant grade.
- Better supervision and assessment will ensure competencies are achieved and can be accredited at any point in training and between different specialities.
- There are substantial indirect costs from implementation of MMC which need to be fully understood.