LONDON MEDICINE & HEALTHCARE

LONDON HIGHER
Supporting Higher Education in London

***London Medicine* response to the Department of Health Consultation June 2017 – Expansion of Undergraduate Medical Education**

This response is submitted by *London Medicine*, the group bringing together the Heads of the five London medical schools, two schools of dentistry and schools of clinical academic disciplines. London Medicine is a division of *London Higher,* the body representing nearly 50 universities and higher education colleges in London working to identify the opportunities and address the challenges of working in London.

We believe London is an exceptional place to learn and practice medicine. There is a unique diversity of students, patients and services and a long history of providing excellent and world renowned medical education and clinical research. As an important national and international centre for medical research and innovative new technologies, London also exposes medical students to an enriched learning environment; building the foundations for careers as our future NHS clinician academic workforce. London's diversity means that our medical schools play an important role in educating a diverse group of students, reflective of its population. As such we successfully attract the most ethnically diverse students compared to other medical schools in England as well as attracting a high proportion of commuter students (Student data for 2015/16 supplied by the Higher Education Statistical Agency, HESA).

London is unique in the UK in terms of providing placement opportunities in its exceptional range of specialist hospitals and services. Alongside these services are opportunities to train within easy access to a significant number of District General Hospitals and a wide range of primary care providers. London based medical students are already undertaking their education and training within a remarkable and distinctive system unlike no other in England.

For these reasons we believe that it is important to ensure the planned expansion of medical students is mindful of the affordances of the London medical student experience. It is imperative the plans include appropriate expansion in London to ensure we continue to produce a diverse workforce, with the experience of supporting the health of individuals from across the UK's diverse population. We must ensure we continue to provide exposure to academia in the undergraduate years that encourages students to contribute to the clinician researcher roles that underpin the excellence of the NHS.

1. **How would you advise we approach the introduction of additional places in order to deliver this expansion in the best way?**

The five London medical schools are world renowned for their education, their research environments and the unique and diverse learning opportunities that arise from learning medicine in London. The London medical schools were pleased to receive notification of the allocation for additional places in the year 2018/19 and details for the competitive stages from 2019/20. There are many benefits to expanding the education we offer to undergraduate medical students and together the London medical schools are committed to expanding medical education in the capital as well as in the rest of England.

We strongly believe that **quality** should be the main driver when considering expansion of medical student places. Medical education is an expensive and high stakes endeavour; both for the student and for the taxpayer. We are educating the next generation of NHS doctors: doctors committed to

excellent patient care but also to contributing to medical education and training, to research and innovation to develop that care and to leadership of the service. An undergraduate medical education needs to set the foundations for all of these abilities.

Alongside quality, **capacity** needs to be a key consideration. The provision of a diverse range of placements with good opportunities for workplace-based learning should also be central to the allocation of additional medical student places. Through *London Medicine's* collaborative approach and our *Vital Signs* initiative we are able to co-ordinate, consider and develop medical education opportunities across London and are currently engaged in a project to review clinical placement capacity and quality across London medical schools. It is clear that London has such a large number of already active and potential new placements that expansion in the capital, if an innovative approach to programmes overall and placement learning in particular, is both possible and desirable.

Whilst new providers are a potential excellent route for expansion we advise some caution given their lack of a track record of quality provision and sustainability in a challenging economic climate. There is potential for the very substantial overlap of proposed placement provision by new providers with the placement provision already used by existing schools, which is currently in place to ensure diversity of placement experience for their students. Additionally, importantly all of these factors should be considered alongside potential impacts to current patient care.

2. What factors should be considered in the distribution of additional places across medical schools in England?

As identified in Question 1, a number of factors should be considered in the distribution of additional places. The main factors remain:

- **Quality of education.**
- **Capacity to provide a diversity of good placements.**

In addition, the following points should be considered:

- **Provision of a broad education for future professionals:** whilst undergraduate medicine is a vocational programme, it provides the foundation for a diverse set of careers; all of which are important to the sustainability and excellence of our NHS. Whilst the NHS has a current need for more generalists, it also has a desperate need for more clinical academics and innovators, more clinical leaders, more clinical educators. For this reason the undergraduate programme must include exposure to a wide range of learning experiences and venues, and a research-led education. This expansion, which is substantial and building the professionals of the future to lead, shape, innovate and deliver health protection and healthcare to the nation, should not get too focused on expediency nor programmes that are insufficiently broad to create firm foundations and pluripotency of graduates. The expansion must also consider programmes that can demonstrate meaningful inter-professional and team based learning opportunities, setting the skills and competencies essential for our future workforce.
- **Current student perspective and the impact of expansion on the existing 6,000 medical students:** expanding medical education will have an impact on the current students already within the system. The expansion proposals need to consider impacts on both in-university and placement element of their programmes. Proposals must ensure current students and recent

graduates have a meaningful input into any expansion plans in order to maintain quality. Additionally it will ensure innovation is sufficiently student-centred, to guarantee prospective students thrive during programmes and emerge enthused and engaged with a career in the medical profession.

- **Diversity of the medical students we train:** we need to do more to achieve greater diversity in the students we attract into medicine: both in terms of ethnic *and* social diversity. London medical schools are already actively working to achieve good diversity in their students. Ethnic diversity is greatest in London medical schools with all London medical schools in the top 5 ethnic diverse schools in England. On average, 56% of London medical students are from BAME backgrounds whilst only 31% for the rest of England (HESA data for 2015/16). London medical schools are already providing more opportunities for people from all backgrounds compared to others in England and this should be considered in the distribution of additional places - over 70% of medical school students in London come from state schools (HESA data for 2015/16). Additionally it is important to consider the proportion of commuter students studying in London and other major metropolitan medical schools, of which a high proportion study in London (see point 3 below).

There are also wider factors to be considered to ensure success of the expansion, many of which are outside of the influence of medical schools. These include:

- **The ability of the Foundation Programme to accommodate an additional 1,500 students across England in order to complete the necessary stages of pre-registration education:** ensuring co-ordination of this expansion with the expansion of postgraduate provision in the Foundation Programme is key. In 2016 applications to the Foundation Programme were oversubscribed with 45 students placed on a reserve list, including 38 UK students (The UK Foundation Programme Office, 2016). The ability of the Foundation Programme to accommodate extra students is an important element of the expansion on the whole across England. Additionally ensuring any proposed legislative changes are made early enough to guarantee undergraduate programmes deliver appropriately skilled and experienced graduates to enter the next stage of their learning: whatever that role/pathway entails.

- **The capacity of universities to develop new programmes in light of the expansion:** in order to expand efficiently and effectively to meet the Government's requirements whilst maintaining quality, more of the same in the same spaces and using the same resources is not going to work. We need to think innovatively in order to approach the expansion; not just in London but across the UK. Over half of the UK's medical schools currently offer fast-track graduate programmes and there are many benefits to developing new or expanding existing fast-track programmes. Additionally there are transfer opportunities with students studying courses closely aligned to medicine, such as biomedical science. However under current EU regulation medical students need to achieve 5,500 hours instruction. This does not allow for transfer of credits from other programmes of study no matter how similar and with the possibility of legislation moving the point of registration and thus discounting FY1 from the calculation of the 5, 500 hours, there are major structural barriers to this approach. Fast-track graduate programmes and conversion courses from biomedical sciences programmes may be excellent ways of creating a suitably educated and motivated expanded number of graduates (if the current regulations regarding

5,500 hours of MBBS study can be reconsidered via accreditation of prior learning arrangements). Universities with existing excellent biomedical science programmes accepting students with similar grades to those required to study medicine, and those with fast-track graduate courses, could be foregrounded in any expansion plans.

- **Timing of the expansion / university staffing and infrastructure:** in order to provide Government with new and innovative programmes to deliver a successful and quality-assured expansion, all medical schools, existing and new, will require time to develop new programmes with placement providers. Additionally they will importantly require time to address university staffing and infrastructure capacity implications of larger programmes. There are concerns that innovative approaches cannot be rushed and should not be driven by a need to implement by 2019/20. Politically driven agendas with an over emphasis on current workforce dilemmas may lose focus on what is important in this long term expansion of doctor numbers.

- **Funding of Tariff for additional places and primary care Tariff:** in order to develop plans around expansion, medical schools need assurances regarding the long term provision of Tariff funding for both placements and for central placement/clinical education-related medical school activities (such as simulation, clinical assessment, etc.). Moreover the Tariff for community based placements needs to be improved to allow expansion in community placements necessary for orientation of students to the full range of healthcare careers, including community based careers. Government should recognise that as with patient care increasingly moving from secondary to primary care, the education of our future workforce should do the same, and the funding should support this.

- **Funding of Tariff for international students:** there are cautions regarding the impact of removing Tariff contributions for international students. If the cost of Tariff is added to international students tuition fees then it will cost c. £70,000 per year to study medicine in London – making London one of the most expensive places to study medicine worldwide for international students. There is a considerable risk to London medical schools that this raise in tuition fees will in fact be a deterrent to international students and that applications may reduce. This will impact diversity, our economy, morale of current students and most importantly in this case the ability to deliver an expanded programme.

- **Realistic consideration of placement capacity:** substantial placements are required on all healthcare education programmes and this expansion of medical student numbers coincides with a very significant expansion in allied professions programmes (such as Physician Associates). Through our *Vital Signs* programme we are currently building a map and database of undergraduate clinical placements (both hospital and community) and capacity in and around London. London medical schools work with over 700 independent placement providers, not all of these are in London and students are exposed to a wide range of experiences and settings. By autumn our database will be complete and will indicate quality in relation to capacity. Capacity is a term which needs further definition and estimates need to be approached with great caution. Whilst Trusts and other providers may indicate they have capacity, this may be financially motivated or unrealistic when considered alongside the provision of placements for allied health professionals. We recommend detailed mapping of realistic capacity with clear criteria for

indicating maintenance of quality and sustainability. In placements distant to the university, this also needs to include accommodation capacity.

3. **Do you agree that widening access and increasing social mobility should be included in the criteria used to determine which universities can recruit additional medical students?**

The members of the medical profession should be drawn from the population it serves. London medical schools are constantly working towards widening access and participation. Widening access to underrepresented ethnic groups is also an important element in ensuring the future workforce reflects society. Widening access also requires medical schools to be mindful of attracting commuter students who, for family, caring, work, or other responsibilities or restrictions, need to live at home whilst studying. London and other metropolitan schools excel at this aspect of access with three out of the five London medical schools having the highest proportion of commuter students in England, and all five London medical schools in the top seven in England (HESA data for 2015/16) [commuter students are defined by *London Medicine* as those students whose term time accommodation is their parental/guardian home or own residence]. Increasing medical student places in metropolitan areas, and ensuring universities selected for expansion have the infrastructure and resources to be able to meaningfully attract and support a wide range of students, is key to this objective. Whilst there are a number of other drivers for selection of which universities will be allowed to expand numbers, access issues must not be overlooked or marginalised.

4. **Do you think that increased opportunities for part-time training would help widen participation?**

Whilst part-time learning in some disciplines is extremely successful, in medicine this would mean undertaking a 10-year undergraduate course before even entering the Foundation Programme. We must be wary of the impact a 10-year course could have on student wellbeing including mental health and morale. Additionally we must consider that workforce demands will be different in 10 years' time and thus by offering part-time programmes to students in the new expansion will not meet the workforce demands we are experiencing now. There are also questions to ask around increasing those students from WP backgrounds and increasing the amount of student debt they have (over a minimum 10 year period) and the financial burden associated with it.

5. **If you have any additional information/experiences around widening access and increasing social mobility that would be helpful in developing the allocation criteria, please provide it here.**

N/A

6. **Do you agree that where the NHS needs its workforce to be located should be included in the criteria used to determine which universities can recruit additional medical students?**

To some extent but empirical research suggests the geographical position of the medical school is only one of many drivers of where graduates practice in England (in comparison to places like the USA, Australia etc.). Whilst good placements and a good experience in a new part of the world or local to where a student grew-up may shape where they as professionals eventually choose to

practice, mobility is an increasingly important part of a junior doctor's careers. The undergraduate effect is likely to be diluted by postgraduate experiences.

Postgraduate training availability and quality may have a more substantial impact on where doctors choose to settle; particularly as this is timed with when young people are making other life choices. Under the current national selection for the Foundation Programme there is no incentive for students to stay in the area where they have been trained and allocation is based on their rankings. Foundation doctors may be more likely to remain in the same area as their postgraduate training having become settled and having built up relationships locally. We believe it might be more effective to encourage people to enter Foundation or specialty training in undersubscribed regions with a range of educational and financial incentives, rather than expect the undergraduate experience to impact into long term geographical and working plans.

Quality of education, availability of education and career opportunities, and quality of life factors feature heavily in location decisions of professionals, like medicine, where mobility is possible. London and the South East have not experienced problems in recruiting and retaining medical students and doctors and this is a testament to the benefits of living and working in London and the institutional reputation and programmes on offer.

One of the major metropolitan cities will feature in the career journeys of many doctors. Clinical academic careers are also centered on the 'Golden Triangle' and so again, the South East will be a draw no matter where students undertake their initial training. London continues to train for the rest of the UK – it is well known that a significant proportion of students leave London after completing their medical training and this can only be a positive factor. These students leave London with a wealth of experience from being exposed to a wide range of health conditions not seen in the rest of the UK.

Rather than framing the major metropolitan cities as less desirable locations for expansion, plans should be mindful of:

- Expanding where students ***want*** to go to study medicine.
- Expanding where there is ***capacity*** for diverse placements at scale.
- Expanding where there is the full ***range of clinical services*** in which to complete placements.
- Expanding where students can learn with other professions and disciplines - i.e. ***multi-faculty or multi programme institutions.***

It is important to remember that although there are many commuter students studying in London (see point 3 above), London schools do not exclusively train their students in London. They send their students to placements in District General Hospitals and community settings in areas where it can be very difficult to recruit and retain good staff (for example to name a few, at UCL students have placements in Basildon and Luton. At KCL students have placements in Dartford, Hastings, Margate, Eastbourne and Canterbury and at St George's students go to a number of District General Hospitals including Maidstone, Chichester and Yeovil) and therefore play a key role in ensuring students are exposed to hard to recruit areas.

7. **If you have any additional information/experiences about attracting doctors to areas facing recruitment challenges that would be helpful in developing the allocation criteria, please provide it here.**

N/A

8. **Do you agree that supporting general practice and shortage specialities to attract new graduates should be included in the criteria used to determine which universities can recruit additional medical students?**

Undergraduate medical education provides a wide foundation for future training and eventual career choices. Improving recruitment to shortage specialities is an important focus for the health service and needs to be addressed in a joined-up way across undergraduate programmes, post graduate training programmes and speciality programmes, the Royal Colleges and NHS employers.

All medical schools are already taking part in important projects to improve recruitment into general practice careers, to reduce stigma associated with psychiatry and to encourage generalist rather than specialist oriented programmes. The effectiveness of these relatively new activities on career choice is not yet known and without sufficient primary care funding for placements, placing students in general practice is difficult. The evidence and survey data focused on immediate recruitment into speciality training schemes from the Foundation Programme (currently used to identify programmes that encourage graduates to pursue shortage specialities) is under developed, patchy and possibly misleading. New schools have had no opportunity to generate any evidence at all. For these reasons this is not a good basis on which to develop criteria for selection of a university for expansion of medical student numbers.

It is important to future-proof these additional medical school places. It will be at least 10 to 15 years before these additional students complete their undergraduate and generalist/specialist training. Workforce challenges and demands will be different in 15 years' time and therefore maintaining a focus on a good foundational, pluripotent undergraduate education is important for future workforce planning.

9. **If you have any additional information/experiences about attracting doctors to general practice and shortage specialities that would be helpful in developing the allocation criteria, please provide it here.**

Structural changes are required for all medical programmes to attract students to general practice. It is imperative that the uplift in the primary care Tariff is agreed. Until this point it is increasingly difficult for all schools, new and existing, to place students in general practice placements and this may be negatively affecting recruitment.

10. **Do you agree that the quality of training and placements should be included in the criteria used to determine which universities can recruit additional medical students?**

Yes. As identified above in question 2. In London, through our *Vital Signs* programme we are currently building a map and database of undergraduate clinical placements in London incorporating over 700 placement providers. By autumn our database will be complete and will indicate quality in relation to capacity.

As previously noted 'capacity' is a term which needs further definition. Whilst Trusts and other placement providers may indicate they have capacity, medical schools may have concerns about student experience if capacity increases in some areas and so robust relationships, service level agreements and quality review processes are central to assessing capacity.

There are some concerns regarding new medical schools and new placement providers that are part of this expansion plan. New medical schools which are opening near current medical schools will create challenges to existing placements in District General Hospitals and community settings and create uncertainties for all regarding placement availability. This has the potential to destabilise current established medical schools not only in London but also in other metropolitan cities where similar situations may arise. Evidence of robust planning and assurances of placement provision – and any sharing arrangements - should be a criteria for allocation of additional students.

Furthermore, if the focus is to be on the quality of training and placements, then there are many unknowns regarding new medical schools and new placement providers who have no track record in placement establishment, service level agreement enforcement, or providing suitable facilities, staff and infrastructure for high quality placement-based education of undergraduates in medicine. Extreme caution should be applied to allocating substantial numbers of students to such providers until robust structures and processes are in place.

11. If you have any additional information/experiences about how to improve the quality of training and placements that would be helpful in developing the allocation criteria, please provide it here.

London Medicine has created a case studies series as part of its *Vital Signs* programme. One case study looks at tracking Tariff funding directly to the education provision at the Royal Free. Education Managers at the Royal Free have successful developed a system whereby funding for education is directly allocated to clinical service lines. This has led to improved quality of placements at the Royal Free.

Case Study: Allocating funding to clinical service lines

At the Royal Free London NHS Foundation Trust Paul Dilworth, UCL Medical School Sub Dean, has helped set up and implement a new process of tracking monies in clinical departments, devolving to service lines. The process began in 2015 and has been fully implemented from 01 April 2016. Historically undergraduate teaching through clinical placements has been conducted by goodwill.

Increased clinical and academic pressures are making this goodwill less tenable and transparency of funding for teaching is very persuasive. Enhancing transparency has been a key part of this new process. It will also aim to facilitate job planning, recognize service line contribution to undergraduate teaching and incentivise quality of teaching.

The process of mapping the money differs between departments, modules, service lines and teaching plans and can vary from a straightforward simple process to one which is more complex. The processes do require ongoing staff time but these will reduce once the initial setting-up has taken place. Currently the allocation to service lines has been calculated by:

-80% of the income allocation for each service line, based on student numbers

-20% on the delivery of educational targets (10% consultant job planning; 10% student feedback)

The key objective for an outcome from student feedback will be in the form of a traffic light system (green, amber or red rating) in the overall rating question on the end of module feedback form. Two red ratings out of three in the previous academic year will result in income not being allocated.

This new system is building in a new way of working, moving away from the threat of moving students away from placements, and ultimately improving the placements themselves. It allows the university to have more control.

12. Do you agree that all providers should be offered the opportunity to bid for the additional medical school places?

Yes. In a system where equality and fairness is valued, it is only right that all providers are offered the opportunity to bid for additional places. However, as already identified there are concerns over new providers who plan to enter the existing market place and the quality and sustainability of their provision on offer. Reassurances are needed from Government to all existing medical schools that new providers are simply not allocated places due to the fact they can implement new programmes quickly to meet political agendas. Existing medical schools have spent decades harnessing quality programmes and developing relationships with placement providers. There are risks that new providers can destabilise the current robust system with little evidence in place to support them.

13. Do you agree that innovation and sustainability should be included in the criteria used to determine which universities can recruit additional medical students?

London medical schools recognise that change is needed in order to expand the current system, and that will require new innovative solutions. However, it takes time to develop high quality programmes which are different to what is currently on offer, and as such, it may not be feasible for existing schools to create robust new programmes within the current proposed expansion time frame. There are concerns from existing medical schools that new providers will seem to be able to deliver programmes quickly, however without proven sustainability and quality programmes, there are risks to both students and tax payers that these new 'quick' programmes will not be successful or sustainable which is detrimental to the expansion plans. New ideas should be welcomed although expediency and anticipated quick-fixes should not be allowed to overshadow the bigger picture and Government should recognise that successful new innovative programmes often take time to plan, develop and implement. Equally, as with Government requiring sustainability from medical schools for expansion plans, medical schools require sustainability and reassurances from Government for placement funding (Tariff) and primary care Tariff. Planning for expansion in London is difficult without funding arrangements in place or proposed, particularly for new innovative ideas.

14. If you have any additional information/experiences about how to encourage innovation and sustainability that would be helpful in developing the allocation criteria, please provide it here.

N/A

15. **We would be interested in hearing views on how meeting the needs of the NHS aligns with the role universities wish to have in the future distribution of places in an expanded market – please provide your views here.**

Medical education is a partnership with placement providers and the NHS – if medical schools held more authority over placement funding lines they would be able to use funding more effectively as a tool to manage quality and capacity. Universities can meet the needs of the NHS more effectively and efficiently if given the appropriate power and control.

16. **Do you agree with the principle that the tax payer should expect to see a return on the investment is has made?**

Whilst the principle that the tax payer should expect to see a return on the investment it has made is fair, we are unconvinced that a bonding scheme will achieve this. Medical students are training for a lifetime of public service in the NHS. They make considerable sacrifices throughout their undergraduate programmes to achieve this and emerge from a long programme of study with substantial debt. All graduates go on to make substantial contributions to society. Indeed a bonding scheme may be counterproductive; particularly to more disadvantaged groups of prospective doctors.

17. **Do you agree in principle, that a minimum number of years of service is a fair mechanism for the tax payer to get a return on the investment it has made?**

There are important practical and fairness issues which are unconvincing that any bonding scheme of any length is a sensible strategy.

A minority of UK medical graduates do not proceed to work long term in the NHS and there is good evidence, for example through Goldacre and Lambert's 2013 national survey of doctors 25 years after graduation (*Participation in Medicine by Graduates of Medical Schools in the United Kingdom up to 25 Years Post Graduation: National Cohort Surveys. Goldacre and Lambert. 2013*). There are a variety of reasons why a small minority of medical graduates do not pursue a medical career long term: forcing those too unwell, unable or unsuited to continuing would be counterproductive and not in the best interests of the public.

Recruitment to medicine may be affected if students are liable, not only to student loan repayments but also for repayment of the state contribution if they do not or cannot continue. It is likely that this would have a greater impact on recruiting students from less advantaged backgrounds.

18. **Do you have any views on how many years of service would be a fair return for the tax payer investment?**

See answer to question 17.

19. **Do you agree with the principle that graduates should be required to repay some of the funding invested in their education if they do not work for the NHS for a minimum number of years?**

See answer to question 17.

20. Can you think of any potential impacts of requiring graduates to repay some of the funding if they do not work in the NHS for a minimum number of years?

See answer to question 17.

21. Is this a policy you wish to see explored and developed in further detail?

No; this idea has a range of potential negative impacts for what would be very minor gains that would further erode morale of doctors.

22. Do you have any comments about the impact any of the proposals may have on people sharing relevant protected characteristics as listed in the Equality Act 2010?

See answer to question 17.

23. Is there anything more we can do to advance equality of opportunity and to foster good relations between such people and others or to eliminate discrimination, harassment or victimisation?

This issue is addressed in our answer to questions 3-5. It is important to remember that maintaining diversity in the medical student population and exposing medical students to diversity of patients is central to supporting the personal and professional development of our future doctors and their attitudes towards difference and diversity. Any plans need to be mindful of unintended consequences in this regard. This may include: expansion in areas of low patient diversity, expansion that is not mindful of the needs of commuter students or those with caring or work responsibilities, expansion that inadvertently favours those with more substantial financial or social capital or plans that marginalise international students. Greater support structures are necessary for some groups.

24. We are interested to hear views about the impact the proposals may have on families and relationships. For example, do you consider training more doctors will have a positive impact on flexible working because of additional system capacity?

These expansion plans need to be mindful that generational changes in attitudes to work and work life balance means the NHS is going to have an increasing number of doctors, both men and women, working less than full-time for at least some of their careers. Whilst training additional UK doctors will help the country to go some way towards addressing workforce issues, Government needs to be mindful of training and employing a different sort of workforce to make a substantial difference to families and relationships.