The number of both trainees and Consultant Cardiologists in the UK has increased steadily over the last few years but there are still gaps in provision and major inequalities in access to cardiac care. The financial climate under which this expansion occurred is now changing and the NHS is facing some lean years. For a number of medical specialities it is possible that there might be an excess of trainees holding a CCT over available consultant posts. In response to this concern the Royal College of Physicians has initiated a debate about the future of the medical workforce. Various scenarios have been raised including the creation of a non consultant specialist grade of CCT holders unable (or opting not to) to obtain a consultant post and a reduction in NTN posts. The Council and Executive of the BCS have been asked for their response and the purpose of this brief statement is to outline our views.

- All patients should always be under the care of a specific consultant.
- In the view of the BCS there is continuing under provision of specialist cardiology in the UK. This is exemplified by the findings of the Access to Cardiac Care Project carried out on behalf of the BCS and the BHF:
  
  http://www.bcs.com/documents/Access_to_Cardiac_Care_in_the_UK_Full_Version_FINAL_1_07_09.pdf

- The BCS has also estimated how much cardiology care the population of the UK requires, and the workforce required to provide this: http://www.bcs.com/doclibrary/bcs/BCS_cardiac_workforce_2005.pdf http://www.bcs.com/pages/news_full.asp?NewsID=19270080

- As the proportion of women in cardiology increases it is likely that more consultants will wish to work less than full time for at least part of their career with a requirement for additional consultants to maintain the WTE workforce
- Many existing consultants still work excessively long hours that are unsustainable in the long term and should be gradually reduced, releasing PAs for the appointment of additional colleagues
- The evidence base for current cardiological therapies is probably stronger than that for any other clinical area. Despite abundant evidence of better outcomes and shorter hospital stays many patients admitted with acute cardiac conditions are not under the care of a Consultant Cardiologist. In the view of the Society this inequality in access unacceptable and ongoing expansion of the cardiology consultant workforce is required to ensure equitable access to appropriate care and compliance with NICE recommendations.
Trainees electing not to train in acute or general medicine is not an issue in cardiology or for StRs in cardiology. Only 7% of consultant cardiologist posts advertised from 2000 to 2006 were combined cardiology & acute/general medicine; 93% of posts were cardiology only.

Any "Miscalculation of trainee numbers" is not the responsibility of BCS or the profession. Neither BCS nor SAC nor STC have had any responsibility for controlling trainee numbers, rather this has been the responsibility of PMETB & Deaneries. Furthermore, the MMC & MTAS debacles resulted in a considerable increase in ST3 posts, which is a "ticking time bomb" with regard to career grade employment opportunities; this has not been acknowledged.

The creation of a subconsultant grade is not the answer. The delivery of high quality clinical care is dependent on the regular input of senior, experienced clinicians and should be lead by consultants. A reduction in the number of cardiology trainees will result in inadequate future provision of specialist care for an aging population and will lead to the sort of swings in trainee numbers that have caused chaos in other specialties and which we have avoided in the past.

In summary it is the view of the BCS that patients with cardiac problems should be cared for by Consultant Cardiologists and that there is a clear need for continuing expansion of consultant numbers to ensure equality of access to appropriate, evidence based care with optimal use of resources.