Shape of Training Review Seminar

3rd September 2014, Royal College of Physicians of Edinburgh

Organised by the Academy of the Medical Royal Colleges

Theme: Broad based themes

Scene setting presentations:

1. **Status of the SOTR: Professor Ian Finlay, Professor of Surgery, Advisor of Scottish Government and member of Shape of Training Review Steering Group.** Currently the status of the SOTR is that the report is being considered and policy being drawn up on a UK 4 health department basis. The role of the steering group is to report to and obtain approval from ministers, determine policy, agree the prinicples for implementation of medical education and training (broad based training, safe, patient centred, flexible, recognise previous training, avoid service disruption, affordable, robust governance).
   The purpose of the 6 workshops is to put flesh on the framework of the reviews recommendations.
   Emphasised that the review addresses a service problem rather than a problem with training itself. The needs of the service are changing: increasing elderly patients, increasing co-morbidities (average patient is > 65 yrs old with 3 co-morbidities), austerity, increasing demands of the public, future 7 day working. The current position is not sustainable to deliver the service.

2. **Views of the profession: Professor Terence Stephenson, Chair of the AoMRC**.
   Consensus: AoMRC represents 21 colleges and 22000 UK doctors. The AoMRC had already conducted 2 ½ day meetings (one attended by Nigel Penfold, RCoA) and broadly speaking the profession supports the recommendations of the SOTR. He emphasised that the terminology that we should use is GP's, specialists and subspecialists there was to be no mention of subconsultants and superspecialists as they did not feature in the reviews recommendations. A CST holder would be the named consultant for a patient and capable of independent practice.
   Relevance: The review has more relevance to some specialities than others, in particular the interface between EM, AM, COTE and surgery where there are significant pressures to admit and then quickly discharge patients (revolving door medicine). Other specialities such as paeds, radiology and anaesthesia already train generalists.
   Length of training: GP training will be increased to 4 years but training for other specialties will be reduced to 4-6 years under the recommendations. This training

should be supervised and protected with the service less dependent on trainees, including out of hours and at weekends.
Unanimity: Any changes should not create a new "lost tribe" by training lots of generalists with nowhere to go. If we are going to train generalists then they will need to have a special interest and allow portfolio careers.

Workshop 1 Information: How few broad themes could deliver future broad based training?: The SOTR has recommended that training in the future should be based upon a small number of broad themes. It is accepted that there will continue to be a degree of "subspecialisation" leading to a CST within these broad themes. It is envisaged however that any training pathway will begin with a block of training in the generality of the theme. For example in medicine theme all doctors will begin with a training period in general medicine prior to developing any specialism as they proceed to CST. On this basis the following 6 broad themes have been suggested for secondary care:

Surgery

Medicine

Women and children

Anaesthetics and Intensive Care

Psychiatry

Investigative medicine

Questions:

1. Are those 6 themes sufficient (given a degree of flexibility) to describe the initial training pathway for most doctors training to work in secondary care?
2. Do we need any additional broad theme pathways? If so what could they be?
3. Please explain why additional pathways cannot be accommodated within the 6 themes described above?

Emphasised that we had to use the terminology described previously and that we had to separate training from experience and think only about training (*Is this possible?).*

Workshop 1 discussion and thoughts:

Surgical group (I attended): First point that was made was that we were meant to be having a workshop to discuss innovative ways of looking at training via broad based themes and yet we had been presented with a list that looked remarkably like what we do now. Everything compartmentalised and historical themed to suit the physician without taking into consideration the patient. There was no mention of the way that patients present acutely to EM with undifferentiated problems on a background of co-morbidities. None of the broad

themes presented would encompass all the skills required to diagnose and start to investigate this group.

We had been told that we should not talk about GP/community care during this workshop however it was felt by most to be impossible to leave out as any broad based themes cannot be in isolation to primary care.

Mental health is not a separate box and would overlap with many themes/specialties.

Discussed alternative approaches: systems approach or a life cycle approach. Are these too radical and change for changes sake?

Neurosciences approach: train neurosurgeons and neurologists together?

Craft theme vs medical theme (including primary care)

Recognised that there is a disconnect between undergraduate curricula (systems approach), foundation curriculum and specialty training. A lot of the skills to look after the critically ill patient are probably present in most curricula but not properly trained and not evaluated. E.g. surgeon spend time on ICU, physician spend time in psychiatry.

It was noted that trainees would change specialty rather than location and that friends and family are very important.

Finally it was surmised by organisers that trainees would probably only do a year in a broad based theme and then specialise?

Workshop 2 Information: Describe a broad training pathway for physicians within the basic theme of medicine. *There were 5 workshops encompassing the themes that we had been given despite the fact this whole seminar was supposed to be about discussing the broad based themes! These were: surgery, medicine, investigative medicine, Women and children and primary/community care. Note anaesthesia and psychiatry not included as separate workshop!*

The SOTR describes a process whereby a doctor who enters training within a basic theme will achieve a CST within 4-6 years. A doctor with a CST will be a consultant who is "emergency safe" and will be required to deliver unscheduled care. These doctors will work in teams and will have access to doctors with credentialed sub-specialist skills.

It is accepted that there will continue to be a degree of sub-specialisation (e.g. cardiology, renal medicine etc). On this basis please consider the following questions:

1. How long should it take to train a consultant physician (CST) to undertake general medicine in the unscheduled care setting?

2. How many sub-specialties within medicine will continue to be required? What are they? Alternatively are there any sub-specialties that should be incorporated into general medicine?
3. How many sub-specialties (currently delivered in hospital) could be delivered predominantly or entirely in the community? What would these be?
4. Please describe possible training pathways for general medicine and some sub-specialties.
5. Please consider the scope for flexibility within the theme and with other themes?

Workshop 2 discussion and thoughts:

Medicine group (I attended): Federation document (Federation of RCP, RCPE and RCPSG) states that can train a general IM physician in 3 years with a further 4 years of sub-specialty training with then possibility of credentialling. Don't feel it is sustainable to have a CST at 4 years. Unattractive to doctors as will be doing acute take without any means of progression potentially. Workload of acute medical take is such that no-one can continue indefinitely. Described by Med Reg as "going to war". Little supervision and poor use of training opportunities mean that very unattractive. Trainees and consultants opting out of acute take as soon as can to enter on of 29 ologies. Need to stop this opt-out. PG Dean from Yorkshire and the Humber said that they have improved things by ensuring that all med reg's (beyone CT3) have to participate in the general on-call rota. They therefore all share the load, frequency of on-calls are less and they still manage to get trained in their subspecialty area. Lots of discussion around the problems in acute medicine, recognition that need to reduce workload and amount of service for AM trainees but not many solutions as to how to provide this. Medical community seem to think any AM/EM job will be unattractive and solution is to allow subspecialisation not to improve training and supervision and make specialty more attractive. Role of perioperative physician or critical care also sharing load with EM/AM?

Need to identify transferable skills between specialties, can take areas from different curricula without having to start from scratch e.g. ICM curricula a recent addition and written using areas from other curricula.

Important to decide how much service trainees should provide? If wish to shorten training time then will need to reduce service component to allow training.

COTE/Dermatology could be community based training. Many others could have community elements. Medical trainees should spend some training time in primary care and vice versa – need to bridge gap between primary and secondary care.

Feedback from other groups:

Primary care/community feedback: Need something extra for the fourth year e.g. community child health, mental health – akin to credentialing. Blurring of interface between

primary and secondary care – is this blurring of where people work or who does the work or both?

Surgery feedback: Early focus on acute surgery in general c.f. surgery in general. Acute care with streaming for 1-2 years. Neurosciences could have a run-through programme with opportunity for transferable skills.

Women's and children's feedback: 2 separate streams. Will only be able to decrease length of training if decrease amount of service required of trainees.

Flexibility: GMC have been doing some work on core training and accreditation of transferable competencies.

Workshop 3 information: This workshop aims to give an indication of the scope of work that can be undertaken by a SOTR CST. It should be noted that almost every other Western Country can train secondary care doctors in 4 years and traditionally UK trainees have been used to provide service (often unsupervised).

Shape of Training recognises that there will continue to be a requirement for sub-specialty skills. It is proposed that doctors who have been credentialed in specific areas will cover these skills.

Questions:

1. Please identify in broad terms areas that should only be delivered by credentialed doctors.
2. How long would a period of credential training require to be?
3. Future CST doctors will be trained in a shorter time but will rapidly gain experience after they commence consultant work. Should they have formal support for a period of time after appointment such as the provision of mentoring or foramlised team working?
4. The proposed system will depend upon appropriate referral to credentialed doctors. How should we ensure that occurs?
5. Other countries with shorter training programs support their trained doctors by ensuring team working lead by a Clinical Head of Service. Is that a model that we should consider?

Discussion and thoughts from workshop 3:

Medicine Group (I attended): This was probably the most interesting workshop as talked a lot about credentialing.

Credentialing: probably both national and local commissioning ? based on market forces e.g. genetics and heart disease. Credentials shouldn't' be about removing areas from curriculum to shorten training, if anything probably need to add to curricula to train a generalist. Rather

than have a "Chinese menu" list of credentials need to concentrate on how to set standards for a credential. A good opportunity to think about the needs of tomorrow and be responsive to changing service requirements – dynamic list not finite, flex to respond to service needs.. GMC's Vicky Osgood said that we should be possible to credential from a multiplicity of routes and shouldn't just be a chronological continuation in training, "cherry on top". SAS doctors and other healthcare professionals should be able to access

Paediatrics: Has a national grid. Sub-specialty areas advertised nationally on the grid based on workforce planning e.g. 5 hepatology trainees nationally. RCPCH introduced SPIN (special interest) modules e.g. care of child with epilepsy. These could also be completed by specialist nurse/GP etc.

Anaesthesia: explained the curriculum, spiral learning and then options for two advanced training modules. These modules could become credentials and thereby shorten training by a year to 6 years. Pain medicine could be a set of credentialed skills which could be gained by other groups e.g. G.P's.

Geriatrics: Broad based training and difficult to cherry pick areas for credentials (perhaps some areas like stroke, movement disorders could be credentialed by several groups). Only way to shorten training is to improve it and reduce service requirements.

50% of medical school graduates will become GP's.

Discussion on what is generalism: 1. Chronic co-morbidity, 2. Front door acute – diagnostics – undifferentiated. These would then refer to specialists. Evidence shows that specialists achieve better results. Ninewells – GI opted out of general on-call to provide 24 hour OGD service as have better results than generalists, however then means not taking part in acute on-call and sharing load. What about cardiology - PCI, other specialties? Expectation of Govt that AM/EM problem will be solved by SOTR and won't "buy" plans that don't.

<u>Community/Primary care feedback</u>: 90% of patient contacts are outside hospital. Some potential for GP's to increase scope of practice – e.g. acute medicine. System seems misaligned to patient population, fragmented. Move some secondary care into the community (community hospitals) or patient's homes (hospital at home). Establish credential system for community based care for physicians. This idea would need whole service redesign not just the structure of training to change.

<u>Women's Health feedback</u>: 4 credential areas based on subspecialty areas of training. Commented that we should be working within a managed team structure where knew lever of expertise of members and requirement for support.

<u>Surgery</u>: Suggested that for credentialing proleptic appointments would be useful. No point credentialing if not job end-point using the credentialed skills. Should be credentials in non-clinical areas: leadership, management, QI.

It was noted that if any of the SOTR recommendations were to be implemented Trusts would have to release clinicians working with Colleges and GMC in order to work on logistics and practicalities. Would need a top down leadership approach to ensure that this happened.

Interactive session: We were given voting panels and asked 7 questions:

Question 1: If they decided to proceed with SOTR in July 2015, the earliest that a new curriculum could realistically be commenced would be Aug 2017. How much notice would trainees and trainers need?

1 year- 34%, 2yrs – 45%, 3yrs – 21%

The GMC would require all trainees to move to a new curriculum unless very nearly finished so it wouldn't just effect trainees beginning training but also those in training. There would be a need for Deaneries to prepare too. (Organiser clearly got frustrated by those with experience of writing and implementing curricula saying that it would potentially take longer than 2 years. Seemed to lack appreciation that all would require approval by GMC. Stated that you already have curricula don't you so they would just require a few changes – didn't really seem to fit with principle of SOTR to restructure training into broad based general themes, with flexibility and transferable skills which would require much more widespread change and collaboration between Colleges etc.)

Question 2 and 3 are relevant if SOTR not implemented fully.

Question 2: Aspects of the SOTR could be implemented in a shorter time frame. Would you support implementation of credentialing.

Yes – 69%, No – 31%

Comments that this might be a good idea to implement first – buy in by those completing training. Minimise vacuum between old and new.

Question 3: Would you support a proposal to implement the blurring of primary and secondary care for example by extending GP training ASAP?

Yes – 89%, No – 11%

Comment that this question was not really about blurring interface between primary and secondary care.

Question 4: During transition there will be trainees in the old and new training pathways. Should there be a mechanism for trainees in "old style" pathway will be able to transfer to new pathway and therefore reduce their time to CST?

Yes -79%, No – 21%

Comment from GMC that there will have to be so question irrelevant. The GMC will not approve 2 curriculum to run in parallel and there would have to be a strategy in place to move trainees to new curricula. (This sort of demonstrated how little the member of the steering group chairing this session knew about implementation of curricula).

Question 5: If old and new curricula trainees are applying for consultant posts should they set a date when all doctors with a CST can apply for any consultant post?

Yes – 33%, No -67%.

Comment that didn't matter which curriculum trainee had followed but that they would need to fulfil person specification to apply. Also related to previous question that as all trainees would need to transfer to any new curricula that this should not really be an issue for long.

Question 6: Some specialties will be ready to proceed sooner that others – should all curricula change at the same time?

Yes – 80%, No – 20%.

Comment that surely this was the whole point that we would changing the specialty themes to broad based themes and so specialties as they are now wouldn't exist. And if there were to be the principle of flexibility and transferable skills that all curricula would need to be reviewed and introduced in tandem. (Again this seemed to demonstrate an innate misunderstanding of the reviews recommendations as most understand them and also a determination to keep harking back to the historical specialty themes that we have now.)

Question 7: SAS doctors make an important contribution to the delivery of healthcare across the UK. These doctors will be able to credential in order to deliver specific skills. Should a defined (preferential) pathway to CST be developed that will acknowledge their current skills levels?

Yes -40%, No – 60%

Comment: Felt a special case should not be made and they should continue to be able to enter specialist register via a CESR route.

(This last session left me feeling that there was a certain amount of commitment from Govt via steering group to do something if not implementing all recommendations. Perhaps why they asked the questions about only implementing credentialing. The continuing use of historical specialty themes made me think however that they were less inclined to radical change and that this all might be change in order to show they had done something without actually changing very much at all in practice. An expensive exercise no doubt as I am sure

most curricula already contain competencies about looking after the acutely unwell, it is just not taught or assessed well.)

Present: Sarah Gibb (GAT Chair), Annemarie Docherty (GAT Hon Sec), Gethin Pugh (RCoA Trainees and AoMRC TDG), Debbie Nolan (RCoA Council), Anna Batchelor (Dean FICM).

(Also President's of Colleges, PG Deans, GMC representatives, AoMRC trainee reps, Workforce planners, NES reps, Scottish Govt reps)