AAGBI response to the Shape of Training Call for Evidence consultation 07.01.13

1. Over the next 30 years, how do you think the way patients are cared for will change?

Patients are likely to become better informed about the options and choices available. The doctor's role will need to include in depth discussion of risks and benefits, and sign-posting patients towards appropriate treatments. Doing this effectively requires experience and expertise – hence, better quality information systems, and a demand for consultant delivered care.

In anaesthesia, patients are likely to expect a consultant delivered service, provided at their convenience. This is likely to include a 24 hour consultant anaesthesia service in acute specialties such as obstetrics, ITU, emergency surgery, and potentially for surgery done in the evenings and weekends.

There will need to be a better link between primary and secondary care so that the patient journey is streamlined. The UK is still under doctored compared to European comparators and a consultant delivered system is likely to lead to an expanding consultant workforce.

The required rationalisation of hospitals will involve challenges due to the geography of the UK. This may lead to problems in areas where services have been reduced or downgraded. We also worry that devolution may further alter the dynamics between patient and doctors as different models may develop in Wales, Scotland and Northern Ireland.

2. What will this mean for the kinds of doctors that will be needed in primary care? In secondary care? In other kinds of care?

In anaesthesia, we will need to ensure there are sufficient people in training to meet the needs of the workforce of the future, based on population demographics, based on the knowledge that an ageing population will require more, and more complex care.

The fastest growing section of the population consists of those over 85, set to increase by 350% within the next 20 years. Education curricula for medical students and doctors will need to reflect the needs of the ageing population.

It is likely that the need for acute hospital care at secondary and tertiary level will increase not decrease as the expectations of the ageing population rise. There is clear evidence that operating as soon as possible after an injury/emergency (e.g. hip fracture /laparotomy), with consultant delivered care leads to better outcomes.

There is currently a gap between primary and secondary care in the service delivered to patients. Patients do better if they can return as quickly as possible to their home environment. In future we will need a new set of doctors who can manage the transition of care between the acute hospital sector and the community, leading to earlier discharge from hospital and better quality recovery.

There will be a need for transferable skills between medical disciplines and settings of care so that some of the tasks are shared. For example, rehabilitation medicine could be shared between primary and specialists in secondary care, but the individuals could work in both environments.

3. What do you think will be the specific role of general practitioners (GPs) in all of this?

Primary care will still have an important "sieving" role diagnosing those patients who need to see a "specialist". However, there will be an onus on primary care to manage more long-term conditions within the confines of primary care.

4. If the balance between general practitioners, generalists and specialists will be different in the future, how should doctors' training (including GP training) change to meet these needs?

The components of enhanced recovery including postoperative pain relief would be an essential component of training for hospital and primary care doctors caring for patients in the surgical specialities. Anaesthesia training should reflect the importance of continuing acute care in the primary care environment, which would include particular attention to pain relief at home, working in partnership with primary care doctors.

It may be better to make medical training "modular", similar to the credit scheme that is used in some university degrees. This would enable the medical workforce to be more rounded, and to pick up areas of specialist training as and when required. This may not necessarily reduce the length of training.

On a cautionary note, there is a danger that radical changes in relative numbers of doctors in different disciplines based on untested dogma may lead to destabilisation of certain medical specialities; there are a number of examples of how the workforce has been unbalanced in the past, for instance in obstetrics and paediatrics.

5. How can the need for clinical academics and researchers best be accommodated within such changes?

It would be useful to review research priorities across disciplines and to map these against the requirements of the population to devise research projects based on quality improvement and patient centred care models. It is essential to look at patient priorities – and to research key questions that would enhance the quality of patient care.

For example, clinical academics could be encouraged to engage in population studies and research to improve heath service outcomes - for instance, how to best achieve a consultant delivered emergency laparotomy service where patients are operated on within a few hours of

arriving in hospital. The UK does have some good national audit projects, but it would be helpful to look to other countries, notably Sweden, where they have many on going National Registries. In this regard it will be important that the UK has a coordinated research and audit strategy across all nations. For example, there is no system for shared incident reporting across the devolved nations, and Scotland is not part of the National Hip Fracture Database.

6. How would a more flexible approach to postgraduate training look in relation to:

a. Doctors in training as employees?

A key strength of UK training is that trainees work in several different organisations and see different ways of delivering a service as well as different consultants' clinical approach. It would be helpful for trainees to hold 'central contracts', so that they could move between NHS institutions. As mentioned above a 'modular' system of training would allow trainees to gain experience in other disciplines outside their core skill area and at different times in their career.

Reconfiguration of health service delivery may result in significant amount of care being provided by other providers, including in the independent sector. Systems will need to be in place for trainees to access training across all areas of healthcare, irrespective of the particular hospital where this occurs.

b. The service and workforce planning?

Workforce planning should be based on future patient need. Responses to the following questions should guide the numbers of people recruited into the specialty

- How many people per year will need care from anaesthetists, and what level and complexity of care will they need?
- What are the effects of an ageing population, new therapeutic interventions, more preventative care and better non-surgical treatments?
- Which service configurations provide the best quality care: small numbers of large, acute hospitals; large numbers of smaller, local units; and/or an increasing proportion of care delivered in the independent (private) sector?
- Highly trained consultants should deliver anaesthetic care. There may need to be a period when there is a "sliding scale" of on call commitment. This has recently been highlighted in BMJ careers article. It is unreasonable to expect those practicing acute medicine well into their 60's to be resident on call. The realisation that there will be different responsibilities as a career progresses.

A reconfigured system where GPs worked for Trusts and in genuine collaboration with consultants, nurses and advanced healthcare practitioners, all delivering services together, may result in a service that was more efficient, with some people leaving hospital earlier, and with rapid access directly to the service needed, instead of a bottle neck of patients coming through acute admissions and accident and emergency departments.

c. The outcome of training – the kinds and functions of doctors?

The current training in anaesthesia provides doctors who are ready to take up consultant posts encompassing a broad range of surgical specialities. Many will have done further units of training in order to pursue special areas of practice, such as acute and chronic pain, intensive care medicine, paediatrics, regional anaesthesia, cardiac and neurosurgery. This list is not complete.

Anaesthetists are able to obtain a broad view of acute hospital services, and have an important role in medical leadership and management of a service as well as clinical delivery of care to patients.

d. The current postgraduate medical education and training structure itself (including clinical academic structures)?

The current system of competency-based training is based on the need to maximise exposure to different medical specialities in different hospital settings. It would be useful for trainees to have a period of stability part way through training, where the trainee works for a year in one department and learns more and contributes more to the running of that department, which will afford them the opportunity to gain experience in quality improvement and medical management.

7. How should the way doctors train and work change in order to meet their patients' needs over the next 30 years?

Training works well in anaesthesia, and has gained maturity over many years, leading to a workforce that is well trained and with excellent outcomes.

In the future, there will need to be more emphasis on the ageing population in medical schools and in postgraduate courses.

Useful additions would be management training or quality improvement.

Others may want to focus purely on clinical work. The same applies to academic medicine; a scheme like this does already exist in some specialties.

8. Are there ways that we can clarify for patients the different roles and responsibilities of doctors at different points in their training and career and does this matter?

Many patients currently do understand that doctors in training may treat them. It would be helpful to improve ‘sign-posting’ for patients to make the seniority of trainee more clear, as was possible with the previous designation house officer, senior house officer, registrar, senior registrar. In particular, doctors at the end of their training are highly experienced and knowledgeable in their field of practice, and this may not always be obvious to patients and their relatives. The tide of opinion does suggest that the public’s demand for consultant delivered care is growing.

9. How should the rise of multi professional teams to provide care affect the way doctors are trained?

There are already good examples where the traditional barriers in medicine have come down. For example, multidisciplinary teams have transformed trauma care, intensive care and pain management. Many skill sets are transferrable, and the proposed modular training system may mean that individuals from different core training specialties can share duties. This already happens on some intensive care units and emergency departments.

10. Are the doctors coming out of training now able to step into consultant level jobs, as we currently understand them?

The current curricula are designed to ensure that those emerging from training are able to step up into consultant practice. This may be harder in some very technical specialties, and it is the reason why some undertake 'fellowships' to ensure that they have the full range of skills required.

11. Is the current length and end point of training right?

In anaesthesia the current programme is about right for length.

12. If training is made more general, how should the meaning of the CCT change and what are the implications for doctors' subsequent CPD?

We can see little advantage in making training more general in anaesthesia. Anaesthetists have a specific set of skills and each person needs sufficient time and opportunity to develop these skills and to become confident with them in their individual practice. There may be different reasons why medical doctors and primary care doctors need to be trained more generally. It is essential to train the generalist in the acute hospital and primary care setting if continuity of care across all specialities is to be maintained; for these doctors, units of training should be available throughout their career.

13. How do we make sure doctors in training get the right breadth and quality of learning experiences and time to reflect on these experiences?

Good departments protect their trainees from too much service delivery, management pressure and disorganisation, although we recognise that there is much variation across different organisations. Doctors in training should be mentored through their training years, and encouraged to seek out appropriate training opportunities according to their needs/interests and those of the department. It would be helpful to involve trainees more in understanding and contributing to the whole department service.

14. What needs to be done to improve the transitions as doctors move between the different stages of their training and then into independent practice?

Mentoring (with trained mentors), work shadowing and reflection on experience are vital for doctors in training. The organisational culture needs to be one in which each individual should feel comfortable to ask for help and to expect help to come from colleagues, including trust managers and leaders. Many doctors change roles throughout our careers, and we should be open about the challenges this presents to us, and how we try to address these. Currently few consultants are trained to manage colleagues in difficulty or to handle complaints. We should encourage a culture where the trainee is invited into the discussion,

so that they learn, and perhaps help us to learn as well. Mentoring should continue as trainees move into independent practice as a consultant.

15. Have we currently got the right balance between trainees delivering service and having opportunities to learn through experience?

Not quite. Trainees working lives have not improved in many of the acute hospital based specialties, including anaesthesia, obstetrics, acute medicine, paediatrics and surgery. The shift-based system has reduced the opportunities for training, and has lead to a weakening the traditional team structure and sense of training by apprenticeship. This could be improved by a move to a consultant delivered service with modules of training delivered during day time hours, with the addition of training out of hours, as appropriate.

16. Are there other ways trainees can work and train within the service? Should the service be dependent on delivery by trainees at all?

Some service delivery by trainees, suitably supported, is an important part of training. Consultants feel well prepared for clinical work – if we make trainees more supernumerary, then they may well feel less well prepared. This is a very fine balancing act although we appreciate that in many intensive care units and anaesthetic departments consultants already deliver most of the care and take the important decisions. This will be further impacted by the move to a 24 hour seven day a week service, where it would be unreasonable to expect trainees to prop up the system.

General questions about the shape of training

17. What is good in the current system and should not be lost in any changes?

Training in anaesthesia is not broken – we should be careful not lose what is good in the current system, for instance, training to a high level of knowledge and skills in a broad range of specialities.

18. Are there other changes needed to the organisation of medical education and training to make sure it remains fit for purpose in 30 years time that we have not touched on so far in this written call for evidence?

Medical practice is continually evolving and it is difficult to predict what is going to happen in 30 years time. In 1983, patients undergoing routine hernia repair stayed in hospital for seven days, now they remain in hospital for a matter of hours. The need for safe anaesthesia, pain relief and intensive care will remain across the range of surgical specialities, albeit achieved using new technologies and techniques. Medical education for anaesthetists will need to focus on delivery of safe effective healthcare, within a multidisciplinary workforce, according to the needs and demands of society.

Any other comments?

The Association of Anaesthetists believe that the views of doctors currently in training are very important to this call for evidence, and as such a separate document will be submitted by the Group of Anaesthetists in Training (GAT).

The AAGBI welcomes measures that will improve the safety of patients within the current medical system in the NHS. However, all change must be thoroughly tested. The mistakes of MMC are still in the recent memory of many trainees and consultants.

About You

Finally, we would appreciate you providing the following information about yourself to help us analyse the consultation responses.

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Would you like to be contacted about the Shape of Training review in the future?

Yes ✔ No