24 October 2012

Expert Advisory Group

SHAPE OF TRAINING

3

To consider

What employers want from postgraduate medical education and training

Issue

1. This paper looks at some of the workforce pressures faced by employers when providing postgraduate medical education and training. It considers how doctors' training could change to address these challenges and how the review will explore these issues with key stakeholders.

Recommendations

2.

a. To discuss issues and possible options for reforms to postgraduate medical education and training that meets the needs of employers (paragraphs 8 to 40).

b. To seek feedback on these issues and possible options with employers as part of the evidence informing the review (paragraph 41).

Further information

3.

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Background

4. In 2007, the independent inquiry into Modernising Medical Careers, led by Sir John Tooke made a number of recommendations about the shape and structure of postgraduate medical education and training in the UK.[1] It called for a more flexible and broad based approach to training, integrating both training and service objectives into workforce planning. The inquiry also raised profound issues about the role of trainees, SAS doctors and consultants within the service and the implications of the Certificate of Completion of Training (CCT) on training and practice. It recommended more clarity and a shared understanding of the role of all doctors within the multi-professional team, including the contribution to service delivery by trainees.

5. Following on from Tooke, other inquiries also highlighted the need to develop the current structure of postgraduate medical training so it continues to provide consistent, high quality and fit for purpose training for doctors throughout the UK.[2] They too have pointed to the need for more flexibility in order to equip doctors to respond better to the changing needs of patients and the service.

6. On 17 July 2012, the Shape of Training Expert Advisory Group considered the drivers changing the way doctors will work such as rapidly changing medical and scientific advances, evolving healthcare and population needs, changes to healthcare systems, the information and communications technology (ICT) revolution and ever changing patient and public expectations. These demands will inevitably impact on how doctors are trained to respond to these emerging trends.

7. This paper sets out some of the challenges with the current structure of postgraduate medical education and training faced by employers. It is based on desk based research and information from organisation such as NHS Employers. The paper also explores possible ways that training could be changed to address the needs of employers to help generate debate. These propositions will be explored and tested through the review's formal evidence gathering processes. We will take account of the views and positions of all the different stakeholder groups including trainees, patients and the public, trained doctors, those involved in education and training and employers.

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[1] *Aspiring To Excellence: Final Report of the Independent Inquiry into Modernising Medical Careers*, led by Sir John Tooke, January 2008, http://www.mmcinquiry.org.uk/Final_8_Jan_08_MMC_all.pdf

[2] *High quality care for all: NHS next stage review final report*, Professor Lord Darzi, June 2008; *Foundation for Excellence: An evaluation of the Foundation Programme,* Professor Jon Collins, October 2010; *Scottish Foundation Programme Review Report*, Dr Alistair Cook, November 2010; *Time for Change: A review of the impact of the European Working Time Directive on the quality of training*, Professor Sir John Temple, May 2010.

Discussion

8. In this paper, we use the term ‘employers’ in a general sense for any organisation that employs or contracts doctors’ services. The majority of these organisations, especially where training is provided, take place in the NHS. Within the service, the structure of how doctors are trained and employed varies across countries and between local and regional areas. We recognise that much is in flux with substantial changes being implemented in England as well as a review of the medical workforce in Wales.

9. Organisations that employ junior doctors face several challenges when managing their responsibilities for medical training, service delivery and patient care. Potential reforms to postgraduate medical education and training will have to mitigate tensions between these responsibilities both in the short term and when planning the workforce in years to come.

10. The balance and shape of the medical workforce and the need for more flexible training are likely to be core areas for organisations that employ doctors. Employers are concerned with providing medical care that is adaptable to changing patient needs and ensuring their doctors are able to meet those needs. They must anticipate the number and kinds of doctors needed for their service and aim to have the right level of medical staff to provide safe and effective care.

11. Employers also want to provide a positive, flexible and innovative work environment for their medical staff. They have to make sure junior doctors are properly supervised and have enough training opportunities (and of the right kind) to become safe and experienced practitioners.

12. Pushing against these workforce and employment demands is the pressure to provide a good value for money in an ever tightening financial climate. They must also be balanced by the expectations of patients and aspirations of trainees. The patient and trainee perspectives are considered in more detail in items 4 and 5.

13. In this paper, however, the key question is whether the current system of education and training delivers what employers need and, if it does not, what sort of model might do so.

Supplying the medical workforce

Size of current medical workforce

14. The number of trainees and consultants working in the UK is set to rise over the next five to ten years as medical students and trainees progress through their careers. Currently, the medical workforce is composed of[3]:

a. Over 41,000 medical students

b. 14,851 Foundation Programme doctors

c. 40,991 doctors in specialty training consisting of 9, 500 junior doctors training to be GPs and 31, 000 becoming other specialists

d. About 46, 500 consultants and 43, 500 GPs are working within the NHS with 71,307 doctors listed on the Specialist Register and 61,156 doctors listed on the GP Register.

15. If the number of medical students remains the same or increases and there are no substantial changes to the way doctors are trained and employed, the number of fully trained hospital doctors will increase by over 60% to 60,000 by 2020.[4] The question then becomes how does the service make effective use of these doctors and if consultants are doing more within the service, should that result in a different approach to trainees as part of the workforce?

16. There is also the issue of affordability of a service that employs more consultants. The Centre for Workforce Intelligence (CFWI) estimate the salary cost of a larger consultant workforce could reach £6 billion by 2020.[5] The review will need to consider the impact of changes to the current postgraduate training structure will have on the service, including value for money.

Changing work patterns

17. Employers have to take into account the changes to work patterns and how the medical workforce is managed at local levels. All doctors are now limited in the number of hours they work because of the Working Time Regulation (WTR). Both trainees and Local Educational Providers (LEPs) have found it challenging to complying with the WTR, particularly when managing rotas, gaps in rotas and work

[3] Information on the medical workforce is based on 2011 from the GMC S*tate of medical education and practice,* September 2012 and the British Medical Association April 2012 *Briefing note on the 2011UK medical workforce*.

[4] CFWI, *Starting the debate on workforce numbers*, 2012.

[5] Ibid.

load intensity for all doctor grades.[6] Tensions are particularly evident when service pressures compete with time for training and education activities. Trainees now have fewer hours and opportunities for training experiences. They also have less access to senior doctors and consultants, particularly in the evenings and on weekends.[7]

18. The medical profession is also shifting towards more flexible work patterns and part-time working. This trend, driven to some extent by an increasing numbers of women becoming doctors, will become more prominent as the current training cohort comes into its own. Flexible working helps keep highly trained doctors working effectively within the NHS throughout their careers.[8] But there are challenges in adapting the current and somewhat rigid training and service structures to cope with growing numbers of people seeking flexible work arrangements and career breaks.[9] For example, some specialties, particularly those with a higher proportion of female doctors in training, face some workforce difficulties. The Royal College of Paediatrics and Child Health has reported problems in filling middle grade rotas, with consultant paediatricians increasingly having to cover middle grade duties as a result.[10]

19. A service that relies more on consultants and trained doctors working in teams that include trainees could help mitigate problems in covering shifts and gaps in the rotas. A move towards a more general and shorter training programme could also result in a larger number of doctors able to deliver front line services – the areas that tend to struggle with frequent gaps in staff coverage.

Recruiting into specialities

20. While some specialties struggle to fill posts, other specialties attract fierce competition, often in areas where there is a need for a smaller number of specialists. For example, some specialties such as paediatrics, psychiatry and emergency medicine have reported lower competition rates for training places than more popular specialties such as surgery.[11] Employers rely on a robust supply of trainees recruited

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[6] WTR research by GMC – unpublished until end of October 2012. Summary available at: http://www.gmc-uk.org/04___Working_time_regulations_research_update___report_of_the_primary_study.pdf_49994882.pdf

[7] AoMRC, Report on consultant-led care, 2012; John Temple, *Time for training*, Medical Education England, 2010; GMC National Training Survey 2012.

[8] Royal College of Physicians, Women in medicine, 2009.

[9] D. Roland, P. Dimitri, V. Walker: The extent and effect of the recruitment crisis in the UK trainee paediatric workforce. *The Internet Journal of Healthcare Administration*. 2010 Volume 7 Number 1.

[10] Royal College of Paediatrics and Child Health (2009) *Modelling the Future III: Safe and sustainable integrated health services for children, young people and adults* London, RCPCH, p94

[11] Medical Specialty Training (England) Competition Information 2012. Available at: http://www.mmc.nhs.uk/ specialty_training/specialty_training_2012/recruitment_ process/stage_2_-_choosing_your_specia/competition_ information.aspx [Accessed on 9 August 2012]

into specialty training to deliver large parts of the service. Difficulty in recruiting into specialty training has, in some cases, resulted in junior doctors already in post or locum doctors filling in the rota gaps, raising patient safety issues.[12]

21. The CFWI warned that, all things being equal, some specialties such as neurology if projecting forward from current numbers will not meet demand by 2020 while others such as anaesthetics and general surgery need to make moderate reductions to their training numbers. It anticipates a shortfall in England in the number of GPs and suggests GP training posts should be increased to ensure over 3,100 GPs are produced each year while specialty posts should be reduced to produce roughly 2,700 consultants each year. Pressures like this could be lessened if we adopt a training structure that allows doctors to transfer more easily across specialties and programmes. As workforce needs change, doctors could retrain relatively quickly to fill any potential gaps.

22. Challenges also abound in recruiting into specialities within some geographic areas. The Wales Deanery recently reported a recruitment crisis in many specialties. It has raised concerns that hospitals will not be able to provide adequate training. If this trend continues, it may result in closures to some medical services.[13] Similar issues have been raised for other rural or isolated parts of the UK.

23. These supply side workforce pressures, along with the growing demand for a healthcare system tailored and driven forward by patient expectations, mean we can not maintain things as they are now. In order to respond to these changes, employers want more control over the planning and managing of their medical workforce, including how they use and support junior doctors.

A flexible medical workforce

24. Dame Julie Moore, Chairwoman of the NHS Future Forum's education and training group, summed up one of the main difficulties facing employer organisations:

> 'The problem with workforce planning is I can say next year that I need more ENT surgeons, but it takes 10 or 12 years to make one and by the time you make one somebody might have invented a cure. There has always been that tension in the system and we have never ever been very good at workforce planning. One of the ways to get round that is that we believe there should be more flexibility in training so that, if somebody did invent a cure that meant you did not need a certain specialist, or you needed far fewer, then it would not take for ever to retrain somebody.'[14]

[12] GMC, State of medical education and practice, 2012.

[13] BBC new (web) http://www.bbc.co.uk/news/uk-wales-19778640

[14] Dame Julie Moore giving evidence to the House of Commons Health Committee, 24 January 2012.

25. Employers want a system that future proofs their medical workforce. Employers argue flexibility at a workforce level requires a mix of doctors, trained both as generalists and specialists, who can provide care in different settings and in a range of ways. Studies show that more specialists involved in community care as well as the use of generalists in co-ordinating hospital care results in better patient outcomes, higher levels of patient and staff satisfaction, and reduced hospital stays and emergency re-admissions of acutely ill patients.[15]

26. But perhaps more crucial is a medical workforce able to adapt quickly to local pressures or to accommodate shifts in medical care and the way the service is delivered. The current structure of training and career development focuses on moving quite quickly trainees from a level of general knowledge and skills into specialities, some with very narrow areas of practice. If things then change, employers need doctors who can meet these new demands. Under the current structure, employers are faced with recruiting doctors who already have the right knowledge and skills or retraining their medical staff over many years (if indeed they want to retrain). In either case, it means potential gaps in service delivery, upheaval to teams, less continuity of care for patients and poor value for money.

How to make the medical workforce more flexible

27. Employers are keen to develop a training structure that meets their demands.

Training and education driven by service needs

28. A training structure driven by employers and linked to local needs is one mechanism for injecting more flexibility into the medical workforce. Employers would be able to identify learning opportunities for their teams and service delivery including all grades of doctors.

29. This is the thinking behind changes in England. From April 2013, the healthcare workforce's education and training will be commissioned and managed by employers. This move is meant to give providers greater accountability to plan and develop their workforce within multi-disciplinary teams. Local organisations, linked to Local Education and Training Boards (LETBs) for strategic oversight, will take responsibility for deciding what learning is necessary to make sure their staff are competent and meet the needs of the local community.[16] Discussions are happening in the other UK countries about aligning medical education and training more closely to service structures. However, there are potential risks in this approach to medical training, such as lack of transportability of competences if

[15] Kings report page 30 – insert references to research studies

[16] DH, Liberating the NHS: Developing the healthcare workforce, January 2012 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_132087.pdf

training is devolved entirely to local needs and the need for training to be within a regulatory framework to maintain standards.

Different ways of training

30. With more control over training, employers will be well placed to recruit and train the kinds of doctors that will be most relevant for their local patient population.

31. Two reports published recently challenge the current way healthcare is delivered in the UK. Both the Royal College of Physicians and the Royal College of Obstetrics and Gynaecology suggest the NHS can no longer cope with a large number of specialists spread across several hospitals. More care should take place at general practice surgeries or community hospitals and facilities. Specialised care should be delivered in specialised centres by people who have substantial experience with difficult and complex cases.[17]

32. A change in the way healthcare is delivered will inevitably change the way doctors train. More doctors will increasingly work within community based teams away from the more conventional hospital based settings. Employers will need substantially more doctors with a strong grounding in generic knowledge and skills coupled with the ability to manage not just the clinical diagnosis but the interface between different services and specialists. Specialised centres will need doctors steeped in detail of particular specialties, but in far fewer numbers. In terms of future training, this might point towards a more general approach to training leading to a doctor who can provide care in community and acute admissions settings. Doctors could then go on to further specialise through modular programmes.

33. Setting aside the increased cost implications, employers would benefit from a medical workforce made up largely of trained doctors in order to better manage the day to day rotas, make sure patients see the right doctors and provide trainees with more support and supervision. Work by the Academy of Medical Royal Colleges on the benefits of a consultant-led service points towards a structure in which trainees provide far less service delivery.[18] Evidence suggests this approach results in better patient outcomes as well as more effective training experiences. Trained doctors undertake many of the roles and responsibilities once reserved only for trainees. Patients always have access to a highly qualified doctor who can rely on years of experience. Trainees have better supervision and support but are not relied on to deliver substantial parts of the service.

34. In *Time for Training*, Temple recommended that only departments and/or hospitals that can deliver high quality training and provide resources and support for

[17] Royal College of Physicians, Hospitals on edge: Time for action, 2012; N Timmins, *Tomorrow's Specialist: The future of obstetrics, gynaecology and women's health care,* Royal College of Obstetrics and Gynaecology, 2012.

[18] AoMRC, *The benefits of consultant-delivered care*, 2012.

this should be designated as training locations.[19] With an increasing number of consultants providing care, employers may choose to limit training to particular locations or teams where more training resources could be funnelled.

Adjusting work patterns

35. Where junior doctors are in training, employers have reported they sometimes struggle to build effective teams.[20] Most specialty trainees rotate through different posts every 6 to 12 months once they have completed the Foundation Programme. Trainees benefit from this work pattern because they get more experiences and learning opportunities. But employers often find these short timeframes make it difficult to plan out work loads, rotas and development opportunities for the rest of the team or unit. They also raise concerns that by constantly changing key team members, it affects the way the team works. Research on how teams work found that where teams are functioning poorly, there is less cohesion, leadership, innovation and quality of care. [21]

36. The current structure of the medical workforce often results in no or few senior staff working on weekends or evenings. Employers then have to rely on locum doctors and trainees to meet service needs, raising patient safety concerns and providing poor levels of supervision.[22] Moving towards more shift based rotas for all grades of doctors could alleviate this gap. For example, Birmingham Children's Hospital has adopted this approach by reducing the number of junior doctors and increasing the number of consultants. They have developed a 'sliding scale of intensity' rota system to provide consultant delivered care in the pediatric intensive care unit. This resulted in a new consultant working pattern: the number of consultants on duty at any one time rose from one to two, and twilight consultant shifts (a consultant present until midnight) were introduced. The net financial cost of this change in workforce was zero: the increased cost attributable to the consultant salaries was offset by the reduction in junior doctor posts.[23] This move towards shifts would allow trainees to experience different learning opportunities at different times of the day in a supervised capacity.

More granularity of roles at the consultant level

37. Employers have raised the idea of introducing a more flexible approach to trained doctors. As the number of consultants increase and more care is delivered by trained doctors, it would be more cost effective to have different levels within the

[19] John, Temple, Time for Training, May 2010.

[20] Medical Education England, Employer workshop for Phase 1 Shape of training project, 2011.

[21] C Borrill, The Effectiveness of Health Care Teams in the National Health Service, 2011.

[22] GMC, State of medical education and practice, 2012; AoMRC, The Benefits of consultant-delivered care, 2012.

[23] A Plunkett et al., A sliding scale of intensity: novel rota system for consultant delivered care, *BMJ Careers*, 31 Aug, 2012.

consultant grade[24]. If one were to accept this model there would be no assumption that doctors would progress through the different grades, rather it would be determined by their professional development and job planning processes. In this scenario, doctors just out of training would work in more junior and supported roles. If appropriate they would then move into positions where they would manage teams or units, become trainers and take on more leadership roles. Finally, some doctors would move to a more senior and strategic role. Doctors would draw salaries appropriate to their level.

38. Indeed, if training shifts towards a more general broad-based approach, then the majority of doctors would be delivering front line care to patients. But they will still need some supervision and support as they build up their experience. For some of doctors, they may go on to build a career as a generalist and would move towards more management type roles. Other doctors may decide to further specialise and become experts in particular areas.

How could training change to meet em

39. Employers want a training structure that allows them to address local needs when they arise. Possible approaches that could address concerns from their particular perspective include:

a. Introducing an opportunity for trainees, who have completed two or three years of training, to work within the service for a period of time to consolidate their learning before completing their training leading to a CCT. Sub-specialisations would happen post CCT based on the needs and sponsorship of their employers. Doctors would begin to work at a much earlier stage in their careers, without many of the restrictions imposed by training programmes. They would be able to provide diagnoses and broad levels of care as well as potentially fill gaps in some front-line services such as emergency care. Doctors would work in different environments and in different ways, helping them to think about their future career options before finishing their specialty training.

b. Introducing a much shorter training period (five years) in which doctors would receive general specialist training leading to a CCT. Crucially different from the first model outlined above, training would not be interrupted by a consolidation period. Trainees would still work under supervision and continue to be assessed against training requirements. Most doctors would enter the workforce as generalists within specialty areas, either in the community or in a hospital, depending on workforce and patient needs. Further specialisation would take place post-CCT through credentialing or modular training.

[24] CFWI models paper

c. Developing a period of consolidation for doctors after they complete general medical training. During this period, they would work with consultants in a more supervised role in order to gain experience within a specialty - almost like apprenticeships. Eventually this work would lead to formal specialty training.

40. One other consequence of a service-driven approach to training could be to divorce the CCT from the Specialist or GP Register – a recommendation of the Patel Review.[25] Doctors would work within the service while undertaking formal post-CCT specialty qualifications, informed by service needs and supported by employers.

Recommendation: To discuss issues and possible options for reforms to postgraduate medical education and training that meets the needs of employers.

41. To test and develop these ideas further, we will give employers the opportunity to feedback to the review through seminars, the written call for evidence and oral evidence sessions. We are also discussing these issues with CEOs and Board members at various hospital and primary care sites throughout the UK. We have developed an extensive stakeholder list that includes both national bodies such as NHS Employers and local bodies such as individual trusts and boards.

Recommendation: To seek feedback on these issues and possible options with employers as part of the evidence informing the review.

Resource implications

42. As we begin to explore and develop potential reforms for the future shape of postgraduate training we will identify the resource implications of the different options.

Equality

43. The review will consider the impact of its recommendations on patients, doctors, trainees and medical students. We will include specific questions and opportunities to feedback about equality issues through our formal evidence gathering activities.

Communications

44. Information about the review will be available on the Shape of training website.

[25] Lord Patel, Recommendations and Options for the Future Regulation of Education and Training, GMC, 2011.