19 December 2012

Expert Advisory Group

SHAPE OF TRAINING

6

To consider

A possible approach to postgraduate training

Issue

1. This paper looks out some possible ways postgraduate training could be restructured in the future. It builds on the evidence and information set out in items 3, 4 and 5 and anticipates a mixed model of generalists and specialists working across different care contexts.

Discussion point

2. To discuss possible options for the organisation of postgraduate training in the future (paragraphs 7-21).

Further information

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Background

4. On 24 October 2012, the Expert Advisory Group asked us to flesh out possible approaches to the way postgraduate medical education and training could be reorganised. Members asked for more concrete examples of what training might look like in the future, in light of discussions and feedback from stakeholders.

5. This paper builds on the ideas and themes drawn out from the review activities in item 5 and some of the issues discussed in items 3 and 4. It anticipates a mixed model that emphasises broad based training for most doctors but recognises the continued need to train specialists.

6. This paper does not set out the direction of travel or any agreed proposals or recommendations of the review. It does not reflect an agreed approach or suggest the model in the paper is the way forward. It is intended to illustrate a possible way of organising training to stimulate discussion and debate by members. Comments and feedback on this approach or any other ideas and models will help us identify and focus further work for the review.

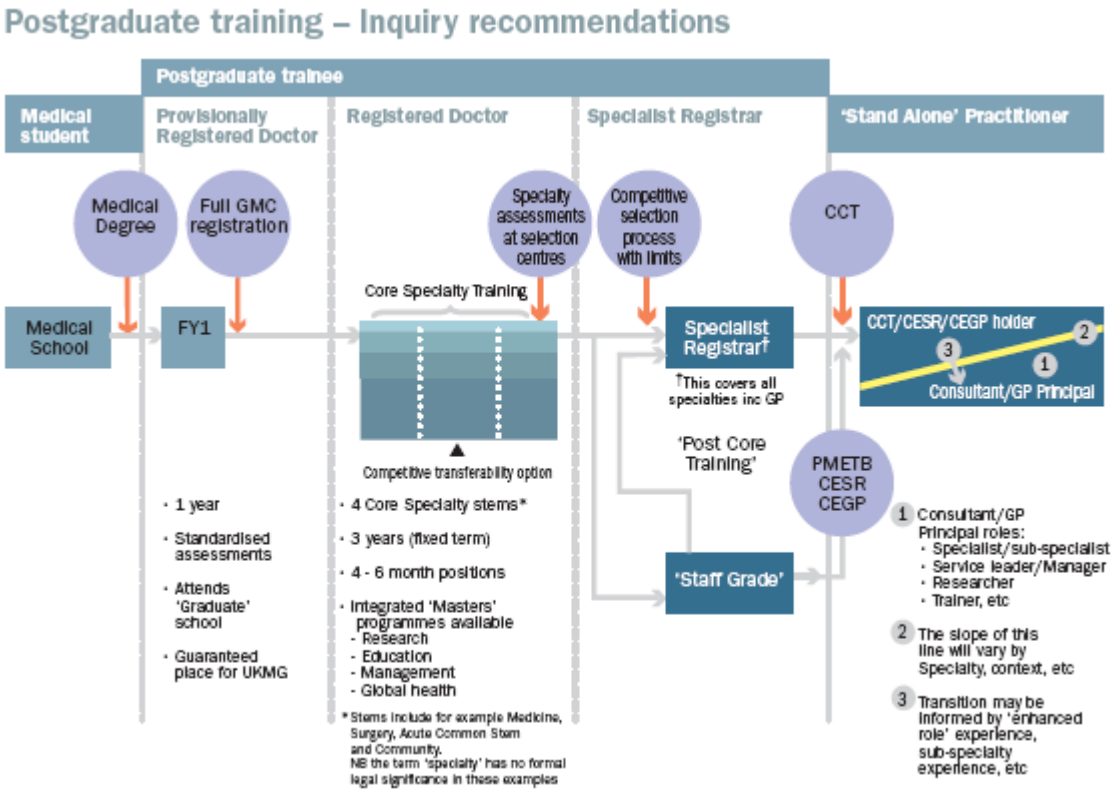
Discussion

Are doctors already training in this way in the UK?

7. Medical practice in the UK is fairly specialised with most doctors training in discrete medical fields once they have completed the Foundation Programme. In *Aspiring to Excellence* led by Professor Sir John Tooke, concerns were raised that doctors needed a far longer period of their training dedicated to providing them with broad based competencies.[1] The report recommended doctors should initially train in only a small number of defined types of core programmes in the first few years after the Foundation Programme, such as medical disciplines, surgical disciplines, or family medicine. These programmes would be the stems for specialty training. This approach is shown in Figure 1.

[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

Figure 1 from Aspiring To Excellence: Final Report of the Independent Inquiry into Modernising Medical Careers, 2008



8. To some extent, many doctors are already training in general programmes within medical disciplines such as general surgery, general medicine, and general psychiatry. During the early years of these programmes, they are provided with a broad grounding across the field. For example, a General Surgery training programme provides a background in all areas of general surgery, over the first two years of rotation, followed by more specialised training during the final years.

9. Recognising we may need to train more generalists, are there ways of adapting the current training structure to make sure most doctors train in more general disciplines as suggested by the Tooke Inquiry (see figure 1)? Are the current general training programmes already adequately providing doctors with general knowledge and skills? These general programmes still involved roughly eight years postgraduate training including the Foundation Programme. Arguably, doctors on these general training programmes begin to specialise during the core years into more specialised areas. An even more general programme following on and building on the Foundation Programme may better meet patient and service needs in the future. But with this approach, do we need to avoid it becoming an extended Foundation Programme?

10. A number of doctors move quickly during their training into very narrow practice areas without spending substantial time developing general capabilities. For example, doctors training in neurosurgery complete an eight year, run through training programme after the Foundation Programme. The initial stage incorporates a first year of core knowledge in the clinical neurosciences. During the next two years, trainees undertake one or more placements in complementary surgical disciplines to acquire core surgical skills and knowledge. By the end of the third year, all trainees will have done a minimum of 12 months' full time training in basic neurosurgery. The intermediate stage provides two years in full time general neurosurgical training. The final three year stage encompasses advanced neurosurgical training and incorporates a final year of training in one of the neurosurgical sspecial interest areas. There will always be a need for doctors with highly specialised knowledge and skills. The challenge is getting the balance right between generalists and specialists.

11. Most specialties could benefit from doctors who can help manage particular medical conditions but with an understanding and overview of other factors affecting their patients and impacting on care. It may be the case that for some craft specialties, it could be better for doctors to focus directly into these specialties and subspecialties without first acquiring a general level of training. But in the future these numbers might be much smaller than now. These doctors will not have sufficient general capabilities to provide care outside of their narrow scope of practice. They will also have much less flexibility in moving between specialties or care settings.

12. Postgraduate training (including the Foundation Programme) takes at least five years for GPs and up to ten years for specialists. In many other jurisdictions, doctors work relatively unsupervised in front line and acute settings after four or five years of postgraduate training. Their approaches are bound by the healthcare system in which they train. But are there ways of reorganising the current structure in the UK to produce doctors who can provide broad based care at an earlier point in their training? A training structure with different way points (rather than an end point), coupled with a much more regulated approach to learning and development throughout doctors' careers may provide some solutions. The legal and regulatory issues raised by changing the structure of postgraduate training are discussed in item 5.

13. Doctors in training who want to pursue both a clinical and academic career also need a system that gives them the flexibility to develop their technical skills while furthering their research areas or developing a grounding in teaching, leadership and management. These doctors may take a generalist approach and then pursue their research work or may focus their career quite narrowly right from the beginning. The way training is organised, then, should accommodate flexibility for all trainees to develop their career in the way that best suits their interest. However, these numbers and posts will continue to be limited by funding and competition. A more flexible approach would also allow doctors in academic training

move in and out of clinical work without leaving training programmes, provided they remain competent and safe in their clinical practice.

What might postgraduate training look like in the future?

14. We are thinking about a move towards more general training during the first phase of a doctor's postgraduate career. However, this initial idea on how training might be reorganised should not preclude other options. It is meant to stimulate discussion and offer a model to build on or push back against and suggest other ways we may want to develop our thinking. It is not an agreed approach and may not be the best approach. We will also consider the feedback from the review activities, the call for ideas and evidence and the oral evidence sessions before setting out a specific direction of travel.

Insert FIGURE HERE

15. A general level of training would be geared towards producing a doctor who can provide a general and broad based level of care to patients who have undifferentiated or multiple conditions. A more general approach would allow most trainees to choose one of a small number of broad specialty stems/families rather than pursuing a narrower specialist career immediately after foundation training. Doctors would train to the point where they could deliver competent general care within the community and acute admissions settings. GPs could also train within this broad specialty structure, but would focus on specific elements related to primary care towards the end of this training period. General training may have different way points with some doctors developing capabilities to manage acute admissions. Generalists could then go on to extend their broad based knowledge and skills and gain further experiences, which may take as long as or longer than some specialty training.

16. However, this approach should not preclude opportunities for some to move more directly into narrower specialist training. It must also ensure opportunities for doctors to become experts in particular fields where care needs to be provided for those with rare or specific conditions. But even in these highly specialised areas, some opportunity to train in related areas of medical practice would help doctors treat the patient as an individual, not a condition. In other words, what is needed is a different balance between doctors with generalist and specialist skills, along with the ability for doctors to retrain or acquire further training to meet changing needs, and an approach to training which makes this possible.

17. Doctors training to become generalists should be able to hone their knowledge and skills throughout their careers or develop a more specialised focus through modular learning and credentialing if it is needed and supported within the local work environment. Doctors' training should no longer be aimed towards an end point but rather have way points that recognise a certain level of knowledge and skills have been achieved. As doctors progress through the system, they would move

from very hands on supervision towards one of independent practice, supported by a mentor or supervisor. How doctors progress through their training would be based on meeting competencies and outcomes. These would be achieved in different ways and in different lengths of time depending on doctors' in training capabilities, area of practice, and the setting in which they practice and their experiences. This approach, that credentials progress, might help mitigate some of the difficulties associated with the Working Time Regulations and the New Deal. Once they have reached a general level of competence to deliver independent but supported care (a Certificate of General Training), they would be able to continue their personal and career development through modular learning. Learning during this phase would be linked not only to doctors' interests but also to job plans and local workforce needs. They would not necessarily be limited by a specific length of training.

18. Training, like service delivery, should cross the boundaries between different care settings to provide integrated care. Learning opportunities should not be limited to primary or secondary care. Training would take place in the context that is most relevant for their areas of practice. Some training should also be undertaken alongside and with other professions that deliver care within the team. Doctors' roles in the future might be very different than they are now, with more technical aspects moving to other healthcare professionals. But doctors will be expected to make decisions when outcomes are uncertain.

19. A new approach to training may in fact be a return to some of the elements that were built into earlier training structures with a stronger emphasis on doctors in training undertaking an apprenticeship, linked to one specific clinical teacher. They would be attached to one trainer who would make sure training focuses on competencies and outcomes needed of the individual doctor in training. This approach would help both parties build confidence in individuals' knowledge and skills and allow them to move towards more independent practice as that confidence builds.

20. But this approach is limited by the current training and service configuration. Doctors in training often fill gaps in rotas and usually link to different consultants depending on rotas. To develop an apprenticeship model, doctors in the early years of their training may have a more supernumery role in service delivery. This would allow them to couple their rota to their teachers. But as they progress in their training, they would be able to provide more independent service with their teacher shifting toward providing mentoring and support.

21. A move towards apprenticeship in postgraduate training would have to address concerns and issues with negative experiences and role modelling. Some formal recognition of trainers' roles as part of their job plan might help attract people to develop their teaching and training skills.

> **Discussion point:** To discuss possible options for the organisation of postgraduate training in the future.

22. The Centre for Workforce Intelligence estimates the increase in consultant numbers will cost the service over £6 billion in additional salary costs by 2020.[2] Given the pressures on the service, the health service in the future might not be able to support a consultant workforce as we understand the consultant role now. But leading organisations like the Academy of Medical Royal Colleges are advocating for 24/7 consultant led service because it provides better patient care and better quality of learning for doctors in training.[3] Little work has been done on the cost effectiveness and value for money on the impact of a service delivered by more consultants.

23. If we are moving towards a 24/7 system, how will our understanding of the consultant role change within a new training structure? As we develop our thinking about the organisation of training in the future, should we also consider how this may impact on the service and the way doctors may work in the future. Any thoughts or ideas on these issues could be explored at the next meeting.

Resource implications

24. 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

25. 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

26. Information about the review will be available on the Shape of training website. This paper is meant to provoke discussion and debate about some of the emerging issues in this review, which will be revisited and refined through the written responses to the Call for ideas and evidence and the oral evidence sessions.

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

[3] AoMRC, *Report on consultant-led care*, 2012.