Expert Advisory Group meeting

Approved

Minutes of the meeting on 19 September 2013

Members present

David Greenaway
Tom Dolphin
Paul Stewart
Clare Marx (TC)
Peter Nightingale
Bill Reid
John Jenkins
Angela Coulter
Peter Dolton
Ajay Kakkar

Staff Present

Vicky Osgood
Jessie Moye
Paula Robblee
Stuart Carney

Apologies

John Savill
Malcolm Lewis
Susan James
Richard Marchant

Item 1 - Chair's business – Update on activities of the review

1. DG updated the group on his recent meetings with key stakeholders.

Oral evidence

2. A full analysis of the evidence gathered at these sessions is now underway and will be published in the next two months.

Speaking engagements

3. John Jenkins met with the Northern Ireland Public Health Agency on 29 July. John highlighted that the commissioning board were unaware that the review was taking place yet they have just embarked on a review of workforce so expressed an interest in the review. John also met with the director of public health, who seemed very interested, engaged and was positive about the direction of travel. As the commissioning body was unaware of the review, when the final report is due this should be picked up in the communications strategy.

4. Peter Nightingale presented to the Health Education North West Workforce Planners meeting on 11 September. The group were interested in the impact the review will have on workforce development activities.

5. John Jenkins presented at the NAMEM conference on 11/12 September. Attended by those involved in medical education and management such as postgraduate deans and medical directors, it was useful to see their take on the review.

6. Vicky Osgood has met with Wendy Reid, Medical Director HEE. This was a positive discussion, HEE aligned with general principles of review, though have competing issues with delivering their mandate. Also discussed plans for an implementation group, it was agreed that this should be the sponsoring board organisations with enhancement in devolved areas and inclusion of direct employer contribution and representation from the BMA.

7. Bill Reid has spoken with the Royal College of Ophthalmology, who have considered likely outcomes of the review and produced a good framework around how they can deliver general ophthalmology at the end of five years and then deliver the sub-specialty training. There is general agreement across the college to progress the idea.

Item 2 - Minutes of meeting 23 May 2013

8. Paragraph 4, needs amending. PN highlighted that at the end of their training an anaesthetist is a generalist who is able to care for all patients coming through the front door but if their training is shortened, by removing significant sections of time devoted to specialist areas, this would not be possible.

9. The minutes of the meeting on 23 May 2013 were approved.

Item 3 – Draft of final report

10. DG presented the report, explaining it is a living document and that a final draft will be sent to the sponsoring board on 26 September ahead of their meeting on 30th September. He asked the group for feedback on the coverage of the report.

Pages 1 - 6

11. Important to highlight under the figure of current structure of postgraduate training on page two, the parallel work around academic training pathways in the four countries.

12. Paragraph two does not mention the transition from schools into undergraduate training and the career support needed at this stage. However, this is not within the terms of reference for the review. PS highlighted the work around 'Selecting for Excellence', chaired by Tony Weetman which is looking at this issue. Suggestion to make reference to this work.

13. It is important to look at the report from the point of view of those who will not be familiar and may not understand some of the terms used.

14. There was a suggestion that page three should include a more detailed summary of the recommendations and the proceeding reports, as currently very vague. More detail on the previous reports, what was recommended, what was taken forward etc. would be helpful.

15. Page five, paragraph 14 – comments were made as to the tone of the report in some places, which could be perceived as offensive.

16. On page six, the case for change is not well made. Highlighted issues with paragraph 24 around changes in demographics, there is an expansion of the ageing population with multi-morbidities, which is fundamental to the arguments of this review. This point needs to be made clear.

17. There are other arguments for why change is needed, such as attitudes around the role of the patient, which are changing fundamentally. Patients want and expect to be much more involved in their care. The shift which is needed in medical training is about working in partnership with patients and shared decision making. There is need for a much stronger case for this review.

18. The group questioned whether we should be sensitive to the localism agenda which is driving the healthcare debate more now. There is a political emphasis on keeping local hospitals open and for that you will need generalists able to manage acute takes.

19. The group questioned whether we should comment about the lack of paediatric training in general surgery, though risks involved if commenting at that

level of detail. This should be flagged as an issue, but it is not for the review to offer a solution.

20. Importance of including recognition and retention of strengths in the current system, suggestion to include in executive summary.

21. The recommendation that follows paragraphs 23 to 28 does not relate to the content. The paragraphs do not capture the breadth and importance of why the review was needed. The concept of professionalism does not follow from the paragraphs. We also need to clearly define what we mean by professionalism.

22. We should not be making recommendations where there are concepts already clearly defined in existing standards, such as GMC *Good Medical Practice*. The recommendation implies that professionalism does not currently exist in medicine, which is not intended. The important aspect of the recommendation is about enhancing and promoting professionalism to reflect demographic change.

23. Recommendation needs to be restructured, suggestion: '*training needs to reflect the change in demographics, in patient expectation, in society's relationship with the medical profession*. Importance of highlighting at an early stage that professionalism is an issue.

24. Comments were made around the systems that patients are placed in, which makes is difficult to treat patients in a holistic way.

Pages 6 – 10

25. The recommendations in this section do not link well enough to the text; some of the recommendations are very weak, suggestion that page seven needs rethinking.

26. The group have often discussed the need for examples (UK wide) in the text. JJ suggested at paragraph 33 around blurring the boundaries between primary and secondary care, to include the large work in Northern Ireland on transforming your care, promoting integrated care. This would illustrate the direction of travel in one country of the UK.

27. Not a lot of comment around inequalities of care, this should be highlighted under changing demographics, strengthen paragraph 26.

28. Emphasis is needed on doctors working within multi-professional teams, paragraph 29 could be expanded to include this.

Pages 10 – 23

29. Issue of career expectations is crucially important; we need to ensure that medical students have realistic career expectations.

30. If we recommend a move of full registration to the point of graduation we need to be realistic; the introduction of a national licencing exam will not deliver what is needed and is not cost effective. However we do need reassurance that we are delivering on the issue of preparedness.

31. The group questioned how a move to full registration at the point of graduation fits within the terms of reference of the review and how it would be beneficial to the profession, patients and service. The issue at the moment is that doctors in foundation training are still under the jurisdiction of their medical school, which is difficult to manage. Moving the point of full registration will ensure responsibilities of institutions are clearer, and that the responsibility for foundation doctors sits within the postgraduate domain. It is about reducing the current fragmentation. This argument needs to be made clear in the report.

32. We must ensure that UK medical graduates are not disadvantaged when applying for F1 posts, for which competition will have increased.

33. Introduction of a national exam to be removed from the recommendations.

34. Management of workforce numbers is not part of the review's remit, if there is a good educational reason for moving the point of full registration, it should be something that we recommend. The recommendation needs to be better articulated. Student registration may also need to be considered.

35. We should simply make the principle about solving the issue of trying to manage people at a distance, rather than a full detailed recommendation.

36. Recommendation 2: the group agreed on the principle, though more detail may be needed on how this could be implemented. Comments were made that patient involvement in training already exists. Recommendation should recognise that there is already good practice to be built on and that just having one patient involved in teaching is not enough. Examples given of how to enhance this.

37. Recommendation 3: sentiment of this recommendation is captured in quote at bottom of page 10. Clear understanding of realistic career expectations and changing NHS demands is needed throughout medical education and training, starting at the point of entry into medical school.

38. Recommendation 4: the phrase 'patient journeys' may not be clear to all audiences, what we mean is the balance of patient needs and demands in the future.

39. Recommendation 8: should make comment on assessments, as paragraph 75 talks about assessment.

40. Points on individual paragraphs

i. Paragraph 48, doctors and patients want a safe service.

ii. Paragraph 42 and 49, there are different meanings of flexibility, need to clearly define what we mean.

iii. Paragraph 43, may need some text to explain what graph below shows.

iv. Paragraph 47, need to clarify what is needed for the future.

v. Paragraph 56, there is a difference between feeling prepared and being prepared. Concern that the graph shows perceptions and opinions rather than actual preparedness of F1 doctors. Include data on perceptions of trainers collected by Clare van Hamel.

vi. Paragraph 64, could we include a comparator, e.g. the difficulties faced by doctors later on in their careers compared to difficulties faced by F1 doctors. This is difficult to compare, not about referrals to GMC, it is about doctors not getting through foundation training.

vii. Paragraph 74, include expression 'standardisation of outcomes, but individualisation of pathways'.

viii. Paragraph 80, include value of apprenticeship.

ix. Paragraph 82, explicit recognition needed that failure to meet outcomes is due to training placements. More detail needed on learning environments and recommendation that not all doctors should be involved in training.

x. Paragraph 86, changes needed to language used, avoid use of term 'emergency safe'. Do the levels of competencies described map onto existing model of training? Only have competency levels (b) and (c), but keep concepts in (a). Use term 'acute safe' or 'post foundation, pre CST' or 'training in the management of general medical emergencies and emergencies in their specialty'.

41. Paragraphs 101 to 103, unclear how they relate to recommendation 13 and the terms of reference for the review. This was included to illustrate the difference in the cost of the consultant workforce and doctors in training workforce. We have not

done a full economic analysis. Negotiations are underway which may lead to a different structure. Include information in an annex.

42. Recommendation 12: direction of travel correct but more detail needed on how this relates to individual specialities.

43. Paragraph 104, issue of doctors in training staying in the area in which they train, should we not mention where the workforce numbers should be. This is an issue for government, though is important so we should at least identify it but without suggesting a solution.

44. Recommendation 13: implication of more control from employers, concern of losing control of a lot of specialty training. Make role of regulator in credentialing clearer.

Pages 106 – 123

45. Still have not captured concept of fostering innovation, on-going learning culture, responding to challenges of genomics, informatics etc. This will need postgraduate education embedded for the duration of a person's career, this should be encouraged and emphasised more in report. Concern that this would be a requirement for progression. Not simply academia and research, but continuous innovation and enhancement of healthcare. The group suggested Innovation, Health and Wellbeing as a headline.

46. Paragraph 118; make reference to initiatives already in place around credentialing. Expand this section to include definition of credentialing.

47. Paragraph 111, the phrase middle grade out of date.

48. Recommendation 16: reference to specialty and sub specialty reinforces where we are now and does not capture the innovative, evolving and dynamic opportunities that credentialing provides. Include worked example of credentialing pilots.

49. Remove paragraph 112 and more detail on paragraphs 120 and 121 needed.

Model for postgraduate medical education and training

50. Bullet point two on page 32 states: '*Key generic capabilities will include a focus on patient safety through quality improvement'*. Ara Darzi's definition of quality would be useful here, which is about patient safety, clinical effectiveness and patient experience, doctors need to be competent in all those areas. Also include multi-professional aspect here.

51. Concerns around shortening the length of training for some craft specialties due to the optional year in different area of medicine.

52. Revise text on model to reflect changes to terms in final report.

53. Difficult to understand the difference between ‘stem’ and ‘theme’. Lose the word ‘stem’ and use the term ‘broad based specialty training’. The graphic suggests that the themes are outputs of training.

54. We need to think about what the audience is able to see interactively and what the audience can see in the report. Examples will pop up interactively, and examples will be part of the text in the report.

55. Themes (child health, women’s health etc.) to be moved to beginning of broad based specialty training on diagram.

56. Last stage of training should not be labelled as independent practice. Doctors practise with peer support throughout. Within your defined scope of practice to be able to practise independently. Enhance the idea that people need multi-professional supportive teams around them.

Action: Minor drafting points to be circulated to the executive team.

Item 4 – AOB

Value of the Doctor in Training Charter

57. This work will be incorporated into the final report as an annex, with minor amendments.

58. Title should be changed to ‘Valuing the Doctor in Training Charter’.

59. Trainee involvement: more emphasis needed on equity of access to training opportunities.

60. Working Time Regulations may not form the framework in which training is delivered in the future; the document should be amended to reflect this. Relationship between training and service: removal of reference to EU Working Time Directive, replaced with ‘*relevant legislation’.*

Action: VO to speak with Academy to suggest changes to document.

Action: Circulate annexes to group.

Next steps

61. Another version sent on Tuesday, further comments from group to be sent this week and next.

62. Sponsoring Board meeting to be held on 30th September, a final revision will be sent after this meeting.

63. Comments on the communication plan to be sent to the executive team.

64. DG thanked the group for their input to the work of the review.

This was the final meeting of the Expert Advisory Group.

Minutes will be circulated to the group for approval.