19 September 2013

Expert Advisory Group meeting

SHAPE OF TRAINING

Approved

Minutes of the meeting on 24 July 2013

Members present

David Greenaway
Tom Dolphin
Paul Stewart
Susan James
Clare Marx
Peter Nightingale
Bill Reid
John Jenkins
Malcolm Lewis
Angela Coulter
John Savill

Staff Present

Vicky Osgood
Richard Marchant
Jessie Moye
Paula Robblee
Stuart Carney

Apologies

Peter Dolton
Ajay Kakkar

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. We have now completed all 54 oral evidence sessions and team are now analysing the evidence collected.

Speaking engagements

3. PN presented at the BMA SAS Committee on 04 June. The group were concerned about how they would fit into a new system of training.

4. PN presented at the National College Tutor's meeting at the RCoA on 13 June. PN highlighted that at the end of their training an anaesthetist is a generalist who is able care for patients coming through the front door but if their training is shortened and the specialist work that they do taken out, this would not be possible. The generalist and the specialist could be trained in a shorter time, but an anaesthetist who is going to become a specialist could not. They supported increased flexibility and ability to easily move in and out of training.

5. VO presented to the Foundation Trusts Network on 18 June. This was a very productive meeting with an engaging discussion, the principles and models were tested out with the group.

6. JJ presented at COGPED on 20 June. The different perspectives on the detail of the models and principles were very encouraging.

7. DG presented at the International Medical Conference on 20 June. This was a lively discussion but many issues raised were outside the remit of this review.

8. PR presented to the Paediatric Trainee's Committee on 09 July. The group were keen to have increased flexibility within training but felt that the paediatric curriculum is already quite general.

Workshops

9. All engagement activity is now complete and the team will be producing a summary of these workshops.

Research

10. Trajectory work is nearing completion and the results will be produced in August.

Item 2 - Minutes of meeting 23 May 2013

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

Item 3 – Detailed outline for final report

12. PR presented the outline for the final report. She asked the group for feedback on the structure and coverage of the report.

13. The group agreed that the content of the report is correct.

Structure

14. The group suggested that the report should be structured around the original terms of reference for the group and ensure explicit cross reference to this and the recommendations throughout the report.

15. There was also a suggestion to compare current report to previous reviews of postgraduate medical education and training.

16. The report should have a clear statement at the start that the review has engaged with all four UK countries and is a UK wide review.

17. We need a clear understanding of the audience for the report. If it is for a wider audience, it may be necessary to include more detail around what training looks like at the moment and the relationship between the service and training.

18. Some comment should be made around SAS doctors being integrated into the training process and not sitting outside it. In the future there may be a blurring of the boundaries between doctors in training and SAS doctors due to increased flexibility. We need a workforce that is training all the time. All of these issues need to be drawn out in the report. VO gave clarification on the two groups of SAS doctors.

19. Important that it is clear we are concerned with training, rather than terms and conditions of service; our focus is the on-going training needs of all doctors. We also need to make clear the difference between further training/credentialing for enhancing skills and CPD for maintainingthem.

20. The need to fill service rotas has always prevented change in training. If we move towards a trained doctor delivered service then pressures on filling rotas may not be so great.

21. We need to be careful to ensure that any recommendations we make are within the remit of the review.

22. The report needs an effective and compelling title.

23. Certificate of Completion of Training (CCT) is not really an end point. Medical training is a continuum. There was a suggestion of a Certificate of Independent Practice for example, though it was highlighted that the concept of people reaching a certain level of competence at CCT should not be lost.

24. No understanding of acceptable and valuable way points in medical training; this may need to be expressed.

25. Members commented on the general structure of the report-the text needs to reflect the recommendations more clearly.

Drivers of change

26. Currently there is demographic data missing from England and Northern Ireland. PR explained that we are waiting for the data to be collected.

27. Francis and Keogh reports important to include.

28. The report comments on patient expectations as a driver for change. We should be referring to changing patient needs. 'Expectations' implies that people are becoming more and more demanding and unreasonably so and there does not appear to be much evidence to support this.

What kinds of doctors do we need to train to meet future demands?

29. We need to embed a learning culture throughout a person's medical career; more emphasis on this within the report is needed.

30. More information needed on how doctors perceive their role in relation to patients.

31. In relation to GP training, there is nothing in this section about the value of clinicians in the community and the fact that patients want to receive more care closer to home. Quotes to fuel this view would be helpful.

32. There needs to be more recognition that doctors in training are also service providers and understand how much of the service is provided by doctors in training.

What is happening in training now?

33. There was discussion around the principles outlined in the report. The support for academic medicine needs to be part of these principles to ensure that academic activity is not considered out of programme. Suggestion of a principle that 'training

programmes should capture alternative career pathways including academic medicine and medical management'.

34. The group suggested the report should be strong about recommending all doctors to be actively engaged and fully supported in CPD.

35. The group questioned how decisive we are going to be in the final report and whether we are simply suggesting for discussions to take place in various bodies responsible for medical education and training. This was felt particularly important in terms of any recommendation to move the point of full registration to the end of medical school.

36. The section on *Competence and capability based training* appears primarily about doctors reaching CCT level, it is important that we acknowledge doctors training in grades other than consultant.

37. It is necessary to define what we mean by apprenticeship.

38. Generic capabilities should include multi professional team working.

39. It is important that we make the distinction very clear between additional training/credentialing and CPD.

40. The report talks about patient pathways, we need to be careful about the terminology that we use in the report, suggestion to use the term integrated/coordinated care.

41. The report should recognise the benefits of spreading good practice through clinical placements at medical school.

42. We should be talking about readiness for practice at differing levels as opposed to reaching CCT and continued professional development as a way of demonstrating lifelong learning. There is difficulty in determining levels. A specialist is not necessarily working at a higher level; it is about the ability to work without supervision.

Item 4 – Draft approach to training

43. VO presented the model which centres training on patient pathways.

44. At first glance the model is not easy to understand, particularly in terms of how speciality areas fit within each stem. The emphasis of this model is around the flexibility of how you go down different routes. The model clearly shows training in a flexible way.

45. PS was supportive of the previous three models which have been presented at oral evidence sessions and various workshops. Time axis is missing on this model. VO explained that this model is simply a first draft and that we have not completely lost the previous three models.

46. The large circle which suggests the skills that all doctors need, currently only has diagnostics, other elements such as communication, team working and care management also need to be included.

47. General stems should become narrow as you reach the end of your period of generalist training.

48. Suggestion that paradigm shift may be needed, getting rid of all specialities in order to simplify this model.

49. The model is good at demonstrating that patient pathways need to read across the various areas of training. This model does not need a time axis, but should be complemented with another diagram which addresses what the key stem specialities are amongst other details.

50. At some stage it will be important to include a time axis as it is important for people to know how long each stage of their training will be.

51. Currently this model does not indicate what happens to those not within training; it also does not look significantly different to the training system we currently have and understates the gravity of change being proposed.

52. We need to express the recommendations in a simple diagram.

Item 5 – Draft recommendations

53. VO presented paper and asked members to give feedback on the recommendations.

54. We need to be firm and decisive with recommendations rather than simply asking organisations to talk about certain topics.

55. If recommending that the point of full registration moves to the end of medical school, many would have concerns over introducing a national licensing exam.

56. Recommendations are currently too long and too wordy. We need to sharpen the recommendations by ensuring they link to the text in the report.

57. There is no mention of cultivating the expert and super specialisation in a more constructive way with more competition.

58. Concern that recommendation about credentialing would create a situation where people are not able to get into a consultant grade until after taking up fellowships or acquiring a credentials. GMC is working actively on credentialing.

Item 6 – AOB

a. Correspondence regarding Call for ideas and evidence

i. Correspondence and evidence submitted from Chris Evans was put before the group and was discussed.

ii. The team will respond to Chris Evans explaining that his evidence was discussed by the group.

b. Value of the Doctor in Training Charter

iii. This work will be incorporated as part of the review. The group recognised the importance of this work and that it should be disseminated widely.

iv. The charter is focused on the expectations of doctors in training, what is expected of doctors from employers would be necessary to include.