19 September 2013

Sponsoring Board meeting

SHAPE OF TRAINING

Approved

Minutes of the meeting on 27 March 2013

Members present

Stewart Irvine
Tony Weetman
Ian Cumming
Keith Gardiner
Derek Gallen
Terence Stephenson

Staff Present

David Greenaway
Vicky Osgood
Jessie Moye
Stuart Carney

Apologies

None.

Item 1 - Chair's business – Update on Review (David Greenaway)

1. DG gave a presentation to the group on the progress of the review and inviting the group to comment.

2. The group emphasised the success of the work already carried out by the review team and commented that the breadth and scope of work undertaken has been phenomenal.

3. The group then went on to discuss some of the themes of the review and in particularly the balance between generalists and specialists in the workforce. The group questioned whether 99% of the workforce could consist of generalists. A number of colleges produce data on what types of work doctors continue to train in.

It was suggested that the review should gather hard data to form a picture of the current balance.

4. It was highlighted that work around international comparisons may be lacking and that further work may be needed before any final conclusions are made. We are currently conducting a literature review which includes looking at a variety of international comparisons and DG stated that he has gathered evidence from his recent trips to Canada and Australia.

5. Members emphasised the need not to generalise in terms of possible recommendations as there are a number of varying training needs for each speciality. The review should aim to make recommendations which cover both specialist and generalist aspects.

6. The groups raised a concern that organisations invited to oral evidence sessions may think that the proposed models focus on dealing with the emergency medicine crisis and we need to be careful that we are not focusing on the training of physicians.

7. The group questioned if the review has been mindful of other work that is progressing at the same time, for example timeline of registration and the over supply in Foundation and how this might effect how postgraduate education and training will look like. We need to be cognisant of competing interests, DG recognised that other pieces of work relating to medical education and training will need to be informed by the outcomes of this review.

8. It was suggested that further work may be necessary around defining the term 'generalism'. What is the generalist? What is the skill set for a generalist? What are we training them for? For example, General internal medicine skill set is different to the skills needed for a generalist.

9. Some members raised the impact of the advance in technology on healthcare. Further advancements in technology will effect the way in which care is delivered and will create changes to the doctor/patient relationship.

10. Patients of different ages and doctors of different ages, have varying expectations and perspectives of healthcare, particularly those living through the technology era. Some members were surprised that not many organisations and individuals responding to the call for evidence made comments on this issue.

11. The group discussed the difficulties of workforce planning; they questioned whether we are confident in collecting data to inform future models of training. This is very difficult due to a number of complex interactions. It is essential to be able to plan the workforce effectively.

12. The introduction of LETBs may improve workforce planning, as they will have access to real time information and can monitor trends appropriately to be able to make workforce predictions.

Action: The report should be run past international experts. Contact Nick Busing about the findings of the review.

Item 2 - Preliminary analysis of the call for ideas and evidence

13. The board commented that the preliminary analysis undertaken by the team is phenomenal work.

14. The group asked how we have weighted individual and organisation responses. DG explained that we have not weighted any particular comments more than others based on the fact that it has come from an organisation.

15. The board suggested that recommendations should be made around transitions. DG agreed to take this forward.

16. The need for a balance between training needs and service demands needs to be better understood. Doctors in training need to recognise that they are learning within service provision.

17. Members suggested having an education contract, which is not about time spent training, but how training time is used. It may also be necessary to define the expectations of a service post and what is 'pure' service.

18. The group discussed issues around preparedness and reflection for doctors in training, time is not always set aside for these activities in all specialties. More emphasis is needed on the importance of the role of Educational and Clinical Supervisors.

19. Members were keen that the preliminary analysis of evidence is shared with key stakeholders to help them to understand the way in which the review is progressing. A synthesis of evidence will be published on the Shape of Training website in May.

Item 3 – Possible approaches to medical education and training

20. The group highlighted the importance of gathering the employer view of the models, short term issues of running the front door service may be solved by a generalist approach, but there are still long term issues to solve.

21. The review needs to be cognisant of current contract negotiations which are underway with doctors in training and consultants. We need to ensure we have employer backing for any changes that are introduced.

22. These negotiations only concern England and Northern Ireland. VO explained that we have contacted Gill Bellord and have agreed to share our analysis of evidence and proposed models and for them to share with us the principles coming out of the contract negotiations.

23. The group questioned if the review is looking at changing the current length of training. DG explained there is no strong desire to lengthen training.

24. The group then asked how far the review will go in terms of developing the detail of the concept of core stems. DG explained that the review is not constrained by the concept of CCT, but it somewhat constrained by nomenclature, CCT is not completion of training as doctors will continue to learn and develop throughout their careers. The board suggested the review should define more clearly the meaning and purpose of CCT, DG agreed to take this forward.

25. The board were happy with the proposed models and the flexibility for them to be adapted in further discussions at oral evidence sessions. Members suggested exploring the Canadian model proposed by Richard Resnik of training surgeons straight out of medical school.

26. In each model the Foundation Programme remains, DG explained the models are not final and can still be adapted.

27. Members asked where the current workforce would sit in each of the models proposed. VO explained that we will be approaching Royal Colleges and asking them to identify how each model would fit with generalist and specialist aspects of the curricular.

Item 4 – AOB

28. The Academy of Medical Royal Colleges wrote to DG about their work on the role of the trainee, which is being taken forward collectively by the College, HEE and the Royal College of Physicians of Edinburgh. It was suggested that this work should be joined up with the review. DG agreed to take this forward.

29. It is important that the review is cognisant of the different political demands in the four countries, particularly in Scotland with the upcoming referendum. A timetable for the final report should be circulated. It was suggested that the four countries should be pre-warned about when the final report will come out.

30. The board emphasised the importance of carefully co-ordinating an approach around the final report and managing expectations. Plans should be made to present the report to each CMO individually.

31. The board suggested sending proposed principles and models to those attending oral evidence sessions, DG agreed.

32. A final meeting of the board should take place when the final report is completed.

Next meeting to be held in 30 September 2013.