SHAPE OF TRAINING

Item 3 Annex A

Shape of Training oral evidence

Introduction

1. This annex explores some of the key themes emerging from oral evidence sessions and highlights some of the issues which are specific to different stakeholder groups.

Academy of Medical Royal Colleges

2. Consent from all colleges for GP training to lengthen to four years. There is also consensus for training more general specialities. Model A would be the best approach to achieve this.

3. The idea of Certificate of General Training as a halfway point in training would face a lot of opposition. The college emphasised that training a general physician or general anaesthetist for example takes longer than training a super-specialist.

4. It is important that the differing training needs in craft specialities are considered.

5. No appetite for Model C, though colleges understand the importance in the acquisition of skills post-CCT. There are differing views on run-through training, with some colleges arguing that it does not produce doctors who are pluri-potential.

6. There is consensus that academic activities should not be classified as out of programme.

7. There will be difficulties in reaching a consensus between all colleges on the duration of training.

8. There is a desire from doctors in training to restore aspects of the apprenticeship model, particularly in early years.

9. There is lack of recognition for the high standard and amount of care provided by SAS grade doctors. These posts need to be more attractive and need access to structured training and support.

National Association for Patient Participation

10. There was a large emphasis on the importance of effective communication with patients. Interpersonal interaction is the most important thing for all patients.

11. It was highlighted that there are issues with participation and communication with carers in decision making; the needs of carers need to be better met. Information is not accessible for carers, particularly for those caring for patients with dementia.

12. In general most patients are quite happy to be treated by doctor in training, provided they are supervised and communicate well with them.

13. The length of consultations needs to be increased.

14. Patients need to start taking more responsibility for their own health care.

15. There are a number of patient courses available, which could be integrated into medical training. Training needs to be interchangeable between specialism and general practice to benefit patients and the healthcare system.

National Voices

16. Doctors should focus on treating a patient as a person rather than a condition.

17. Patients need to engage more with education and training and be aware of the duties of doctors at each stage in their training and post-CCT.

18. The importance of co-ordinated and integrated care was highlighted.

19. For co-ordinated care to work effectively there must be someone who is the care co-ordinator and can provide continuity to patients.

20. Better integration and communication is needed between primary and secondary care in relation to follow up care with patients back in the community.

NHS Employers

21. Employers were very clear that they do not support the extension of undergraduate education into the Foundation Programme. Employers are keen for new doctors who are quickly accustomed to the idea that they are employees.

22. From the point of view of workforce planning you want doctors who are pluri-potential generalists for as long as possible.

23. The CGT should be at a level which equates to independent practice - that is to say, at consultant level, though the role of the consultant might need to be different.

24. Preference for model A.

NIMTDA

25. Keen for all doctors in early years of training either core or foundation, to develop skills of dealing with frail elderly patients, possibility that all doctors spend a period of time within geriatric medicine.

26. We need skilled doctors who are able to deliver safe care, but can also suggest ways to take the service forward. Innovation and improvement needs to be embedded in the training structure.

27. Foundation should remain but rotations should be less so that doctors in training are able to build relationships with other healthcare professionals and feel part of time, which is something foundation doctors value highly.

28. The service is currently too dependant on doctors in training to provide the service, often decisions about training are made based on service needs rather than training needs, training is considered from the wrong perspective.

29. Doctors in training need a degree of basic research knowledge and need to know what the research opportunities would be if they wanted to pursue that further and what a career in academic medicine would be like.

30. Suggestion that the models need to be more clear about the end points of training and what the certificate of general training means.

31. Support for credentialing and further development of skills post-CCT particularly for GPs.

COPMED

32. It is fundamental for any reform to training to be generic for all the four countries, because we need cross boarder transfers.

33. Support for Foundation Programme to remain.

34. The end point of GP training should still be specialists, as you risk GPs being classified as generalists and currently people do not recognise the value of a generalist, so less people would apply for GP training.

35. It is important that the current culture is changed, so doctors no longer think of terms of ‘what I want to do is’ but think ‘I will do what the service needs me to do’.

36. Any change to the training structure needs to ensure that we can identify what everyone can do, the public deserve to know that a doctor is at a particular level of competency and that must be a level of competency that is needed by the NHS so doctors in training are employable.

37. Support for reform of GP training structure and the way in which general practices provide training and care. GP contract is no longer fit for purpose.

COGPED

38. The priority at medical school and early training should be to produce highly skilled generalists. Specialisation should come much later.

39. Change in the nature of professionalism and the need for doctors to be adaptable to different ways of delivering health care in the future.

40. Keen support for credentialing and the GMC’s work on identifying generic capabilities or generic outcomes.

41. Assumption that GPs provide continuity of care, providing ‘medical home’ where patient records are kept in one place and easily accessed, this is the continuity that patients have begun to accept, recognising that they will see someone within the team at their ‘medical home’ if not always seeing ‘their’ doctor. Continuity of care diminishes after this point. It was vital that patients are not just passed across generalist or specialty boundaries with nobody maintaining overall care.

42. Considerable emphasis on the need for the boundaries between general specialist training and specialty run through to be 'porous' so folk can move back and forth between the two.

43. Supportive of the idea of a specialist generalist with a CGT, but not the very broad mixed disciplines implied by model A, as potential GPs would not have the requisite GP specialist skills.

44. Also concerns about appointing a sub-GP grad which would not have full autonomy or ability to practice independently on the GP register and therefore would be unattractive.

45. Preference for model B which appears to work for all specialties.

RCOG

46. Supportive of the concept of generalist, but the current approach in O&G training delivers an O&G generalist. The College does not want to see a diminution of skills as a result of a move towards generalism, but see the value in the development of a more outward facing (non-hospital) discipline.

47. Generalists have to have the same status as specialists - have to incentivise the role.

48. Support continuation of run-through training in O&G following Foundation - it is currently working and they have a very low rate of attrition of trainees.

49. Transferability of skills is important. Specialties need to recognise the possibility of skills learned in other disciplines being transferrable - particularly in generic capabilities such as communication skills, decision making, and management of crises etc. rather than technical skills.

50. Strongly supportive of Foundation Programme and would like to lengthen the duration of rotations. The college also felt that only minimal structural change should be necessary.

51. Not supportive of the 'stem disciplines' descriptions in models A and B. These need to be refocused and re-aligned to reflect patient not professional needs - women's health, child health, care of elderly etc.

52. Felt that Model A does not reflect service re-configuration in England.

53. Want to see an end to CCT being seen as end point of training. What is required is a more structured post-CCT CPD. Supportive of the approach in the top left box of Model B.

54. Strong support for credentialing, which the specialty now has as ‘advanced modules’, but want to see credentialing cross the CGT line into further development of generalist areas.

MSC

55. There must be adequate flexibility in the system to accommodate the needs of clinical academics.

56. We need to ensure there is a degree of uniformity in research and innovation training for all medical graduates.

57. It is important to reconsider whether full registration is rewarded after medical school.

58. Generalism is currently not highly respected and needs to be attractive and incentives are necessary in terms of career recognition and progression, financial, incentives would also be important. More generalism is needed within the undergraduate programme.

59. It is important that we address the changing nature of the workforce, not just feminisation but the increase in male doctors who also want to work less than full time.

60. It is important that we can ensure that there is the structure and facilities to support training and teaching within the community.

61. Support for ARCP and clinical academic pathways to remain. Also supportive if credentialing post-CCT.

62. Favoured Model A.

GMC

63. High level skills which should be taught at undergraduate and developed throughout postgraduate training, managing risk, dealing with uncertainty, handling complex important information and personal accountability/personal responsibility for your actions. These skills must be embedded in any training structure.

64. Globalisation of healthcare and developments in technology as ways to deliver care in the future needs to be considered, we need to train doctors who are able to communicate and consult and advise using all sorts of new communication media.

65. Emphasis that flexibility is the most important aspect within training and the need for transferable skills between specialties.

66. Chronic disease management to be delivered more by specialists nurses, to enable doctors more time to care for complex conditions of co-morbidities.

67. Training structures in the four countries do not need to identical so long as the outcome of training is the same.

68. For clinical academics, geographical stability is very important.

69. Effective and supportive mentoring schemes to be in place for newly appointed consultants.

NIHR

70. Comfortable with all the models as they did not appear to threaten the continued operation of NIHR's programmes.

71. Emphasis throughout the discussion was on the importance of flexibility in all ways (OOPE, length of training, CCT dates etc) and ensuring that the boundaries between the different elements of the models remained porous so that those with research and academic interests could move back and forth between academia and clinical worlds.

72. Need to build the training programme around the person not the person around the programme.

73. Doctors need to understand research methods and training models need to ensure this.

74. Recognised the risks of producing a very narrow run-through academic or clinical CCT pathway - individuals risk obsolescence if practice moves on. May also be viewed by others as less than the 'full' doctor if they haven't got sufficient breadth.