23 May 2013

Expert Advisory Group meeting

SHAPE OF TRAINING

*Approved*

**Minutes of the meeting on 14 March 2013**

**Members present**

David Greenaway
Tom Dolphin
Peter Dolton
Susan James
Clare Marx
Peter Nightingale
Bill Reid
John Jenkins
Paul Stewart
John Savill

*Staff Present*

Vicky Osgood
Richard Marchant
Jessie Moye
Paula Robblee
Stuart Carney

**Apologies**

Paul Stewart
Angela Coulter
Ajay Kakkar
Richard Green

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

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

*Site visits*

2. We have now completed all 8 site visits across the country, we have produced a summary of the themes, which we will feed into the review's evidence and put on our website.

*Seminars*

3. We have now completed all five seminars for people involved in medical education and training in Cardiff, Belfast, Edinburgh, London and Manchester. We have produced a report that draws together the main themes and issues. This will feed into the report on the data analysis and will be put on the website.

4. We have plans to engage with medical students, doctors in training, general practitioners, patients, academics and employers. We intend to hold small, targeted workshops with these groups from March through to July.

*Call for ideas and evidence*

5. Our call for ideas and evidence closed on 8 February 2013 and we received 382 responses from various stakeholders. We are busy analysing the responses and will have a final report on the analysis by the end of May.

6. Peter Nightingale, John Jenkins and Stuart Carney have volunteered to evaluate the analysis against the raw data to make sure we have reflected respondents' view points accurately and to check we have not missed any crucial issues.

*Oral evidence*

7. We have begun organising oral evidence sessions which will run from April through to June. Members have kindly offered their time to assist with these oral evidence sessions.

8. We will invite the Sponsoring Board organisations, along with the BMA and other key stakeholders to give oral evidence. We will also invite organisations and individuals who have raised particular points of interest through the call for ideas and evidence.

9. We will ask for feedback on particular points from their written responses or relevant to their stakeholder group. We will also ask them to comment on the possible approaches to training. We would also like some ideas about how to implement any changes and how they might affect their organisation or stakeholder group.

*Research*

10. The literature review is making good progress and is expected to complete in May. We have also commissioned Trajectory to undertake work looking at critical changes to healthcare in the future which will change the shape of the workforce.

11. JS asked whether we have identified an appetite for major structural change from stakeholders throughout the various review activities. VO suggested it is evident from these activities that change is desired, but this may not be major structural change.

12. The group emphasised the need for profound change without major structural change as there is clearly dissatisfaction with the current system, recognising that implementation of any changes will be different for the four countries.

**Item 2 - Minutes of meeting 19 December 2012**

13. The minutes of the meeting on 24 October 2012 were approved.

14. Amendments to paragraph's 19 and 32 have been made.

**Item 3 – Evidence**

15. RM presented the paper highlighting that the response rate for the call for ideas and evidence was very good.

16. A full report on the analysis of the call for ideas and evidence will be finished by the end of May.

17. PD commented that from an economist perspective a response of 382 responses is not effective as quantitative data and that there was an imbalance between certain stakeholder groups. Lack of response from GPs needs to be addressed if making changes to move towards a more generalist approach to training.

18. Some members thought a targeted questionnaire to gather quantitative data might be useful.

19. The group emphasised the difference between surveys and questionnaire and highlighted that this call for evidence was an idea gathering exercise which produces qualitative information. It was simply one of a number of ways in which we were gathering the views of stakeholders.

20. JS expressed positive comments about the preliminary report and confirmed that the issues and views expressed in the report resonate with the views currently being heard from the profession. JS emphasised that qualitative data naturally leads to quantitative research.

21. There was a suggestion that if we aim to introduce a generalist approach to training we need to collect more information to support this change such as how many doctors are already trained to deliver a generalist service and how many are actually delivering that generalist service.

22. The group highlighted that there is nothing in the evidence gathered so far relating to issues about hospitals at night, which is the environment in which most doctors in training work and is a generalist function.

23. There is a need to understand the level of training needed to achieve competency in generalist training to provide a safe 24/7 service, also the numbers of doctors currently in workforce able to deliver this.

24. PD highlighted that although the qualitative data collected is useful evidence, we need to supplement this data with survey numbers. PD questioned how we are crediting comments made by organisations and individuals and that comments need to be evidenced by quantitative data.

25. Members considered whether extending the length of training could be a solution to doctors feeling unprepared to take on consultant roles. This would allow doctors to consolidate their learning while in training.

26. The concern was raised about introducing a two-tier consultant grade unless value is given to doctors practising in general capacities.

27. The group felt it would be interesting to know which organisations did not respond to the call for ideas and evidence.

**Action:** Executive team to collect data on those trained to deliver generalist care and the numbers actually delivering that care.

**Action:** JM to circulate list of organisations who responded to the call for ideas and evidence.

**Item 4 – Models**

28. VO presented this paper, explaining that we have produced a variety of models and developed a number of principles based on the evidence collected through review activities.

*Principles*

29. The group suggested principles and models should be tested with stakeholders through oral evidence sessions.

30. JS suggested that one option for a training structure should be minor changes to the current system. JS questioned whether one of the principles should be

whether run-through training needs to remain. The group did recognise the importance of run-through training for specialities that have difficulty recruiting.

31. TD suggested a number of principles:

- Changes to the training structure need to be effectively integrated into the current workforce.

- We should not rely on task shifting. We need to be sure about which aspects of medical training are necessary and which are appropriate for other members of the multi disciplinary team.

- Academia for all should not be forced; one good thing from MMC was that not everyone had to undertake aspects of academic training.

- Any changes to the training structure must recognise that medical training, knowledge and skill should be integrated across the whole of the knowledge base that doctors have. Out Of Programme training should be valued, all experience is valuable training.

32. The group commented that currently CCT portrays the wrong message that training ever completes. Learning and development are lifelong.

33. Other principles suggested by the group were:

- Training doctors to deliver safe and high quality care, whilst understanding their personal responsibility for delivering care and the need to engage with the training process. Delivery of care needs to be driven by motivation.

- Need for transparency as to the different levels of capability for employers and patients.

- Learning environments must be suited to delivery of training. Training environments should require constant monitoring.

- The principles should be mindful of doctors' responsibility to the system as a whole in order to effectively delivery training.

34. The group emphasised the importance of identifying patient needs.

35. It is important that we frame a definition of capabilities.

*Models*

36. The group commented that MMC's idea of introducing a number of core stems enabled people to become more specialised.

37. It is important that the principles reflect the issues around women being recruited into specialities.

38. There was a suggestion that we should produce three possible approaches to training to discuss with stakeholders. One model should focus on the Tooke recommendations, one model should focus on the current system with minor changes and another should focus on radical changes.

39. We need to explore how we can develop curricula in a way which is more flexible and introduce the idea of transferable competencies between specialties.

**Action:** PR to compile principles document based on comments from today's meeting. Document will be circulated for further comment.

**Item 5 – AOB**

40. None.

The next meeting will be held on 23 May 10:00 – 13:00.