17 July 2012

Expert Advisory Group meeting

SHAPE OF TRAINING

Approved

Minutes of the meeting on 17 July 2012

Members present

Angela Coulter (Senior Research Scientist at University of Oxford)
Tom Dolphin (Chairman of the BMA's Junior Doctors Committee)
Peter Dolton (Professor of Economics at the University of Sussex)
David Greenaway (Chair of Review)
Susan James (Chief Executive at Derby Hospitals NHSFT) (by phone)
John Jenkins (Chairman of GMC's Postgraduate Board) (by VC)
Malcolm Lewis (Director of General Practice at the Wales Deanery)
Clare Marx (Consultant Orthopaedic Surgeon) (by phone)
Peter Nightingale (President of the Royal College of Anaesthetists)
Bill Reid (Postgraduate dean in South East Scotland)

Staff Present

Vicky Osgood
Richard Marchant
Jessie Moye
Stuart Carney
Richard Green

Apologies

Ajay Kakkar (Director of the Thrombosis Research Institute)
Paul Stewart (Dean of Medicine College of Medical and Dental Sciences at University of Birmingham)
John Savill (Chief Executive of the Medical Research Council)

Welcome and Introductions

1. DG introduced the purpose of the review, his role as Chair of the review and the function of the Expert Advisory Group. Members then introduced themselves.

Item 2 – Introduction to the themes in the Shape of Training Review

2. The group recognised the impact and importance of previous reviews such as the Tooke review. Their recommendations should be built on as part of this review.

3. Members suggested the review should look at the transition from medical school to the Foundation Programme to specialty training and into practice. Further consideration should be given to the role of credentialing and the impact of the current assessment system.

4. Work by other organisations such as the Academy of Medical Royal Colleges' work on transferable competencies should be considered by the review.

5. Concerns were raised in terms of resource implications and the cost of implementing recommendations. It is necessary to identify a sense of what the future will look like in order to consider resource implications. There needs to be certainty that recommendations made can be implemented, this should be considered before beginning work on themes. It was highlighted that the theme of flexibility will be most difficult in terms of resource implications.

Breadth and scope of training

6. Doctors will increasingly need a breadth of knowledge and skills to address the health needs of the UK population. Members suggested more doctors will have to take on a generalist role with further specialisations coming after completing training through credentialing.

7. Members suggested the review will have to reflect on the meaning of the Certificate of Completion of Training (CCT) and how this may change if training becomes more general. Work will also have to take place to change the perception that specialisation has more status and value.

8. The review should address some of the challenges for trainees when they pursue a non traditional medical career such as Academic medicine.

9. Members suggested training which is undertaken outside of training programmes such as fellowships should not remain unregulated. Training should encompass these activities to allow for them to be regulated effectively or in order to promote flexibility this type of training could remain outside regulated programmes.

10. Members reflected on the factors that influence trainees into different specialties and patterns of work such as work-life balance, geographical location of training programme.

11. *Training and service needs*

12. Members commented that training could be delivered in a different way to allow more flexibility to the service and trainees similar to role of senior house officers (SHO).

13. Despite awareness of service needs and the gaps in posts within the health service, there is difficulty in addressing these needs because there are not enough applications for posts which are in need of filling, for example emergency medicine, psychiatry and general practice.

14. Trainees should be given incentives to move in and out of training. If there is scope for creating a way of allowing trainees to experience different areas of medicine, then the curriculum needs to be longer and any posts outside training must be regulated rather than unstructured.

15. Many roles in the NHS are constrained by service needs and do not allow for flexibility in either training or practice. This is particularly true for Staff, specialty and associate specialist (SAS) doctor.

Patient needs

16. The review should consider what patient need and expect broadly from doctors and the quality of the doctors emerging from training. The review should also think about the relationship between primary care and secondary care doctors and how this relates to the quality of patient care.

17. The review should look at wider reports and scoping documents which detail more in depth information about patient needs such as the PMETB report on the future doctors.

Workforce needs: specialism v generalism

18. Some members suggested obtaining CCT in a breadth of a specialty in order to work in a very narrow and confined area of that specialty is illogical. For certain specialties it is essential to be trained as a generalist with a speciality interest, but for the smaller specialities there is a need to have super specialties, though they need to cover a bigger geography.

19. The balance between generalism and specialism will be very different in certain areas, such as urban and rural environments.

20. There was a general consensus that doctors trained in sub specialities at an early stage has a negative effect on the service, as it is difficult to staff emergency services and does not reflect the changing needs of patients. Also being overly specialised at an early stage, does not equip a doctor with the necessary breadth of knowledge needed for care in the local community.

Flexibility of training

21. Members thought we need to have a better understanding of the existing stock of doctors and trainees, how their career choices are constrained and what doctors want to do in terms of achieving a balance. We can infer various things from application rates and other data:

a. Changes in survey results highlight that applicants make decisions based on geography rather than specialties.

b. Historical data shows that 1/3 of medical students know what they want to do on leaving medical school. 1/3 have no idea of which path to take other than medicine or surgery and the other 1/3 want to experience a number of areas before making a decision, which is where the system becomes difficult.

22. The fact that people are now more routed geographically may have a positive effect on the service, as parts of the UK which were usually difficult to fill such as Wales and Cumbria, can now be more easily doctored.

Summary of points

a. The purpose of the review is not to‘re invent the wheel’ but to look at what has been done before and work on previous recommendations outlined in various reports. It is also necessary to not disregard any work taking place in parallel.

Action: PR to circulate background documents to EAG members.

b. It is necessary not to disregard the important transition between undergraduate and postgraduate education. Undergraduates must be made aware of the profession they are coming into, the difficulties faced and expectations throughout education and training. Should not disregard the transition between medical school and postgraduate education.

Action: DG to meet with Michael Goldacre

c. When looking at the time frame for this review, it is not about looking at the next few years. This review will help shape training for the next generation of doctors.

d. Flexibility issue is essential to this review. There needs to be a consideration of the cost of engineering this into the system. Also a need to look at other career pathways and reduce the assessment burden on trainees and trainers.

Action: PR to circulate historical reports, such as Tooke and Temple to EAG members.

Item 3 – Communication and engagement plans for the review

23. DG outlined the plans to engage and communicate with stakeholders. Members considered the communication and engagement plan.

24. The group identified gaps in the stakeholder list:

a. GMC work on health and disability – input from this group should feed into the review as information becomes available, but will need to go through the GMC internal structures.

b. Other patient minority groups such as gay & lesbian patient user group and ethnic minority patient user group.

c. Emerging Local Education and Training Boards.

d. Employer representatives from Scotland – currently there is work trying to enable better engagement with key people in employment fields across the 4 countries. This will be strengthened to capture evidence regionally.

25. Members suggested patient organisations should be included into the engagement plan as a way of gaining insight into patient needs and outcomes..

26. The review would benefit from looking at the large amount of research on patient and public views, particularly by the Picker Institute.

27. As well as international comparisons, the review could look at comparisons outside of medicine, other professions even outside healthcare. The group discussed comparing countries like Australia, Canada, Denmark, Sweden, France, Germany and Netherlands

28. DG invited members to participate in engagement events.

Action: JM to circulate dates of events to EAG members.

Item 4 – Website demonstration

29. Members viewed the site at the end of the meeting.

30. It was highlighted that the website needed to have a password protected area for members, to share information and contact details/links relevant to the review. PR to contact Peter Markham to create restricted area for members on the website.

Action: PR to contact Peter Markham about restricted access on website.

Item 5 – Research to support the review

31. PR outlined possible areas where research could be commissioned.

32. Members cautioned about commissioning research about how other countries structure their medical education and training due to the implications of EU law.

33. DG outlined that the list of possible research areas is not exhaustive. Work on the structure of the current workforce and its expectations in the next few years, plus work on patient needs will be fed back to members.

34. Members discussed the impact of the Working Time Regulations. The GMC currently has a work stream relating to these issues, which can be fed into this review, including a literature review on working time regulations.

35. It was suggested that the review looks at data already collected, including access to Goldacre data and other reports.

Item 6 – Future meetings

36. Dates for further meetings will be circulated.

Item 7 – AOB

37. There was a discussion around the privacy of meeting papers and it was decided that papers should be available on the website. It was also agreed that the Sponsoring Board for the review will have sight of the minutes.