19 December 2012

Expert Advisory Group meeting

Approved

Minutes of the meeting on 19 December 2012

Members present

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

Staff Present

Vicky Osgood
Richard Marchant
Jessie Moye
Paula Robblee
Stuart Carney

Apologies

David Greenaway (Chair of Review)
John Savill
Ajay Kakkar
Richard Green

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

1. PD chaired this meeting on David Greenaway's behalf. VO updated the group on DG's recent meetings with key stakeholders.

2. BR fed back on the BMA Academic Trainees Conference which he attended on 3 November 2012. Flexibility was the main theme which raised discussion and it was a good exercise for raising awareness of the review.

3. VO fed back on the ASME Medical Research Conference which she attended on 21 November 2012. Again this was a good exercise for raising awareness of the review as Shape of Training is now on the ASME agenda.

4. PN fed back on the BMA SAS Doctors Committee he attended on 5 December 2012. The group was very receptive and enthusiastic about the review and most were aware of the progress and work of the review.

5. VO and SC fed back on the BMA Junior Doctors Committee which they attended on 7 December 2012. There was a lengthy discussion and the themes raised were balanced views of how the service will develop. The presentation was then reported in BMA news which was highlighted as an issue. VO raised the importance of ensuring that presentations are not reported on without our knowledge. Press related queries should be escalated to the executive in order for our press team to effectively support press around the review.

6. VO fed back on the site visit to Musgrove Park in Taunton which took place on 22 November 2012. The visit was very useful, the trust board, trainees and trainers were very committed and had begun thinking of what doctors they will need in the future. SC highlighted an issue with the visits so far which was how we engage with patients and public. At Musgrove Park they discuss a patient journey at every board meeting which the team felt was good practice.

7. VO discussed the upcoming activities in 2013. There are six more site visits planned, five in January and one in February. Two more seminars are due to take place in January, one in Manchester on the 8th and one in Northern Ireland on the 23rd.

8. The call for ideas and evidence launched on 8 November 2012 and will run until 8 February 2013. So far we have received over 150 responses.

9. Oral evidence sessions will also take place in 2013, between March and June. We hope to representatives from the group present at these sessions.

10. In January 2013 we will be contacting the chairs of each LETB and work towards organising a seminar in the spring which focuses on employer's needs and the LETB's role in medical education and training.

Item 2 - Minutes of meeting 24 October 2012

11. The minutes of the meeting on 24 October 2012 were approved with changes made to attendee's titles.

12. There was a suggestion to revisit the paper presented on patient needs and work towards developing our patient engagement strategy. It was felt that the numerous existing data on what patients want was not reflected in the paper. There is a possibility to extend our current literature review to encompass patient data.

Action: Contact Medical Schools Council, Deanery and Royal College lay groups as well informed forums for patient engagement.

Item 3 – A definition of generalism

13. PR presented the paper. It focused on what generalism means for this review and encourages discussion on how we can define generalism. It gave examples of how generalism is understood in different jurisdictions, particularly starting to look at generalism as an approach of care.

14. It is necessary to identify whether we mean generalism across the whole of medical education including surgical specialists, or whether this view of generalism only applies to medical specialties. The generalists are likely to be within specialties and would seek advice in particular areas of speciality medicine from specialists.

15. It was suggested that generalist training should follow the foundation years. The group were in agreement that there should be a period of prolonged core training where trainees gain experience in different areas of medicine.

16. Generalism is not just about chronic and multiple conditions, but also acute conditions. Similarly generalism is not just about primary care, but both primary and secondary care. The review should not focus on dealing with issues in acute medical take.

17. Generalism is incredibly important in the emergency surgical field to enable people to gain a global view of a patient's condition. Broad based general learning should be developed into the early stages of specialty surgical training.

18. The definition of generalism is context dependant. The group mentioned the recent Health Foundation work which looks at generalism as a function of service delivery rather than capabilities. The work also outlined underlying principles of generalism which can be applied to different contexts. The work then looks at the patient's view of generalism and what is best for the patient. The group were urged to develop these aspects.

19. The concept of having a period of consolidation where people would be delivering service for number of years before developing managerial roles or moving into specialist areas would be very valuable for employers.

20. The group discussed how all paediatricians used to be required to do general medicine, but this no longer happens. It was suggested that there may need to an alternative model which looks at training in two aspects: service solutions which would require generalist skills and delivery of those solutions which may not need a broad range skills. Different areas of service delivery will require a different approach to training.

21. The group then discussed the option of having early entry into specialist training which could sit in parallel to a broader model. Comments were made to the work of Richard Resnik in Canada who has developed a model for training specialists straight out of medial school.

22. There are specialties currently which lack a certain amount of broad based generalist knowledge which would be beneficial to learning and development, such as in psychiatry where it would be good for doctors to have some knowledge of patient's physical needs in order to care for the whole patient not just the mental health issue.

23. It is important to have an effective interface with community care and secondary care. Generalism is a route to streamlining care.

24. The group discussed a concept which was raised at one of the review seminars, the concept of connect 4 training, which is modular training where you would acquire core skills and map them against what the service and patients need.

25. With the rise in demand for 24/7 service, we need to think about what volumes of numbers of staff and at what levels of competency we need in order to deliver this service and then work towards designing a training programme.

- SC presented the recent UK Foundation Programme paper F2 Career Destination Report (December 2012). Primary interest for the report is the proportion of people entering GP and psychiatric training.

Action: JM to circulate report to members.

Action: Data on the number of trainees returning to UK and the number of trainees coming from Europe to be presented to the group when available.

Item 4 - The legal and regulatory implications of a new shape for training

26. RM presented the paper, which is an evaluation of the legal and regulatory implications of European law for this review. The paper concludes that there are no

obstacles in terms of European law, though possibly changes to UK regulation are needed for development of a new training model.

27. There is a risk if we change UK regulation to reflect a very unique model that doctors will be unable to work in other countries. If our training programme is too unique then overseas applicants' qualifications could struggle to fit our system.

28. The group was keen to retain the generalist/specialist model.

29. There was a discussion as to the implications of credentialing. Credentialing will need to be regulated and subject to QA processes. The standards would be set and agreed at a national level.

30. It was suggested that the legal and regulatory implications should be assessed after agreeing the structure of a new training model.

Item 5 - Update on events and emerging trends and issues

31. VO presented paper. This will be a regular item at the meeting.

32. Feminisation of the workforce and the rise in demand for career breaks, although raised as an earlier issue within the group. The theme of flexibility should be expanded to include these issues

Item 6 - A possible approach to postgraduate training

33. VO introduced proposed model and explained all aspects of the diagram. The group offered views on the model.

- What is the minimum core training everyone should have? Important to identify timings of different stages. Should be common curriculum which allows you to easily move between primary and secondary care.

- There needs to be an academic run through stem on the diagram. The academic stem should be infused in all stem disciplines. There should be academic outcomes for all.

- The exact length of generalist training should be primarily concerned with what is needed to deliver 24/7 care, not what the profession wants.

- Idea of run-through mixed economy received positive feedback from the group. Idea of career progression through management and leadership should be part of the earlier training curriculum.

- There was concern as to how SAS doctors would fit into this model. Possibility that future consultant careers will have way points.

- It was suggested that all salaries could be held by service for doctors in training in a managed training system.

- The group discussed the idea of apprenticeships, where you become a journeyman at the end of your scheme and are able to do most things without supervision, but will need some mentoring and support.

- Model anticipates that the only way through to speciality training is after completing general training. Those in further general training should also be able move into a specialty.

- Timing and competencies will be different in each speciality. An additional section should be added to diagram for subspecialties.

- We need to think about how we ensure hospital based doctors have community based skills and vice versa, we cannot rely on incoming trainees to manage critical mass of change.

Action: Members to give comments on diagram. Adapted diagram to be presented at meeting in March.

Item 7 – AOB

34. None.