24 October 2012

Expert Advisory Group meeting

Approved

Minutes of the meeting on 24 October 2012 (draft)

Members present

Angela Coulter
Tom Dolphin
Peter Dolton
David Greenaway
Susan James
Malcolm Lewis
Clare Marx
Peter Nightingale
Bill Reid
Ajay Kakkar

Staff Present

Vicky Osgood
Richard Marchant
Jessie Moye
Paula Robblee
Richard Green
Mujtaba Husain

Apologies

Paul Stewart
John Jenkins
John Savill
Stuart Carney

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

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

2. He fed back on the site visit to Altnagelvin Area Hospital in Derry. DG emphasised that he felt the site visit moved the review forward a phase.

3. PN fed back on the London Deanery Conference which he attended on 23 October 2012. On the whole people were very keen to get involved with the review. Delegates emphasised that many SAS doctors will be retiring and were interested in how the review will drive re-configuration of the service along with the future hospital commission work. It was a good exercise in raising awareness of the review but PN found many delegates were unaware it was happening.

4. DG discussed the upcoming activities with another 7 site visits planned from November 2012 to January 2013. Five seminars will take place across the UK starting in November 2012 and running through to January 2013.

5. The call for ideas and evidence will launch at the beginning of November along with a newsletter to stakeholders.

6. DG outlined the work that we have commissioned on a literature review that will look at information and evidence related to each of the review's themes. He also described the plans to commission another piece of work around the shape of the medial workforce.

Item 2 Minutes of meeting 17 July 2012

7. The minutes of the meeting on 17 July 2012 were approved.

Item 3 – What employers want from postgraduate medical education and training

8. PR presented the paper. It focused on what employers want from the medical profession in order to provide effective medical care in the future and looked at how training may be reorganised to provide the kinds of doctors needed over the next 30 years.

9. Members agreed that training can't be distanced from service, particularly through this period of change and reconfiguration. We also have to consider changes in the way other health and social care professions will work, especially emerging groups like physician assistants.

10. Members discussed the need to address the expectations and career aspirations of medical students. Medical students need to be made aware, not necessarily about the review, but about the way service and training will change and how this might differ from how they currently view their future. Students will need to understand that many of them will become generalists and work within the community as opposed to pursuing narrower specialist careers.

11. Although outside the remit of the review, it was noted that the way in which medical students are selected into medial schools may not emphasise the right balance of skills that will be expected in doctors in the future. For example, if service in the future requires fewer surgeons and more general physicians and psychiatrists, then we should be selecting medical students with skills specifically needed for those areas of medicine.

12. In order to bridge the gaps in service we need to develop a way to enhance the status of certain specialities. This would include developing incentives for people to pursue less popular disciplines. For example, there is ongoing work to address issues with shortages in emergency medicine. The Emergency Medicine Taskforce is carrying out work to improve recruitment by looking at ways to re-configure the service.

13. The group discussed the value of providing primary and community care within secondary care settings.

14. The group discussed the rise in GP referrals to hospitals. The work that GPs do to keep care of patients within the community is sometimes overlooked. The rise in referrals is not based on a GP's incompetence or inability to refer appropriately, but on poor availability of community services such as access to GPs at weekends.

15. The group commented that moving the CCT forward to enable doctors to start working at an earlier stage in their career would require far more intensive supervision by consultants or managers. The group discussed whether doctors who have had four or five years of training could deliver key services at a generalist level, provided they were being supervised appropriately.

16. Members suggested four or five years of generalist training with progression into service would not be adequate for some specialties because they have not yet had enough time and experience to gain necessary knowledge and skills to practice in that specialty.

17. Some members suggested there should be a period of employment where people are not chasing after training but are consolidating their skills to work within teams and be part of the wider hospital community.

18. However, other members doubted there would be any demand from trainees to step out of training to consolidate experience, particularly if this meant a risk to their subsequent career progression. It was argued that if training programmes are

not currently producing doctors with enough experience, then training programmes need to be longer.

19. The group suggested we needed to have a better understanding of the definition of generalism. They emphasised that the objective of generalism was not to introduce a sub-consultant grade. But the number of specialists and generalists would have to be managed.

20. It was also noted that any new model for training (including a generalist model) would need to take account of the European and UK legal and regulatory frameworks for training.

> **Action:** The review needs to discuss the definition of generalism at the next meeting.
>
> **Action:** A paper to be prepared for the next meeting setting out the legal and regulatory context for postgraduate training.

Item 4 – What trainees want from postgraduate medical education and training

21. PR presented the paper. It looked at what doctors in training want from their training. It focused on the need for more flexibility, more time to learn and reflect on learning, and a closer relationship with trainers and supervisors.

22. The group commented that due to changes in shift patterns some trainees are unable to get effective feedback from patients or to follow patients through their care pathway.

23. Members discussed the feminisation of medicine and the impact of more women entering training. But the group acknowledged that men as well as women are looking for more flexible work patterns and a work/life balance.

24. The group considered how it would be possible to change societal views of certain specialities in order to raise the status and value of generalist training.

25. There is evidence that some medical schools which expose students to general practice at an earlier stage have a higher number of students going into general practice.

26. It was highlighted that trainees working after midnight and on the weekend in emergency departments often feel they do not have the competence or confidence to deal with a variety of situations. Many trainees step out of training in order to gain experience and consolidate their knowledge before continuing with their training.

27. The group discussed the way doctors' roles might change throughout their career. We cannot deal with the aspects of early training without considering career progression over the lifetime of a specialist.

Item 5 – What patients want from postgraduate medical education and training

28. PR presented the paper. It looked at what patients may want and need from their doctors and how this might impact on training.

29. Members suggested that research and work on patient expectation was extensive and a careful consideration of this information should inform the review.

30. Increasing fragmentation of medicine is seen as a large problem for patients. We also need to ensure that a patient's care flows smoothly across the boundaries of primary, secondary and social care.

31. Patients want a more personalised and individualised approach to their care. Care needs to be organised in a proactive manner as opposed to reactive, and patients want to be involved in identifying and monitoring a care plan.

> **Action:** To obtain the Future Hospital Commission slides on patient issues for information.

32. The group acknowledged that patients do not care about the different levels reached by doctors in training. Rather, they want to know they are being seen by the right doctor at the right time. More work needs to be done in this area.

33. It was highlighted that the RCGP has been attempting to extend and enhance GP training.

34. It was suggested that in order to gain patient feedback and identify patient needs, we should speak to the NHS Ombudsman. This would provide an analysis of complaints about doctors.

Item 6 – Opportunity to consider and discuss the possible questions for the written call for evidence (presentation)

35. The group did not get a chance to discuss the proposed questions at the meeting. Instead, the questions were subsequently sent to EAG members to comment on electronically. In the light of their comments the call for evidence was issued on 7 November 2012.

Action: Questions for the call for written evidence sent to DG and members of the EAG.

Item 7 – AOB

36. The group asked for a paper at the next meeting to set out possible approaches or models.