ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW

CONSULTATION:	The implementation of the working time directive – and its impact on the NHS and health professionals – call for evidence
ORIGINATING SOURCE:	Working Time Directive Taskforce
CONTRIBUTORS:	Dr Frank Dunn, President, RCPSG Professor Hazel Scott, Honorary Secretary, RCPSG
Submitted:	12 November 2013

Response from the Royal College of Physicians and Surgeons of Glasgow to the Call for Evidence from the Working Time Directive Taskforce

Along with other Colleges, we have previously expressed concerns that medical training, especially in procedural disciplines, is very dependent on experiential learning, gained through exposure to hours of clinical work. Previous published work has noted the reduction in total hours of such experience gained, by those attaining consultant status today, as compared with their predecessors 10 years ago[1] and concerns, not just within the UK, that effective quality training cannot be delivered within the available hours[2,3].

We concur with the view expressed in the Temple report[4], that 'what matters most in training doctors is not just the hours of work but what they do in those hours' and we believe that considerable efforts to structure training and its assessment and to focus hours of work on the delivery of training have been very beneficial. However, we remain convinced that the actual hours of clinical exposure are also important. Training, however structured, supported and assessed, is negatively affected by rigid restrictions on hours that can be worked by trainees. We are particularly concerned that such restrictions may doubly impact on the quality of future craft specialty practice if the proposed 'Shape of Training'[5] generalist CST holders are to be created in the specified time frame.

Just as the reduction in contact hours with relevant clinical scenarios is a concern, so too is the reduction in continuity of contact with a single trainer or mentor. The more personal relationship that such continuity of trainer-trainee contact permits is an important, and now often absent, contributor to a trainer awareness of issues with trainee development and to the fostering of excellent skills and clinical leadership. Similarly, continuity of trainee contact with the patient is important to the trainee understanding of the totality of their patient's journey and the impact that their clinical decisions may have had. Both types of contact are restricted by the working patterns that are a direct result of the European Working Time Directive. In this regard we would commend the Shape of Training's call for a longer duration of placements as this may help to counter the breakdown in contact created by reduced weekly hours.

In addition, the number of medical staff required to sustain a viable acute care rota, is made much greater, under EWTD restrictions, than would previously have been necessary. There appears to be a conflict, between the numbers required to fulfill patient care within the EWTD, and the numbers projected as necessary to train to create a consultant workforce. We believe that this is having particular impact on care within 'district general' hospitals. The quality of care such hospitals can provide for the communities they serve, is jeopardised by the frequent staff transitions and vacant rota gaps that result from the above conflict. In addition, the quality of training is frequently a casualty of over-stretched clinical environments. Moreover, despite the EWTD, trainees continue to work long shifts with resultant stress and the potential for risk to patient care[6].

1) http://www.asit.org/assets/documents/ASiT_EWTD_Position_Statement.pdf
2) http://archsurg.jamanetwork.com/mobile/article.aspx?articleid=406024
3) http://www.gmc-uk.org/static/documents/content/Training_survey-FINAL2010.pdf

4) http://hee.nhs.uk/healtheducationengland/files/2012/08/Time-for-training-report.pdf
5) http://www.shapeoftraining.co.uk/static/documents/content/Shape_of_training_FINAL_Report.pdf_53977887.pdf
6) http://www.gmc-uk.org/about/research/14413.asp

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW

CONSULTATION:	Knowledge Network Subscription Consultation
ORIGINATING SOURCE:	Healthcare Improvement Scotland
CONTRIBUTORS:	Mrs Carol Parry, Library and Heritage Manager
Submitted:	15 November 2013

SBAR: Knowledge Network Subscription Consultation

Having read the consultation paper, we feel that Option 2 would be preferable and would make the following comments:

a. Most of our members use library resources to support their clinical practice rather than research roles. Our preference of Option 2 is made in the expectation that those in research roles are likely to have access to a wide range of research journals already through their university or similar institution.

b. Those in clinical practice would prefer the re-introduction of *UpToDate* as part of a suite of similar point of care resources, even if this means a smaller range of journal titles. Our endorsement of option two is on the assumption that *UpToDate* would be re-introduced as suggested by the consultation. There was considerable concern from some of our members when *UpToDate* was withdrawn. The alternative resource provided has not proved sufficiently satisfactory.

c. We do not know the usage statistics for our members on the Knowledge Network so we are unable to compare statistics for journals/databases versus point of care resources but presumably these latter win out overall, hence their preference in the Knowledge into Action strategy. Nevertheless, we would wish to emphasise the importance of resources available for remote use by clinicians, rather than an increase in the availability of knowledge managers, as regards the financial planning for Option 2.

d. Greater clarity over the implementation plan for Option 2 will be needed as the business case develops. It would be helpful if a list of the journals that are being removed could be shared with stakeholders, so that we can make alternative arrangements for access in advance.

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW

CONSULTATION:	Professionalism and Excellence in Scottish Medicine
ORIGINATING SOURCE:	Scottish Academy
CONTRIBUTORS:	Dr Frank G Dunn, President, RCPSG Mrs Alison Lannigan, Consultant Surgeon Mr Mike McKirdy, Vice-President (Surgical), RCPSG Dr Colin Perry, Consultant Physician Professor Hazel Scott, Honorary Secretary, RCPSG
Submitted:	14 November 2013

The Royal College of Physicians and Surgeons of Glasgow welcomes this summary of Scotland's emerging approach to support the understanding and enhanced practice in the important domains of medical professionalism

- leadership
- management
- quality improvement

Such a report is especially timely as Scotland collectively develops strategies to implement the recommendations of the Francis Report.

We would wish to make the following comments:

1. We particularly welcome the development of combined activities to increase theoretical understanding in these domains as well as experiential learning and learning from others in the field.

2. We welcome the suggested spiral approach to learning across the clinical career. We think it is important that management, leadership and quality improvement are all embedded in this and that there not be any disproportionate emphasis given to leadership. Quality improvement is clearly a key component in securing both excellence and professionalism.

3. We acknowledge the diversity of clinical curricula and the need to have a greater degree of explicit coverage of each of the above domains, mapped to generic standards. We look forward to working with stakeholders to develop this, in response to the recommendations of the Shape of Medical Training Report. We hope that the five key points raised by our trainees will be embraced through the Greenaway Report. There is no doubt that the establishment of professional behaviour in trainees is directly related to the conduct and support of their seniors.

4. Much of the work outlined by the report focuses on medical leadership. Our College is particularly interested and committed to support this domain of development and host a series of lectures and leadership courses to emphasise our commitment to this very important area.

5. The elements within the report that relate to the growth of quality improvement in medical management expertise appear to sit more within the work streams designed to develop leadership. We would welcome a further piece of work to map development opportunities in these three domains separately (both learning and experiential). This would help to identify gaps and clarify elements that support the three domains and thereafter progressing to a combined frame working.

6. The chapter on professionalism includes work on quality improvement and leadership. This is important work but, reported under this heading, masks the need for a continued, career-long focus on professionalism and the development of a framework to support this. We would also welcome greater detail of a) how undergraduate and postgraduate recruitment policies are informed by work to support professionalism and b) how undergraduate courses across Scotland may contribute in future to the foundations of the frameworks for each domain.

7. Chapter 4 seems to be rather unfocused and it would seem there is a requirement to make more clear-cut those who take ownership of these strands of work rather than identifying particular organisations such as Government, Academy and Medical Directors etc.

8. Once again we applaud this initiative and appreciate the importance of all of these strands and the need to embed them clearly from the earliest possible stage in medical training.

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW

CONSULTATION:	Help us shape the scrutiny of your healthcare
ORIGINATING SOURCE:	Health Improvement Scotland
CONTRIBUTORS:	Dr Frank G Dunn, President, RCPSG Professor Hazel Scott, Honorary Secretary, RCPSG
Submitted:	30 October 2013

RCPSG is pleased to comment on the important plans for ongoing healthcare scrutiny in Scotland, by Healthcare Improvement Scotland. We note and endorse the principles this document upholds and would make the following additional comments.

We are surprised that there are plans to scrutinize medical revalidation at this stage in its evolution and hope that this does not adversely affect the implementation of new systems within boards.

We are concerned at the lack of scrutiny of the timely availability of senior clinical decision making for inpatients.

Such decision making underpins effective quality care but also efficient patient throughput, that in turn impacts on the quality of care at hospital front doors. Recent evidence has identified the relationship between poorer patient outcomes and the lack of such decision making throughout the week. We believe that HIS is well placed to take forward important work to establish mechanisms for the monitoring of barriers to such effective decision making and its impact on patient care.