ROYAL COLLEGE OF
PHYSICIANS AND
SURGEONS OF GLASGOW

CONSULTATION:	The Shape of Training (Greenaway)
ORIGINATING SOURCE:	*Independent Review*
CONTRIBUTORS:	Dr Frank Dunn, President, RCPSG Professor Hazel Scott, Honorary Secretary, RCPSG Members of College Council Lay Advisory Board
Submitted:	24 January 2013

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW

From the President

5th February 2013

Professor David Greenaway
Chair of Shape of Training Review

Dear Professor Greenaway

Re: Submission of Response of The Royal College of Physicians and Surgeons of Glasgow

I am pleased to attach the response of this College to your review and one which everyone I speak to within the profession appreciates the need for and the importance of.

We fully appreciate the challenges that lie ahead and the changes that are occurring within the Health Service which, in many respects, are outwith our control. We are all conscious of the influence of the European Working Time Directive, the feminisation of the workforce, the major financial pressure that the Health Service is under and the progressive privatisation of the Health Service, particularly in England. All of these factors significantly challenge the requirement to deliver best possible healthcare to our patients. I am sure many of those responding to you will emphasise that, in all of this, we must not forget the need to direct all our energies towards retaining excellence in the care of our patients. This requires to be central and it is very appropriate, therefore, that your first question deals specifically on the way patients are cared for and how this will change over the next 30 years.

There are a number of issues which, within our response, we would like to emphasise as being of key importance in planning the shape of training for the years to come. These are not to under-estimate other areas but we feel they are fundamental and require particular attention:

1. **The interface between primary and secondary care**

   There seems to have been over the past 20 years, separation of these two entities and this has challenged greatly the ability of both sectors to optimally care for patients. We have seen over the past 10 years in palliative care, a realisation that the needs of some patients can be served better in the home environment, provided resources are put in place. Palliative care is a good example of how the service is delivered with the patient very much at the centre of all planning.

   Many elderly patients would be better served by having continuing care in their home or in a nursing home rather than within a hospital environment when any medical issue develops. Many of our hospitals now, particularly those funded by Private Finance Initiatives, have a reduced number of acute beds and this combination with increased admissions is de-stabilising. There is therefore a need to have a more integrated relationship between primary and secondary care thus facilitating, where possible, the management of patients in the community. At the same time, doctors within the hospital environment should also have an appreciation of

the issues in primary care and the need to work more closely in partnership with colleagues in the community. In all of this, the support of social services is key and there needs here to be a re-integration of social services between the primary and secondary sectors.

2. **Training Issues**

We agree that there needs to be more flexibility in training for junior doctors and a much longer common stem which allows them to differentiate at a time when they are more clear about where their future lies. The current problems could be traced back to the programmes in FY1 and FY2 which are partly dictated by rotas and European Working Time Directives. Although doctors may be assigned to a particular department or unit for a period of months, in effect, they often only end up spending a few weeks in each of these units. Therefore, it becomes difficult for them to feel integrated into the unit and for the permanent staff in the unit to advise and guide them. One solution to this would be to put in place a longer period of time in each unit. We would suggest a total period of six months. Clearly, within that, there will be rotation out for acute receiving and other rota responsibilities but this would allow senior staff to get to know the junior doctors. It would also allow better use of mentoring and also career guidance. At the same time, the junior doctors would be able to grow in confidence. There would still be exposure to other disciplines within the hospital and this environment would provide a more stable base for decision making in regard to future careers. A total period of two years at FY1 and FY2 does seem to be appropriate with four periods of six months, at least one of which should be in general medicine and one in general surgery.

After FY2, a more prolonged common stem with a detailed exposure to general aspects of care in hospital, whether it be on the medical side or the surgical side, seems appropriate. The rising tide of patients with undifferentiated illnesses and multiple co-morbidity make it imperative that this general training is regarded as an equal to the specialist training. Those who decide to continue in a career related solely to the general aspects of care should be accorded the same senior status as those who specialise. We fully agree that training lasts throughout one's medical career and that much of what happens in specialisation and sub-specialisation sits just as comfortably within the Consultant grade as earlier. We also see a role for doctors who train in the key aspects of primary care and also have experience in secondary care so that this can be utilised at the primary-secondary care interface.

3. **Training Versus Service**

We all acknowledge that the health service as it is currently set up, requires junior doctors to assist with the service component and therefore, achieving the right balance between training and service a major challenge. It would seem to us that more positives steps have been made in regard to supervision and training in elective situations. It seems also that junior doctors are more exposed in the evenings, at night and on weekends with emergencies and it is in this area that more senior support is needed. This would require an increase in the Consultant workforce and this is something we believe is also needed for other reasons, including European Working Time Directives, feminisation of the workforce, revalidation and the need for a Consultant-led workforce. Without recognition of the need for more Consultants, then achieving a balance

between training and service for junior doctors will not be possible. This requires to be recognised.

We would be more than happy to submit oral evidence as required to your review. We hope that government agencies will recognise that for the implementation of such a review as this, there are resource implications and we hope that all the hard work that goes into such a review will not be lost by a financially driven failure to deliver its findings.

Best wishes

Yours sincerely
ON BEHALF OF THE ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW

Dr Francis G Dunn, PRCPSG
President

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW

Royal College of Physicians and Surgeons of Glasgow
Response to Shape of Training Review for Academy of Medical Royal Colleges
January 2013

1. Over the next 30 years, how do you think the way patients are cared for will change?

An ageing and enlarging population, a greater prevalence of chronic disease, a projected further feminisation of the medical workforce and the impact of fiscal challenges will require new approaches to patient care. We believe these will include:

a. Enhanced focus on primary prevention at all levels of care

b. Increased role for primary care in the co-ordination of the patient journey

c. Improved capacity for patient management in primary care, founded on a greater community-based working knowledge of core conditions. Primary care practice in key specialty areas (including shared care) and local diagnostic or AHP services would also be supported by primary care services being provided by larger groups of practitioners and customised bus services

d. Increased multi-professional working

e. Improved and equitable co-ordination of access to AHP services and social services in the community, releasing primary and secondary care medical time

f. Seven day secondary care clinical and diagnostic services supported by seven day access to social services and senior medical presence

g. Greater numbers of clinicians practising at senior medical level who are available to assess and advise on patients admitted acutely to secondary care

h. Greater senior clinician capacity for the management of patient co-morbidity, fostered by increased experience of a wider range of relevant presentations, including in older patients

i. A move away from out of hours primary care services that are potentially disassociated with GP patient knowledge at the time of assessment, towards one of seven day practice-based involvement in decisions made in primary care and active use of practice-based interventions or follow-up as alternatives to secondary referral

j. Greater use of electronic and patient held records to support communication flow across a team and patient ownership of care

2. What will this mean for the kinds of doctors that will be needed in primary care? In secondary care? In other kinds of care?

a. Doctors in primary care will require a greater working knowledge of core clinical conditions currently managed primarily in secondary care and doctors in secondary care will require a greater understanding of the patient journey and care feasible in primary

care. This may require a greater practice by doctors from both sectors in the opposite sector.

b. Both groups of doctors will need training and a shift in cultural practice to develop greater team-based care delivery: within each sector, across each sector and multi-professionally.

3. What do you think will be the specific role of general practitioners in all of this?

a. General practitioners should have an enhanced role in the co-ordination of the patient journey and as gatekeeper to services.

b. General practitioners should have a greater role in out of hours service provision – providing greater clinical leadership and ownership of the out of hours response, relevant to the patients known to the practice and to the services provided within hours. A return to home visits should be considered with social support to manage patients at home whereas possible. This is key to reducing ongoing rise in medical admissions

c. General practitioners should also have a role to provide greater locally delivered advice and management of a specialist nature. However current primary care workload is such that it could not safely and effectively deliver additional services in its current format. Measures that do not include training (detailed in section 4) that may be useful to support this include:

- release of primary care medical time, through revised social and AHP service provision
- greater and more rapid access to seven day senior secondary care advice

4. If the balance between GPs, generalists and specialists will be different in future, how should doctors' training including (GP training) change to meet these needs?

General practice and specialist interface – recommended changes in training to meet these needs include:

a. greater specialist interest training of GPs, both during and after training: GP training should routinely include extra time devoted to qualifying in one specialty interest for further development and practice (when qualified as a GP) as a GPwSI, affiliated to a regional specialist service

b. greater input of trainees training in secondary care to GP practice based delivery of specialist care: for the vast majority of specialties it would enhance future practice in secondary care for trainees to extend higher training and spend a day per week in large primary care establishments for one or more year of higher training (at year 2 or above), providing out-patient specialist advice, drawing on senior specialist advice where required, liaising with GPs, acquiring an understanding of community practice and how their secondary care discipline can best work with it and developing skills as an independent practitioner.

c. greater involvement of trainees training in general practice with supervised secondary care out of hours provision: trainees training in general practice should continue

throughout their training to be part of a secondary care out of hours service related to their GPwSI interest or a relevant parent generalist specialty. This would preserve skills in acute assessment and management in this discipline and contribute experienced trainee input to such service delivery.

For secondary care training, it is important that equitable access to specialist skills is maintained. Nevertheless, there is a strong public and professional desire for acute service provision to benefit from a greater delivery of service by doctors who are trained and confident to cope with the range of conditions presenting to all hospitals. The following are recommendations relevant to these needs:

a. It would be unwise to create such generalists simply by stopping existing training at a mid-point. Equally, newly qualified CCT holders have been acknowledged as lacking confidence in acute generalist settings. This has been attributed to a focus on general training at early stages of their training, rather than throughout it and to an overall reduction in clinical exposure to such settings. If new generalists are to behave in such a way as to reassure the public of their independent practitioner status, they will require greater experience than currently included in the 'general' component of most dual specialty CCT curricula. Pending changes to the EWTD, it is recommended that the training required to achieve a 'generalist CCT' should be a minimum of 6 years experience post Foundation.

b. Additional time during generalist training should be made available in a specialty interest for those considering defined and approved specialty-CCT fellowships. This will enhance the subsequent interface between generalists and specialists and contribute to more informed selection of suitable applicants for such fellowships.

c. It is recommended that the number of specialties and specialty curricula are reduced. Consideration should be given to identifying the features of specialty curricula that are less frequently used and reserving these for additional specialty-CCT training. Coverage of more commonly required specialty competencies should be achieved by additional time within a parent generalist curriculum.

d. A training long contribution to acute generalist service delivery in a relevant parent discipline, irrespective of whether a CCT in generalist care is required, should, for trainees training in all bed-holding specialties be seen as an essential requirement. This will enhance the generalist knowledge needed to manage patients with increasingly multiple co-morbidities.

e. Additional more structured post CCT development for the initial years after CCT is recommended. Much has been made of the effect of reductions in hours of training exposure on the competence and confidence of new consultants. Appraisal (if outside of the specialty) and informal mentorship are useful as additional measures, but do not replace optimum training exposure.

f. A team-based focus to senior medical practice is key to successful future patient care. Difficulties with risk management, potential 7-day working and projected workforce demographics require new approaches to training regarding working in teams. The current focus on such training has been on the multidisciplinary team. However, it is important to bring a new focus to the workings of the medical team within this. Clinicians of the future will require, ethically and legally, to be more concerned about the output of

the whole team, rather than simply their own. Clinical monitoring and appraisal may need similar adjustment.

g. A close clinical team is key to safe patient care delivery. The current dissociation between senior and junior members of the medical team fostered by recruitment that is not owned by teams, frequent rotations and shifts, is hazardous to care and detrimental to training and mentorship. New ways of working should seek to mitigate this.

5. How can the need for clinical academics and researchers best be accommodated within such changes?

a. Audit, research and also clinical teaching should be seen as core elements of generalist and specialist curricula and in primary as well as secondary care.

b. A career in clinical academia or clinical education should generally be seen as an area of specialism. However, this is expected to need additional input develop alongside the latter years of generalist CCT, rather than be a 'post CCT' specialty only.

c. Time out of service for research and re-entry should be assured at all later stages of training.

6. How would a more flexible approach to postgraduate training look in relation to

a) Doctors in training as employees?

An integrated extended common stem to postgraduate parent specialty training is seen as a key development to support flexibility and greater service provision. Required periods of service at specific points in the trainee journey are felt to be dangerous to patient care as new approaches to monitoring of progress and care delivery would be required.

Rotations during the Foundation years are too brief. They do not provide opportunities for the trainees to be integrated into the unit and thereby be given more experience and responsibility. The permanent staff do not have long enough to get to know them and therefore to build them into the team. Consultants find evaluation and appraisal difficult, often struggling to remember subsequently any details about the trainee. The current arrangement is more akin to a "taster" programme and would be more appropriate as an undergraduate. A base unit of six months should be considered with the usual spells in acute Medicine.

b) The service and workforce planning?

A period of generalist training would support workforce planning by reducing the numbers of doctors committed solely to one particular specialty and, through additional structured post CCT training, develop additional desired specialists.

c) The outcome of training – the kinds and functions of doctors?

A reduction in the number of specialties and wider generalist training, by almost all specialties, to create a generalist CCT, prior to additional CCT specialist training should be the norm.

The public is most assured by the concept of a 'consultant'. Equally for medicine to continue to attract highly motivated and able individuals it is important to retain such a term and a status of this nature.

To protect the quality of care delivery, a continuing career as a 'generalist' should be regarded and rewarded as highly valued, rather than seen as a cul-de-sac with transition to a specialist (and current consultant status) reserved for a favoured few. Indeed, the specialist is arguably a 'partialist', needing less training and requiring less to maintain their skills than the generalist, who must be equipped to cope with a much wider range of presentations. Attitudes about the value of practice, as a specialist versus a generalist, will need to change if effective care can be delivered in future. Future structures should not imply a 'pecking' order imposing the 'specialist' above the 'generalist'.

d) The current postgraduate medical education and training structure itself? (including clinical academic structures?)

The current end-point of such training is at CCT. This training supports a quality assured and standardised output, fit for purpose. Lesser arrangements for any new post-CCT training risk the quality of patient care in the UK. Mentoring and appraisal are useful but a structured, competency-based, curriculum focussed approach will be key to ensuring specialist services can be delivered to their current standard. Postgraduate deanery and LETB structures will be best placed to support the delivery of this, but as training will be within existing practice, a more flexible and supportive approach to delivery will be necessary.

7. How should the way doctors training and work change in order to meet their patients' needs over the next 30 years?

This has been addressed elsewhere.

8. Are there ways that we can clarify for patients the different roles and responsibilities of doctors at different points in their training and career and does this matter?

a. This does matter. Patients need the assurance that the individual seeing them or responsible for them is competent to practice at the level required. The multiplicity of titles for trainees is confusing. Equally, terms such as 'nurse consultant' are felt to be unhelpful if the term consultant is to be used to define to the public a senior medic.

b. The term Consultant, or whichever term is reserved for a medic of sufficient experience and confidence to practice independently and without the requirement for any further formal training, needs to be used for those who will indeed have such experience and provide such confident practice.

c. To practice as a generalist at the equivalent level of a current 'consultant' will need more training than the 'generalist time' currently contained in core and specialty curricula. Simply stopping training after the equivalent of 'Core training' to create a 'generalist consultant' would be misleading to the public. The equivalent of approximately 6 years post Foundation training is recommended as noted previously.

d. The term 'generalist' should be avoided. A term such as 'consultant physician' is preferable to the term 'generalist', with perhaps a double-barrelled term for those with more narrowed practice e.g. consultant physician-rheumatologist.

9. How should the rise of multi-professional teams to provide care affect the way doctors are trained?

As above, specific training targeting medical and not just multi-professional team-working is needed, as are quality assurance and appraisal vehicles that reflect team rather than individual practice.

10. Are the doctors coming out of training now able to step into consultant level jobs as we currently understand them?

Trainees appear generally able to secure posts. However, trainees also report feeling less equipped than their predecessors to take up these posts.

11. Is the current length and end point of training right?

Current trainees suggest their Foundation training feels too long and their higher training too short. A range of end-points would give greater flexibility as would an emphasis on core parent specialties. Ideally, training should be competency rather than simply time-based.

12. If training is made more general, how should the meaning of CCT change and what are the implications for doctors' subsequent CPD?

a. As above, training for a CCT requires to remain meaningful for it to generate an individual capable of independent practice.

b. An additional CCT, or structured and assured specialty-CCT fellowship is a reasonable approach to those pursuing a career with more limited and focussed practice in a defined specialty.

c. Both types of doctor will require CPD. If anything, those aiming to maintain skills in the broader 'generalist' area of practice may need more than those in a more narrow specialty field. CPD on its own is not a sufficient route to specialty training, if specialty practice is to remain at its current UK standard.

13. How do we make sure doctors in training get the right breadth and quality of learning experiences and time to reflect on these experiences?

a. Greater use of formal job-plans for doctors in training with protected time for training and teaching could be considered.

b. A focus on clinical education, as a core skill to be developed throughout the clinical career (in addition to leadership, management and research) would support the development of medical teaching faculty in the postgraduate setting, who are equipped to deliver teaching rather than just know their field.

14. What needs to be done to improve the transitions as doctors move between the different stages of their training and them into independent practice?

Mentoring and supervised 'acting up' would contribute to this at all career stages.

Periods of independent practice at a specific level of training could also support this but, except for those suggested in section 3, we are concerned that this would create a confusing array of practitioners for the public and would require additional monitoring mechanisms.

15. Have we currently got the balance right between trainees delivering service and having opportunities to learn though experience?

We currently focus much trainee time on emergency service provision. It would be better to ensure trainees can undertake care and procedures unsupervised in the elective setting before being required to deliver care or procedures without direct supervision, in an emergency setting.

16. Are there other ways trainees can work and train within the service? Should the service be dependent on delivery by trainees at all?

a. It is not desirable to separate training and service as both enhance the delivery of the other.

b. The financial model required to deliver service entirely without trainees is thought likely to prevent an entirely trained doctor delivery.

c. It is important for trainees to experience decision making, a sense of responsibility and growth in independent practice rather than being sheltered from it till later in their career.

17. What is good in the current system and should not be lost in any changes?

Clinical exposure and experiential training.

18. Are there any other changes needed to the organisation of medical education and training to make sure it remains fit for purpose in 30 years time that we have not touched on so far in this written call for evidence?

There was a strong feeling from trainers and trainees alike who contributed to this response that training is best within a system that can deliver proper mentorship and apprenticeship from trainers who are skilled and qualified in training and not just their field of practice.