The Royal College of Physicians of Edinburgh Trainees and Members' Committee (RCPE T&MC) Response to the 'Shape of Training' Review Call for Evidence

SUMMARY OF KEY POINTS IN RESPONSE TO REVIEW

The RCPE Trainees & Members' Committee (T&MC) represents the views of over 3000 doctors across the United Kingdom including all grades of trainee doctor, medical students and SAS doctors.

We welcome the 'Shape of Training' review for its recognition of the need to develop the current structure of postgraduate medical training to ensure it continues to provide consistent, high quality training for doctors throughout the UK with patient safety and high quality care at its heart. In recognising the tension between training and service provision, the Review presents a significant opportunity to start to address some of the inter-related problems which exist in medicine in the UK and which previous, narrower, Inquiry Reports have unfortunately failed to resolve.

In earlier recognition of these issues the RCPE T&MC published the Charter for Medical Training in 2011 which provides a practical foundation for ensuring that both doctors' training and patient safety can be improved [1]. The Charter for Medical Training is relevant to all doctors working within the medical specialties in the hospital sector and lays out detailed commitments covering patient care and safety, recruitment and induction, balancing training with service provision, ensuring quality training, assessment and curricula, and support and development. **We believe the Charter for Medical Training provides a firm and ready-made basis for cross-specialty adoption and its key recommendations should be integrated within the output of the Review.**

Other key points -

1. Patient safety and the continued provision of high quality care must be central to the review; continuity of patient care and of training are of paramount importance

2. CCT/CESR is fit for purpose and is an international benchmark of competence and ability for independent practice as a consultant; postgraduate training however is life-long

3. The introduction of a subconsultant grade would be detrimental and is opposed; the consultant model ensures the highest standards of safe and effective patient care, is what patients choose and ensures that medicine remains an attractive career; similarly the terms "trained doctor" and "stand-alone practitioner" cannot be supported

4. Flexibility in training encompassing LTFT training and movement between specialties with recognition of previous experience is crucial

5. The aging population and increasing co-morbidity require an expansion in the number of generalists; it does not follow that the number of specialists should be reduced as most specialties already operate beyond capacity; robust data must remain central to workforce planning

6. Generalism must not be seen as a "stepping off" point in medical training and cannot be completed in a shorter time frame than already exists in postgraduate medical training

7. Consideration should be given to training for all doctors in medicine for the elderly and general practice within their early postgraduate careers

8. Consideration should also be given to the extension of Core training with further consideration of a return to six-month core general medical and surgical placements in F1

9. It is difficult to separate training from the medical workforce as a whole; in particular senior doctors must be able to lead on training and service organisation requiring sufficient time and resource within job plans

10. Any changes to the current system of medical training must be phased to avoid destabilisation of the medical workforce and compromise of patient care

Our response will now provide further discussion of some of these main themes:

1. Changes in training to meet the changing needs of the population

Consideration of the future medical workforce must address the challenges of an aging population with multiple co-morbidities. Patients will increasingly require integrated teams to meet all their healthcare needs and thus thorough generalist training both in primary and secondary care will be essential for all. These population changes will occur alongside continuing advances in treatments and delivery of healthcare including telecare. Training programmes must ensure that doctors entering the Specialist Register have the necessary experience and skills to meet all these challenges. We advocate comprehensive broad based training during the early stages of training programmes, incorporating experience of medicine for the elderly and community based general practice for all. As training progresses, trainees will continue to require access to adequate specialist training opportunities within their chosen field to ensure they develop experience and are up to speed with the latest developments.

2. Flexibility within training programmes

Many hospital medical specialties are facing a recruitment crisis with inflexible training and perceived poor work/life balance recognised as significant hurdles. Current training programmes do not provide adequate flexibility either to the health system or to trainees. A number of dimensions are suboptimal in the current training system and need to be addressed when planning future training programmes.

a) Less than full time training (LTFT)

The majority of UK graduates are now female. Many will choose to do some or all of their training LTFT. There is also a growing desire for a better work/life balance amongst male trainees, especially given predicted increases in future retirement age. Whilst this is acknowledged within current training programmes and consideration of requests for LTFT is mandatory, widespread opinion and experience indicate that the process and outcomes are variable and often inconsistent. Many jobs, particularly in hospital based medical specialties, leave LTFT trainees feeling they must try to fit the commitments of a full time job into part time hours or leave LTFT trainees feeling under pressure as their commitments may need to be covered within the existing trainee workforce without additional support or cover provided.

b) Flexibility regarding career choice and transfer of competencies

Many trainees feel that the impact of Modernising Medical Careers (MMC) has been to commit them to a career pathway early in their career before they have had time to establish their area of particular skill and interest. Medical training is arduous and expensive and we must ensure that, as far as possible, trainees are making informed and sustainable career choices. Once in a specialty 'run through' programme trainees invariably struggle for recognition of transferable competencies should they decide to transfer specialty. This is frustrating to the trainee and a waste of time, resource and money both to the employer and trainee. In some cases trainees, when moving specialty, are required to repeat periods of training already successfully carried out. Thought must be given also to the shelf-life of competencies (for example following return to work after an extended absence) and how retraining would be overseen and supported. Clearly defining pathways for maintaining competencies would be highly desirable.

A recent RCPE targeted membership survey revealed that 1 in 4 (24%) have considered changing specialty, but decided against this due to additional training requirement without recognition of prior learning and 52% believe the ability to transfer to another specialty and

count previous experience would have had a positive impact on their decision to enter medical training. These statistics support greater flexibility and suggest a partial solution to the perceived unattractiveness of medicine as a career [2].

c) Flexibility to advance skills in an area of particular interest

There has been a trend towards reduced flexibility in trainees taking time out of training to develop skills and experience in areas such as research, teaching and leadership. Whilst opportunities do exist (and indeed have expanded in some areas in recent years), the challenges of service provision including staffing rotas, particularly in medical specialties at senior trainee level, has meant that these opportunities have not always been easily accessed. To meet with the changing demands and skill-set required within the future NHS, trainees must be positively encouraged and supported to take additional time away from training through 'Out of programme research/experience/training' opportunities in future training programmes. In parallel, flexibility must be built in to allow this additional experience to be gained at the appropriate time, which is likely to vary between trainees, and there must not be the expectation that clinical commitments must be covered by the existing trainee pool with no additional support or cover as this is detrimental to patient safety and risks burn-out and attrition amongst trainees. Opportunities to enter specific routes of training, for example academic training, must be available beyond Foundation programmes.

With particular reference to Academic Medicine, we feel that Foundation academic programmes should incorporate dedicated research time alongside mentorship and development of research skills, and that similar academic core training programmes be developed, again with dedicated research time and perhaps an in-built M Sc over 3 years of core training. Whilst recognising that the appropriate time for research will vary between individuals we feel it is generally best placed during Higher Specialty Training, and a wider availability of academic HST posts with in-built research time would be encouraged. It is also essential to ensure as far as possible that research time and funding is likely to benefit patient care as well as training and is not simply undertaken as a tick-box exercise.

3. Length of training programmes

The RCPE T&MC strongly believes that training programmes in medicine cannot be shortened and may in fact benefit from longer initial broad based stages. To shorten training programmes further would significantly compromise the ability of trainees to gain sufficient skills and knowledge to practise as well as compromising patient safety and quality of care. In particular, and for the reasons out-lined, any move to shorten training to four or five years and move CCT forward to this point (as mentioned in minutes of the Shape of Training Expert Advisory Group meeting of 24th October 2012) is not considered a viable or efficient option by the T&MC.

In fact, we suggest that consideration is given to the extension of Core Training programmes to ensure adequate thorough grounding in recognising and managing common core conditions. The increased number of trainees could be used to incorporate ring-fenced training time at points throughout each rotation. We also feel that a return to six-month attachments in core general medical and surgical specialties in F1 would be beneficial to ensure wide exposure to common presentations and consolidate learning as well as establishing a sense of team-membership and patient ownership which have undoubtedly been lost in the move to shorter rotations. Longer rotations would also support longer periods of mentorship within the allocated team. F2 could continue to offer shorter blocks of exposure to a variety of specialties thereafter though we would advocate continued emphasis on broader, more general hospital posts at this stage. More specialist posts such as medical microbiology could instead be offered as taster weeks (though we believe this system also has its problems and could be improved). We also suggest consideration of a year longer in specialty training to further develop confidence.

Our recent RCPE targeted membership survey revealed that 75% of respondents believe the current system requires them to specialise too early. 68% made their decision regarding

choice of specialty during Core Medical Training and 42% believe that longer CMT would have had a positive impact on deciding their specialty[2].

4. **Position of Certificate of Completion of Training (CCT)/Certificate of Equivalence for Specialist Registration (CESR)**

Consultant-led care is the most effective model to ensure patient safety and quality of care and, furthermore is what patients both want and expect[3]. This has been borne out by successive independent reviews and enquiries. We continue to emphasise that CCT/CESR is an international benchmark of competence, and is highly regarded, recognising quality training and acknowledging the ability to practise independently as a consultant. Achievement of CCT/CESR indicates competence for autonomous consultant practice and the assumption of over-arching responsibility for patient care. The CCT terminology may be misleading with its implication of the end of training where, of course, training is life-long and CCT/CESR are "waypoints" in training rather than markers of its completion. Terminology aside, we do not question the robustness of the current assessment systems or that doctors achieving CCT/CESR are competent to practise independently and safely as consultants.

We must put patient safety and quality of care at the centre of any debate such as this. Patients have confidence in the consultant role and would choose to have their care overseen by a consultant. Attempts to move CCT forward to a point where trainees have not acquired the skills to practise independently would seriously undermine public confidence as well as risk producing poorly motivated and disenfranchised doctors. The degree of senior and managerial support doctors with an earlier date of CCT would require is impractical and we cannot see the advantage of such a move. The RCPE T&MC categorically does not support any attempt to move CCT forward.

Patients in hospital clearly identify with 'their consultant' and trust and respect the consultant model. Whilst acknowledging that the current terminology of junior doctors can be confusing, we do not feel that stage of training needs to be made more explicit to patients. It ought to be a given that doctors do not practise beyond their level of competence and are adequately supervised until deemed competent for independence by entry onto the Specialist Register. This is also enshrined within the General Medical Council's codes of conduct. We believe that patients have the right to expect their doctor to practise within the limits of their competence and that no change in terminology is required for this. Trainee doctors must ensure that they introduce themselves as part of the consultant team. Of interest, but separate from this discussion, in our recent RCPE targeted membership survey, all respondents confessed to using the old junior/senior house officer and registrar terminology when referring to training grades[2].

Finally, the RCPE T&MC strongly opposes the introduction of a subconsultant grade, and similarly, we do not support the terms "trained doctor" or "stand-alone practitioner". For the reasons outlined above, we believe the consultant model to be the best model for patient safety and quality of care and there is a sound evidence base for this. Moreover, we re-iterate that this is the model that patients trust and would choose for their care, and it is the best model for ensuring that medicine remains an attractive career with realistic prospects of career progression. The introduction of a subconsultant grade would unquestionably exacerbate recruitment problems in medicine and lead to further attrition and disenfranchisement.

5. The position of 'generalists' within the medical workforce

The RCPE T&MC recognises that the aging population and increasing co-morbidity are placing an almost overwhelming demand on acute medical services. All physicians and GPs will need to be well equipped to deal with the elderly population and training should be adapted to reflect this. Doctors with generalist skills (equivalent to the 'General Physician' of old) will continue to be required in the future and demand for doctors with these skills is likely to rise. There is recognition that current training models have in some cases developed trainees' specialist skills at the expense of generalist

skills. However, this has often been by necessity to enable trainees to keep pace with the advances in skills and technology for 'craft' specialties. It is important to note that most specialties are running beyond capacity at present and so expansion of the generalist and specialist workforce (and therefore training) should be considered in tandem. Any future changes to training programmes will need to be sensitive to these issues and must also recognise the significant contribution to front door emergency care delivered by specialists as well as by generalists.

In addition we support the recent Royal College of General Practitioners recommendation that the minimum training time in all general practice programmes be extended to four years. We agree that this will ensure that GP training keeps up with the demands of an increasingly challenging and complex environment. If primary care is to play an increasing role this is vital as currently many hospital admissions labelled as 'avoidable' are necessary as the only place that the services which are clinically required are available is the acute sector [4,5].

We strongly argue that training to independent competence and practice in General (Internal) Medicine must not be viewed as inferior or a stepping-off point en route to training in a specialty. The acquisition of skills to practice independently as a generalist must be rigorous and give an excellent grounding across multiple specialties, including a strong emphasis on communication and decision-making. If our medical workforce is to increasingly rely on generalists to provide over-arching care for patients and to co-ordinate their care, we cannot compromise on their training. As such, the RCPE T&MC believes that training for generalists cannot be completed in a shorter time frame than already exists in postgraduate medical training. Greater recognition and reward of the skills of generalists, rather than a continuing erosion of their training and status, may also attract doctors and begin to reverse the mass exodus from generalism which has occurred over recent years.

Despite the recent trends for reduced length of patient stay we need to accept that some patients may need longer in hospital if we are to deal with multiple co-morbidities safely and avoid readmission. We cannot assume that community care and social services will have the capacity to pick up the pieces. We urge consideration of increasing emphasis on larger care of the elderly/generalist wards with specialist outreach reviews. The current model of generalist outreach to specialist wards to review patients whose specialist treatment is complete but have outstanding frailty related or social issues is inefficient and failing.

Finally, where any discussion about workforce planning and skills mix takes place, we urge that robust data are collected and used to plan future numbers entering undergraduate and postgraduate training and that provision of comprehensive and honest careers advice should be mandatory at all stages of training.

6. The interaction between training and service provision

In hospital medicine there has been a gradual erosion of the balance between training and service provision [6]. At the same time team working has been eroded in part by employers' responses to the European Working Time Directive. To facilitate rota planning most trainees work shift patterns, often never getting to know their patients properly or having a clear medical team that they "belong" to. Current systems, including the practice of 'hospital at night' teams can compromise training and learning due to pressure of work (particularly in acute medical services). This can result in superficial review of patients with few opportunities for feedback or reflection. Indeed, for more senior trainees, this pattern of working often becomes truly service loaded with limited opportunities for direct supervision or feedback. We believe that this can negatively impact safety and quality of care for patients and that it can produce disenfranchised, demotivated doctors.

We do advocate, however, that training and service delivery should not be de-coupled. The two are inextricably linked with no "one size fits all" solution. We believe that increased consultant presence

within a consultant-led service incorporating on the job training by consultants or senior SAS doctors would not only benefit patient care but improve supervision and support of trainees. This does not mean that the experience of independent practice should be removed from trainees working within this system. It is essential for trainees to take ownership and develop initiative and leadership skills. Protected time should be built into the working week for feedback, assessment, discussion and reflection. We do not support separating training and service, for example in the proposals for "training consolidation" periods. We strongly advocate that training and service are co-co-dependent and, to ensure excellent and safe patient care, cannot and should not be separated.

We must identify and positively select those with a skill and passion for training and trainers should be required to demonstrate competence in training. Training must be recognised within the trainer's job plan and trainers must receive adequate support with robust methods of quality assurance. The health service must be shaped around the needs of the patient. However excellent service provision requires excellent training and will inevitably improve safety and patient care.

Training rotations should be designed with stability in mind rather than the need to staff particular units. Longer periods of time spent in a smaller number of units should be considered with wider experience being achieved through the elements that are training specific. On call teams where different levels of trainee and a named consultant work together regularly is a model which would benefit from further investigation. Returning a degree of local control to trainee recruitment would perhaps encourage stability but must of course take account of national workforce needs and projected consultant numbers. Local recruitment may also alleviate some of the problems caused by the current once a year appointment system.

We also suggest consideration of devolving more responsibility for learning back to trainees with encouragement of self-directed learning. For example large-group lectures could be delivered on-line with self-assessment questionnaires allowing delivery of mandatory curricular elements without depleting hospitals of all GIM registrars for a day, and could be undertaken during timetabled hours for personal study spread across rotations.

7. Modular Credentialing

Decisions regarding long-term career choice need to be made very early in a doctor's postgraduate career and it can be difficult to change direction or side-step and in particular to have previous experience recognised. Longer training at Core level and the provision of sound careers advice throughout training could go some way to addressing this. We support the concept of transferable competencies enabling trainees to have experience and skills recognised to ensure that relevant training need not be repeated should they wish to develop a special interest or change career direction.

The T&MC is aware that at least one 'Shape of Training' workshop discussed 'modular credentialing' as a possible alternative method of structuring future training programmes, however there was no detail of how this might work in practice. Potential benefits of a system involving training modules or 'building blocks' might include recognition of transferable skills and flexibility where a change of career direction is sought by a trainee. This may be worthy of further exploration at Foundation and Core Training level to enable trainees to achieve clear recognition of their skills and experience should they wish to change track. However, an issue foreseen with modular credentialing is a lack of structure and the resultant lack of a clear end point to training. We therefore do not believe this system would be fit to replace existing Higher Specialist Training curriculae. The concept of modular training may sound desirable, implying flexibility and career ownership, but in practice it is vital that we produce the right number of trained specialists in different specialty areas, at the right time, based on national workforce data and projected need. We

envisage the potential for employers to refuse trainee requests for specific 'modules' citing lack of business need, or indeed trainees finding themselves unable to acquire sufficient modules to progress to CCT. Similarly if modules span broad specialties, we envisage difficulties with Colleges and Faculties collaborating in trainee assessment and agreeing on outcomes of training.

At this stage, with little specific detail of what this means as a term, or how it would work in practice, the RCPE T&MC cannot support such a proposal, however we do remain open to discussions.

8. SAS Doctors

Increased flexibility of movement between specialty doctor and training posts should be welcomed and further exploration of the idea is encouraged. However, the T&MC strongly refutes the attendant implication that SAS doctors are "non-training" doctors and discourages the use of the "non-training" terminology. Within the new SAS contract there is guaranteed training and key features of the contract include appropriate Continuing Professional Development and career development. SAS doctors should be viewed as doctors choosing to train through a different pathway from the standard training programmes. Our recent targeted RCPE membership survey demonstrated that 78% of respondents (including SAS doctors) disagree with the emerging definition of trained versus trainee doctor[2].

The concept of a system whereby smooth transition in and out of training posts might occur is inherently flawed. SAS doctors have chosen their career path for a variety of reasons and location is often extremely important. Therefore the assumption that SAS doctors may be utilised to "backfill" training posts is conceptually unsound. Furthermore, many SAS doctors have amassed specialist skills and will be functioning at a highly independent level such that trainees are unlikely to possess the skills required to deliver the service in these posts and may not have access to the level of supervision they receive in training.

The T&MC welcomes the exploration of the role of SAS doctors within this Review however strongly feels that the integrity of SAS posts must be maintained to allow doctors to take into account a variety of lifestyle complexities and make the positive choice to control their own training paths through the use of such posts. We see no reason that a parallel system of SAS and "standard" training posts cannot coexist.

9. The requirement to review training within the context of wider health and social care provision

A review of medical training cannot be considered in isolation. Training requires a commitment from employers, postgraduate training bodies and trainers. Consultants need time to train and trends of increasing Direct Clinical Care to Supporting Professional Activity ratios in consultant job plans must be reversed in order to secure the delivery of high quality training. Should an expansion in generalists be agreed upon there must be capacity within allied professions to accommodate increased demand based on the decision-making of generalists– for example out-of-hours social care provision for those patients identified for early discharge or those identified as unnecessary hospital admissions and out-of-hours physiotherapy and occupational therapy input.

The RCPE Charter for Medical Training

The RCPE Charter for Medical Training was published in 2011 and provides a practical foundation for ensuring that both doctors' training and patient safety can be improved [1].

The Charter for Medical Training is relevant to all doctors working within the medical specialties in the hospital sector and was developed in response to an erosion in the balance between the time that trainees have for training and providing direct patient care, and their trainers have for overseeing this training.

The Charter is based on five guiding principles –

- patient safety and care are paramount
- all parties recognise that training and service elements must be balanced
- trainees are valued for their service contribution
- trainees are actively involved in the training process
- training is fair, based on principles of equality and fosters the development of professionalism

The Charter goes on to lay out detailed commitments covering patient care and safety, recruitment and induction, balancing training with service provision, ensuring quality training, assessment and curricula, and support and development. Key commitments include –

- the duties, workload and work patterns of trainees should ensure patient safety
- trainees and their trainers should receive protected time for clinical training
- trainee numbers will be based on accurate workforce planning
- trainees should receive supervision and support with their clinical case-load and work at a level appropriate to their level of competence
- trainees have access to a sufficient breadth and depth of clinical work to enable them to achieve clinical competencies
- processes for recruitment, selection and appointment are open, fair and effective with specific details regarding training posts available at the time of application
- trainees receive equitable access to personal, ring-fenced study leave budgets to support their training needs
- trainees are supported in monitoring and accurately documenting working patterns.

The Charter is well packaged and could easily be adapted for wider pan-specialty/-faculty use and we suggest that consideration be given to its use as part of the 'Shape of Training' review.

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Submitted on behalf of RCPE T&MC

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