RCPE
Royal College of Physicians of Edinburgh

Shape of Training:
Call for Evidence

Response from the Royal College of Physicians of Edinburgh
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ROYAL COLLEGE OF PHYSICIANS OF EDINBURGH
RESPONSE TO THE SHAPE OF TRAINING REVIEW GROUP
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A: Introduction

There are currently significant service, recruitment and retention pressures within the NHS that need to be addressed, and the structure of postgraduate medical training in the UK needs to be modified to keep pace with changes in the needs of patients.

This is particularly obvious with respect to Acute, General and Geriatric Medicine. There are rising numbers of emergency medical admissions particularly amongst older adults with complex comorbidity, but also increasing numbers of requests from other specialties to help manage these complex patients.

The role of medical registrar is perceived by many trainees as a stressful and thankless task with little organizational or educational support. There is anecdotal evidence from surveys of Foundation and Core Trainees that this plays a part in deterring them from pursuing a career in hospital medicine. These issues are compounded by recruitment difficulties both at consultant and trainee level that result in frequent rota gaps, which further exacerbates the problem. Attrition rates in core training in Medicine are high, for example in Scotland, 21% are leaving to other specialties or not continuing with training in the UK. A further 16% go to remediation after core training, and not all subsequently enter specialist training in a medical specialty. The attrition rate could thus be as high as 30%[i]. Most trainees in the physicianly specialties currently aspire to become a specialist in a narrow or organ-based specialty. Furthermore, they generally aspire to consultant posts, with any other outcome perceived as 'failure'.

As a result of the feminization of the medical workforce, specialties with less out-of -hours and emergency workload (e.g. Dermatology, Palliative Care) are increasingly popular. Meantime, there is a drive to increase the level of consultant-present care, with at least a 12 hour/7 day presence, as there is evidence that this leads to better patient outcomes and decreased length of stay.

The European Working Time Regulation and New Deal have had unintended adverse consequences on both training and service. While the improvement in trainees' work /life balance has been positive, it has had detrimental effects on continuity and quality of patient care and the training of junior doctors.

The current review represents a real opportunity to address at least some of these issues, and there is no doubt that change is required. The College's evidence to the review group is based on the considered opinions of senior Fellows and reflects the experience and aspirations of the next generation of physicians through our very active Trainees and Members' Committee. The following sections are cross referenced to the Shape of Training Questions.

B: The Needs of the Patient (Question 1)

All patients require:

1. Sufficient doctors available 24/7 to provide safe, high quality care, both in the community and in hospital.

2. Doctors with the necessary knowledge and skills to diagnose and manage their presenting problem.

3. Continuity of medical care.

4. Clarity about the roles and level of experience of the doctors treating them.

Although not required for all patients the following are also important considerations:

5. The increasing numbers of older patients in the population require doctors with the necessary knowledge and skills to manage significant comorbidity, polypharmacy and dementia. At present many doctors across all specialties have not been adequately trained in these.

6. Selected patients may also require doctors with highly specialized knowledge and skills, at some point in their journey of hospital care. However increasing numbers of the population with organ specific conditions are not fit for specialist intervention e.g. renal replacement therapy, surgery or ventilation, or have comorbidities that specialists struggle to manage.

7. Patients with long term conditions and/or multiple comorbidities are at high risk of destabilization that cannot be managed safely in the community, and requires in-patient management. The future health service must therefore be equipped to both minimize the development of long term conditions in the population, and also to provide high quality care when patients develop acute problems, be they de novo or on a background of ill health.

8. Patients have increasing expectations of medical intervention, as technology and pharmacological possibilities advance.

C: The Needs of the Service (Questions 1-3)

The College supports the view that a shift in the balance of generalism /specialism is needed with greater recognition of the value and role of general medicine.

1. Older patients with complex comorbidity and polypharmacy currently get ‘stuck’ in organ-based medical and surgical specialties that do not have the breadth of knowledge or skills to effectively manage them. Many are referred to General and Geriatric Medicine, but there are currently insufficient beds within these specialties to take over all such patients and the impact on patients of missing this specialist input from General Medicine and Geriatric Medicine should not be underestimated. Not only is a change in training required to address this, but also a service change to reduce the number of specialty beds and increase those under ‘generalist’ care.

2. An urgent review of acute, general and geriatric medical services and the associated trainee and consultant workloads is required. Addressing these will not only improve patient care but also help to avoid the imminent recruitment crisis. Purely time-based assessment of workload has been the mainstay of workforce planning until now, with the common currency being whole time equivalents. There has to be a shift to the use of intensity of work in different areas as the basis for workforce planning. If quality and continuity of care is to be achieved this is likely to require more doctors in the areas where workloads are most intense, but a relaxation of the New Deal would reduce the numbers needed.

3. "Consultant present' hospital care 12 hours/7 day on site should be the goal, for the reasons described above. This would also increase the availability of supervision of, and feedback for, trainees, further reducing their stress. Such change will have significant resource implications, but investment is required in this critical area of hospital medicine to secure better patient flow, generate time for training and minimise disruption to other specialties.

4. This could be achieved by a shift such that the majority of physicians are trained to recognize and deliver acute care for a broad range of conditions. Highly specialised input would only be needed for opinions or procedures for specific conditions or where specific skills are required, but the patient would remain under the generalist' s care. The Hospitalist movement in the USA provides a useful starting point: the hospital journey of care is provided within a small medical team, but specialist advice and care is sought as required; ideally this model could be extended across primary and secondary care.

5. The service also needs better integration of primary and secondary care. A period of training for all in the community might assist this, and the management of acute illness in the community also needs to be considered, so that hospital admission is only used when clinical need absolutely demands it. This requires an augmented set of skills to those for which General Practitioners are currently trained: the emphasis is presently on the management of long term conditions rather than the provision of acute medical care at home. The possibility that generalists in secondary care might 'outreach' to the community could be explored, but may not be practical or affordable. More data is needed to confirm that this would reduce hospital admissions and be cost effective.

6. Tertiary teaching hospitals will have different service needs to district general hospitals (although many of the former also provide a 'district general' service to their local populace), with a different balance of generalist to specialist services. The development of training and non-training hospitals requires a great deal of thought: the latter may prove difficult to staff if they are perceived as unattractive to junior doctors whose aim is to become a consultant or to senior doctors with a keen interest in training. The possibility that they may be a stepping-stone for doctors who are competent to work with less supervision, could be considered.

7. In remote and rural services, the balance must favour generalism, but there will also be a need for core specialties. Increased remuneration may be required to address current recruitment difficulties, perhaps comparable to London weighting. Even with the use of specialist outreach and telecare, patients that live in these areas are likely to have to travel centrally for highly specialised care.

8. London itself may have to be considered as a separate case, given the presence of so many highly specialist services. Any model that meets London's needs may not fit elsewhere in the

country. The adverse influence of the intensity of undergraduate training in the capital on subsequent geographical career choice needs further consideration: it is of concern that London training opportunities are rapidly filled, while many are difficult to fill in other parts of the country.

D: Workforce needs – specialists or generalists (Questions 4-6, 14-16)

1. A medical workforce is needed with two populations: a larger generalist group that is capable of delivering holistic care to patients with a broad range of problems whether acute or chronic, and a smaller one that exclusively provides specialist skills or procedures for a narrower range of conditions.

2. A further group is needed with highly developed non-clinical professional expertise in academic and leadership skills. These groups need not be mutually exclusive: leadership skills will be vital in all groups, and academic input will be key to the development of both generalism and the specialties.

3. One approach would be for all to train in generalism in conjunction with specialist training. EU regulations require five years training at specialty level to achieve the status of a trained practitioner so generalist training cannot be shortened further than this. In any case, it takes as long to train in acute or general medicine as the specialties, because of the breadth of knowledge and experience required. The option to "drop" training in General Internal Medicine should be lost.

4. If most trainees contribute in general specialties, workloads for all will become more manageable, which will help these specialties regain their previous popularity and status. However we must ensure that any change in training does not make work as a physician (especially in the acute services) more unpopular. The opportunity to achieve specialist training will still be available, according to the needs of the NHS nationally.

5. In promoting generalism, it is vital that the specialty of Acute Internal Medicine continues to develop to provide leadership within acute medical units.

6. Doctors who have completed training will need formal mentorship – many trainees are currently postponing application for consultant posts by obtaining post CCT fellowships, as the prospect of consultant-hood is so daunting. Shortening the length of training would make this even more of an issue and is not recommended.

7. Newly appointed consultants should continue to participate in acute medical receiving. The option to drop participation in acute medicine should be strongly discouraged in the early years of consultant appointment.

8. Many trainees are anxious that any changes in training might represent a step toward creating a new 'sub-consultant' grade. This must be avoided or there is a serious risk that talented graduates will be lost overseas to countries that provide earlier opportunities to specialize in more narrow fields, or lost completely to the physicianly specialties or even to medicine. Nonetheless a careful review of the consultant contract is required with much clearer pathways for career development post appointment, according to the needs of the NHS.

9. In view of the high attrition rates in core training and current recruitment challenges in the frontline specialties, there is an argument for increasing the number of training posts relative to likely future consultant and GP vacancies. The current workforce planning approach of minimising the possibility of over-supply is creating significant difficulties in providing a service in many parts of the UK. Although much discussed, a 'bulge' in trainees who cannot obtain a consultant post has yet to be seen. Predicting future retirements is notoriously difficult. The fragmentation of workforce planning across the UK is particularly risky, given the tradition for Scotland to export medical graduates and for Northern Ireland to import them.

10. The consequences of any changes to the way physicians train will need to be considered carefully as it may create a temporary and significant gap in the number of doctors progressing into service positions in the transition phase.

11. Nurse practitioners do not represent a substitute for doctor-delivered general medical care: they can provide excellent protocol driven care e.g. for Diabetes Mellitus, Heart failure, and Parkinson's Disease, and can perform specific procedures such as endoscopy. They are not however equipped to make diagnoses or treat multiple comorbidity, and training them to do so would require significant time. It could also denude the NHS of senior nurses who fulfil a vital nursing role.

E : Breadth and scope of training (Questions 4-7, 11-13, 18)

There are a number of potential alternatives that would provide physicians of the future with generalist skills, but maintain their flexibility for subsequent career development. Broader based core training would maintain the development potential and freedom of choice of trainees for longer, and increase the numbers of trained doctors with high level generalist skills. All need some training in dementia and the care of frail older people, to meet the future needs of the service.

1. The development of broad competences has already begun with the introduction of the Academy of Medical Royal Colleges' Broad-based curriculum: a two year programme spanning Acute medicine, Paediatric Medicine, Psychiatry and General Practice. This is currently being piloted in seven Deaneries. On completion of this curriculum, trainees can apply for a training post at ST2 in any of these specialties. This may provide a useful starting point for the development of a more generalist approach to training, and also address the need for all physicians to have some training and experience in the community.

2. A 2 year generic foundation programme could be retained, providing the majority of this time is spend in general specialties allowing trainees to hone their basic clinical skills. However as an option, medical graduates who are certain of their ambition for a career as a physician could undertake a more focussed second year concentrating on the medical specialties. All should achieve some training in the community.

3. Subsequently the core medical training programme could usefully be extended to 3 years as this would guarantee the inclusion of a period of Acute Medicine and Geriatric Medicine for all. There would be the opportunity to obtain credits in a range of areas with a modular approach to certain aspects of training that are applicable to all specialties (e.g. communication, leadership, service improvement, patient safety, NHS structures).

4. Appointments to specialty training programmes will offer the options of general alone, or dual training with a speciality.

5. Those who show early potential or academic interest could be fast-tracked to train in a more narrow specialty in which there is less need for generalist skills such as Clinical Neurophysiology or Clinical Genetics, but this would be the expectation for relatively few. All others would complete generalist training as part of their specialist training.

6. The term 'CCT' needs rethought as it will signify readiness for independent practice as a consultant, rather than completion of training. Training will continue as CPD throughout a consultant's career, with the option of further sub-specialty training as required by the service.

7. The College believes that the critical "way point" for entry onto the specialist register is those who have completed a recognised training programme or achieved equivalent competencies (via the CESR route). Those with dual accreditation would achieve this for both specialities simultaneously (as now) recognising the extra time to acquire necessary competences if time is split between general medicine and another specialty.

8. The development of modular training may allow some flexibility for consultants in general medicine to progress later in an alternate specialty reflecting service needs and individual preferences. Because more doctors would be providing the generalist service, it should be feasible to release a proportion at a time to complete training modules.

9. As indicated above, some specialist and super-specialist competencies that are only required by a small proportion of consultants, would be achieved after appointment as a specialist, and would be targeted by the local service that requires this expertise. Such training would be structured and standardized and could be overseen by the by the Colleges, as several already do for post-CCT fellowships.

10. New Deal (and if possible, EWTR) limitations should be relaxed to improve continuity of patient care and to improve continuity of experience/feedback and training. A trainee should be based on the same team for several months rather than flitting between consultant teams shift-to-shift. This would improve the supervision of trainees in areas that are currently hard-pressed, with a return of the apprenticeship model. Bed-side, out-patient clinic and ward teaching are all greatly valued, and learning enhanced when associated with real-life, real-time education. This allows a combination of experience in making independent decisions to develop confidence and self-reliance, alongside feedback and interaction with more experienced staff.

11. At all levels training will require fully trained and enthusiastic educational supervisors: 9+1 contracts render this impossible as most consultants are overwhelmed by service delivery. The lack of alternative medical staffing to meet the previous losses of trainee numbers has compounded this. The UK Academy recommends a minimum of 2 SPAs for all consultants.

12. The benefit of 1:1 training can be seen in the GMC Trainees' survey where those in specialties that provide this (e.g. General Practice and Anaesthetics) reported the highest satisfaction scores for training.

13. The last few years have seen a burgeoning of bureaucracy for trainees and their supervisors. Whilst the importance of curricula and workplace assessments is recognized, a review of the

necessary documentation would be helpful, as at present this can reduce the actual time available to deliver / receive training.

14. Preservation of current Deanery structures or an equivalent for national planning and management of postgraduate training is essential.

F : Flexibility of training (Question 6)

1. The broad based curriculum described above would achieve much more flexibility at an early stage

2. A modular approach to training would also allow a more flexible approach throughout a doctor's career. Many modules would be common to several broad specialties allowing easy transfer if a doctor was undecided early on about career, or decided later on a change of direction. The trainee would have some freedom to select modules, and could do so on the basis of making themselves competitive for more senior posts.

3. Such an approach would also be compatible with Less Than Full Time Training (LTFT). There needs to be a much more practical response to the continuing feminization of the medical workforce, with training designed to be compatible with LTFT, rather than adapted ad hoc from the full time model.

4. A more proactive approach to "job sharing" at both trainee and consultant level is also important in addressing the feminization issue. Continuous professional development opportunities must be preserved at full time rates for less than full time doctors and this will be a further challenge for the NHS.

Summary

1. There is a rising need for all-age generalist expertise in hospital medicine to ensure patients have equitable access to services that are delivered efficiently and effectively in hospitals. Experience demonstrates that doctors in other (non-medical) specialties feel insufficiently skilled to tackle medical complications in their patients and increasingly call on their physician colleagues for help. Also colleagues in general practice require access to specialist advice in general medicine to support them in preventing unplanned hospital admissions.

2. The status and working patterns for general physicians and their trainees must be addressed urgently to combat an imminent crisis in the staffing of acute medical rotas. This reflects the increasingly difficult recruitment to physician training programmes as trainees apply for other specialties including general practice and the rising numbers of consultants who withdraw from unselected acute medical receiving to focus on specialist care.

3. Patients welcome continuity of care and this could be delivered in some hospitals by the development of a cadre of consultant general physicians carrying lead responsibility for patients throughout their hospital stay and accessing other specialist input as required.

4. The political imperative to treat patients close to home whenever possible is laudable providing there is investment to train doctors in primary care accordingly and ensure they have access to the necessary equipment and support to prevent hospital admission. Further research is needed to demonstrate that community-based care for much of the current acute medical workload is both safe for patients and cost effective.

5. Much is made of older patients causing the pressure of inappropriate medical admissions and that a change to community delivered services will resolve the issue. The College believes this is something of "myth and legend" and calls for more research and pilot projects to assess the safety and financial implications of transferring care. As the population ages but patient expectations are sustained, the demand for secondary care diagnosis and intervention will increase and patients will be admitted more frequently unless the shape of primary care is radically changed.

6. General Medicine and Geriatric Medicine are specialties requiring the same if not longer training than single organ specialties; fast tracking general medicine training will not deliver doctors capable of independent practice (CCT level), will be a highly unpopular option with trainees and will not address patient expectations for consultant delivered care.

7. The NHS requires fully trained clinical practitioners in general medicine to expand the availability of consultants 7 days a week and for an extended working day (patient safety and effective and efficient working). The College understands the financial constraints facing the NHS but is clear that patient safety depends on access to these senior doctors at all times to lead multi-disciplinary teams and supervise trainee physicians.

8. Acute medical specialties should require the great majority of trainees to dual accredit in general medicine, reflecting the continuing need for doctors in other medical specialties to contribute to acute unselected medical receiving. Their level of contribution to general medicine may change over individual careers with perhaps a greater emphasis early after CCT and decreasing as specialty sessions increase. To ensure this remains an attractive training option and to secure a steady flow of fully trained consultants, general and specialty

training must occur simultaneously although the balance of general and single organ specialty may vary over the course of training.

9. It must be remembered that, given their current level of contribution to acute unselected medical receiving consultants in other medical specialties are also under great pressure and have no capacity to increase their general medical work. Recent RCPE surveys indicate that nearly half of consultant physicians in the acute medical specialties in Scotland spend at least 30% of their time contributing to acute and general medicine.

10. In promoting generalism, it is vital that the specialty of Acute Internal Medicine continues to develop to provide leadership within acute medical units.

11. Early broad-based training programmes (that include general practice) are recommended to re-introduce some lost flexibility into the career pathways, reduce wastage when trainees change direction and foster greater cooperation between primary and secondary care. The ageing population demands that all doctors have some training in geriatric medicine. However modular training at sub-specialist level would permit some later flexibility to allow consultants and their SAS colleagues to change/add specialty in line with service needs and their own competences.

12. Trainees and trainers must have adequate time for training to deliver GMC standards. This is currently under severe pressure through gaps in rotas and limited SPA time, particularly for newly appointed consultants. Addressing the continuity of care issues raised by strict implementation of the European Working Time Regulations (EWTR) would also do much to improve the trainee/trainer relationship, contributing to acquisition of skills and development of professionalism.