RCPE TRAINEES AND MEMBERS' COMMITTEE RESPONSE TO THE FINAL REPORT OF THE SHAPE OF TRAINING REVIEW

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The RCPE Trainees and Members' Committee (T&MC) welcomes the debate that has been generated by the Shape of Training Review. There is a recognition that training structures need to adapt to address both the changing demographics of the UK population and the recruitment crisis that many of the medical specialties are facing.

We read the final report of the review with interest and welcome aspects of its conclusions. In particular we support the recommendations for longer placements for doctors in training, a return to apprenticeship based models of training and greater flexibility to facilitate movement between specialties and LTFT training.

Nevertheless the T&MC has consistently expressed significant concerns throughout the review process about some of the proposals. In light of the final report we are keen to reiterate our principal concerns, consider the impact of proposed changes to training to physicianly medicine and what role the T&MC can play in implementing the process of change.

Whilst patient safety issues are acknowledged within the report, we are disappointed that it does not appear to form the principle focus of the Review. We believe it is essential that patient safety and the provision of high quality care must be at the centre of any discussions about doctors' training.

Our key messages

- Proposed changes to doctors' training should be based upon sound evidence that they will improve patient safety and the provision of high quality care.

- Changing patient demographic, advances in technology and rising patient expectations necessitates an expansion in the number of specialists *in parallel* with an expansion in the number of generalists; most specialties already operate beyond capacity.
- For physicianly specialities, training in General Internal Medicine (GIM) should be undertaken in parallel with specialty training, leading to a Certificate of Speciality Training. GIM must not be seen as a "stepping off" point and cannot be completed in a shorter time frame than already exists in postgraduate medical training.
- 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.

- Any changes to the current system of medical training must be phased to avoid destabilisation of the medical workforce and compromise of patient care; stability and security are vital for existing trainees to avoid attrition and exacerbation of the recruitment crisis.

- Any changes to the Staff and Associate Specialist (SAS) Grade and the Undergraduate curriculum need careful consideration to ensure patient safety and high quality care.

- Protected time for training for trainees and trainers is essential to ensure the provision of high quality patient care. Excellent training is fundamental to excellent patient care.

The T&MC will maintain fully engaged with the Shape of Training Review as it moves into its implementation phase. We are committed to;

- Setting up a working group to focus and engage with all stakeholders, including the UK-wide Delivery Group during the implementation phase.

- Working with senior College and national bodies to minimise the impact of changes on current trainees, and maintain stability.

- Supporting up to date careers advice for prospective students, undergraduates and existing trainees.

- Seeking the views of patient groups on their perceptions of medical training and the proposed changes.

1. GENERALISM VERSUS SPECIALISM & BROAD BASED TRAINING WITHIN PHYSICIANLY MEDICINE

We have repeatedly stressed that an expansion in the generalist workforce is required to provide safe and high quality patient care, but this must occur *in conjunction* with a rise in the number of specialists. Most specialties are currently running beyond capacity and so expansion of the specialist and generalist workforce (and therefore training) should be considered in tandem. Any future changes to training programmes must recognise the significant contribution to front door emergency care delivered by specialists as well as by generalists. We also remain concerned about assertions that employers will recruit more broadly trained doctors to work across hospital and community care boundaries, when the evidence that such changes will benefit patient care is lacking.

Paragraph 75 on page 33 contradicts any assertions that a reduction in the number of specialists is required by acknowledging the "dramatic changes" envisioned over the next 30 years with advances in science, technology and medicine. These changes suggest we will need more specialists equipped to develop and deliver new skills and technologies and translate them into clinical practice for the benefit of patient care.

We emphasise that training in GIM for physicianly specialties should occur *in parallel* with specialty training, supporting the assertion in paragraph 28 on page 22 that the "broad, generalist nature of the early years of medical training should continue into the later stages of training".

However, the final report demands that "Postgraduate training must be structured within broad specialty areas based on patient care themes" (paragraph 10 page 11) with "groups of specialties characterised by patient care themes" (paragraphs 91 and 92 page 38). Whilst this may work well for some specialties eg women's health, it remains unclear exactly how the broad based approach described will work for physicianly medicine, and in particular the balance between generalism and specialism. There is huge diversity within the medical specialities and that the exact balance between GIM and speciality may vary between specialities. A 'one size fits all' approach will not work. Similarly, 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.

Any suggestion of moving all specialisation to post Certificate of Specialty Training (CST) or that all physicians will attain CST in GIM and only then progress to specialty training are extremely detrimental to patient care and to physicianly medicine. Effectively forcing all aspiring physicians to train as generalists will not address the current recruitment crisis and will certainly increase attrition and disenfranchisement. Paragraph 43 on page 27 states that "broader roles [must be made] more attractive through career support and development. These moves will not mitigate against the fall-out of a move to CST in GIM pre – specialisation.

We have repeatedly stated that specific consideration needs to be made for physicianly medicine, which along with Emergency Medicine and primary care, are the specialties most affected by the UK's changing demographics and increasing comorbidity.

Greater clarity on how broad based training will work for physicianly medicine is critical, with a clear definition on what is meant by a 'generalist' or 'specialist' within the medical specialities , what will fall into broad based pre CST training, and what will fall into post CST credentialing. Trainee engagement in this process is essential.

2. LENGTH OF TRAINING

We continue to emphasise that training GIM cannot be shortened, and should not be a stepping off point en route to training in a physicianly specialty. Paragraph 77 states that 'extending training excessively will not lead to better trained or prepared doctors and will put unnecessary strain on the system.' Paragraph 94 goes onto state that 'other specialities may have shortened training times when curricula are adapted to deliver a broader speciality approach'.

We reiterate that to shorten training programmes in physicianly medicine will significantly compromise the ability of trainees to gain sufficient skills and knowledge to practise and will compromise patient safety and quality of care. In order to produce doctors with a broader range of skills to meet changing patient demographics it follows that longer training time is necessary.

3.FLEXIBILITY IN TRAINING

The T&MC supports increased flexibility within postgraduate medical training and welcomes moves to improve recognition of trainees' previous experience and skills if changing specialty. As laid out in paragraph 6 on page 13, current systems have often been too rigid and trainees have either been dissuaded from changing specialty, have left medicine altogether, left the UK to work abroad or have had to repeat lengthy periods of training. We believe however, that despite the Report's purported aims to improve flexibility, its proposals will achieve the converse.

Despite acknowledgement that medicine has to be a sustainable career with opportunities for doctors to change roles and specialties throughout their career (page 5), the report consistently refers to patient and service needs as the drivers for change. For example Paragraph 107 refers to 'a training structure driven by employers and linked to local needs'. Credentialling too is described as improving flexibility for doctors; however access to training programmes to gain credentials will "be driven by patient and workforce needs" (page 7).

Primarily tailoring training and post-CST credentialing to meet employers and local workforce needs may also lead to 'postcode training' with an exacerbation of staffing shortages within certain areas of the UK and poorer patient care overall.

We agree that patient safety and the provison of high quality care must be principal considerations, but this approach fails to acknowledge doctors' personal and professional

needs or career aspirations. Box 10 on page 51 gives the only nod to doctors as highly qualified, motivated individuals with aspirations for a fulfilling and stimulating life-long career over which they can exert a degree of control. Medicine must remain an attractive and rewarding career choice. There is already sound evidence that a career in medicine is viewed as increasingly unappealing. In particular there has been a significant drop in the numbers of Caucasian males applying to medical school, as a career in medicine is increasingly viewed as lower status with poorer remuneration than other "equivalent" careers.

The Report also advocates as part of increasing flexibility that, "doctors [are] given opportunities to spend up to a year working in a related specialty or undertaking academic, research or management work" (page 6). The current system, whilst not perfect, already permits some degree of flexibility; however, these new proposals would limit time out to one year, rendering the system more inflexible. This will make it difficult to undertake certain types of work which would benefit the NHS but which require longer training or experience e.g. for those wishing to perform research, one year would only permit an MSc to be gained rather than an MD or PhD.

Finally, we suggest that any move to incorporate F2 into the early stages of broad based training will force even earlier specialty choice than occurs in the current system. This would not be supported by the recommendations of the Tooke report (paragraph 8 page 16).

4. EXISTING WORKFORCE

We emphasised in our response to the call for written evidence that any changes to the current system of medical training must be phased in to avoid destabilisation of the medical workforce and compromise of patient care. We are concerned by the final report's statement that "The principles for implementation of any new model should enable the existing workforce to be incorporated into the new system so as to avoid co-existence of parallel systems."

We urge caution and careful, considered phasing in of changes to ensure ongoing provision of safe, high quality patient care. Doctors currently in training have certain expectations of their career path based on the choices they made when entering specialty training. To radically shift the goal-posts at this stage of training spells disaster for the medical profession and may cause mass attrition and exacerbate the recruitment crisis faced by medicine. Our principal concern is to ensure stability and security for existing trainees, especially those in higher specialty training.

5. SAS DOCTORS

Any report considering the medical workforce must consider the different arms of the profession, and we welcome the Report's attention to SAS doctors. The T&MC 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 are concerned by the image of training on page 13 which suggests that entry into an SAS role will be possible immediately after graduation. The current system mandates that all SAS entrants have successfully completed the Foundation Programme (or equivalent) and in addition have 2 further years of clinical experience. This guarantees a minimum level of competence and experience for a grade of doctor which often functions autonomously and which has not always benefitted from clearly defined roles or governance. We strongly object to the advertisement of non-standard posts, opposing their use and we would be extremely cautious about their educational value and the possibility for career progression. Any moves to change the point of entry into the SAS grade would require very careful consideration, and planning and discussions would need the involvement of all relevant professional bodies and unions.

As acknowledged in the Report, arrangements for the regulatory recognition of the exit points of postgraduate training will need to be established (Paragraph 89 page 37) and this will necessitate consideration of an equivalence route onto the appropriate register (Paragraph 131, page 47).

6. UNDERGRADUATE TRAINING

Paragraph 67 (page 32) supports moving the point of Full Registration to the point of graduation, acknowledging the inevitable knock on effect on undergraduate medical education "which will have to ensure graduates meet more advanced outcomes". We question how deliverable this and the measures outlined in Paragraph 68 are within a reasonable time-frame, the current undergraduate programme length and in the absence of a national undergraduate curriculum. We also have concerns about the prospect of new graduates undertaking placements in rural settings, with potentially less supervision.

Accommodating 'apprenticeship' style training for medical students within the current and already full undergraduate curriculum would likely be at the expense of other areas and may reduce the breadth of experience at undergraduate level overall. Alternatively, lengthening the undergraduate programme poses an additional financial burden to students already stretched by tuition fees. We do not support any lengthening of the undergraduate programme to accommodate these changes.

We support the Report's acknowledgment that early consideration be given to the provision of realistic and honest careers advice to manage the expectations of school-leavers and undergraduates as well as those of existing trainees.

7. TIME FOR TRAINING

Paragraph 121 (page 45) states that doctors should have access to protected time for learning, and Box 7 (page 36) refers to supervisors and trainers being supported explicitly in their role. We welcome this and the reference in Paragraph 98 to the Academy of Medical Royal Colleges Trainee Doctors' Group (ATDG) charter for postgraduate medical training, which emphasises the importance of 'time to learn and reflect on learning'.

However, there is no acknowledgement of the importance of allocating time to allow consultants and senior doctors to do this and we feel the Report should provide clearer emphasis on the importance of protected time for both trainers and trainees. Protected time for training for both trainees and trainers is essential to ensure the provision of high quality patient care. Excellent training is fundamental to excellent patient care.

The report is also overly focused on professionalism issues. Box 10 on page 51 states that "The overarching objective of the system of medical education and training must be to equip doctors, and to instil in them the professionalism needed" to deliver care. We agree these are critically important but they must be taught and learned in parallel with the acquisition of clinical knowledge and skills.