Shape of Training: Response to the Academy of Medical Royal Colleges mapping exercise

OCTOBER 2015

Executive Overview

1. The Federation of the Royal Colleges of Physicians supports the need to restructure aspects of the training of physicians to support the management of acute medical emergencies, chronic disease management, comorbidities, complexity and the needs of an ageing society. In doing so we also recognise an opportunity to begin the process of service and education transformation.
2. There are many ways to better support the acute medical take and acute care, both within the hospital and the community. These are specialty dependent, but with an expectation that all specialties will have knowledge of the acute take, contribute to the care of acutely unwell patients in an appropriate manner, and have the skills to do that.
3. Changes for training in all specialties will be aligned with the General Medical Council changes to Generic Professional Capabilities and a new approach to assessment.
4. The curricula will allow simpler and more regular updating to accommodate the needs of patients and new innovations in treatment. In particular we want maximum flexibility in the early years to permit more pluri-potent training and for later training to ensure appropriate development and maintenance of skills and competencies.
5. In addition to detailing our response to the mapping exercise, we have demonstrated how the proposed model addresses the four themes identified at the recent Shape of Training Panel meeting.

Background

This document is the Federation of the Royal Colleges of Physicians response prepared by the JRCPTB for the Academy of Medical Royal Colleges Shape of Training mapping exercise.

The Federation of the Royal Colleges of Physicians support change to meet patient and public needs by training doctors who can provide better care to the growing number of people with multiple comorbidities, an ageing population, health inequality, ability to recognise and treat acutely unwell patients and respond to the increase in patient expectation.

Within JRCPTB there is an additional challenge of representing the 29 specialties and 3 sub-specialties that we oversee. In order to facilitate this representation meetings have been held with all the chairs of the specialty advisory committees (SACs). In addition the proposed model for the development of a flexible internal medicine curriculum has been shared widely including: councils of the three colleges and regional advisors, the trainees committees of the three colleges, the medical specialties board based in London, with heads of school of medicine and the postgraduate deans and finally, via a podcast, available on YouTube and the JRCPTB website. Overall there is considerable support for the principles from established consultants and trainees groups.

The mapping exercise

As highlighted under *'background'* each of the 29 medical specialties and 3 sub-specialties were asked to consider the questions outlined in the mapping exercise. Appendix 1 outlines the consultation process undertaken to formulate the response.

Service requirements/more generic training (questions 1-9)

The response below addresses questions 1-9, concerning future patient service needs and generalism and areas for joint work and training.

There is unanimous agreement that any proposal must have quality of care and patient safety and need as its foundation. The increasing number of older patients with multiple comorbidities faced by increasingly pressurised acute medical services, as well as the challenge of chronic disease management in most specialties, requires a balanced approach to training. As far as training of physicians is concerned, these views broadly address failings identified by the Francis and several other reports.

All of the specialties are committed to the on-going review and development of their service to ensure the best outcomes for patients. Whether these changes are driven by policy development, such as the clinical geneticists considering the challenge of mainstreaming genomic medicine, or by advances in technology and a drive for early intervention, such as in cardiology, stroke medicine and management of GI bleeding, each SAC regularly reviews and develops their existing curricula to ensure the service demands of the trained specialty physician can be met via the curriculum.

In short, specialties have, where possible, sought to ensure that their training programmes equip their pre-CCT doctors with the knowledge, capability, experience, attitudes and behaviours needed to meet the changing needs of the population. These principles will continue to serve as the foundation for the development of the specialty training content in the coming years.

We have considered the opportunities offered by Broad Based Training (BBT) and Acute Care Common Stem (ACCS). The proposed model will work flexibly with these and other pathways including those proposed by the Royal College of Emergency Medicine. We envisage greater opportunities for training flexibly across primary and secondary care boundaries, following appropriate assessment of transferrable competencies and Generic Professional Capabilities
The majority of specialties already participate in cross-specialty working, whether via formalised routes such as dual-training, or delivery of shared care pathways. For example, genito-urinary medicine (GUM) has considerable interface with other specialties and well developed care pathways with primary care and public health, with trainees in specialties such as dermatology, obstetrics & gynaecology and infectious diseases regularly undertaking attachments in GUM (and vice-versa).

Service improvements and increased patient self-management have resulted in some specialties, for example endocrinology and diabetes mellitus, delivering increasing amounts of care in the community. The need to work across boundaries and in the community is of course important for all specialties, but given the complexity of patient and service need, there will be differences from specialty to specialty. A focus of the proposed model *(page 5)* has been to optimise the spine of internal medicine, which underpins all specialties. Once this is achieved JRCPTB and the SACs will work to ensure that, at specialty level, contextual competence in internal medicine, including models for development and delivery of community-based services (as appropriate) becomes the next development priority.

However, the proposed model *(page 5)* provides an opportunity to enhance the training in internal medicine for all physicians. In particular, to promote the management of the acutely unwell patient with an increased focus on chronic disease management, co morbidity and complexity in the main specialties supporting acute hospital care and therefore producing physicians able to deliver care in line with expected future patient need. This should be in conjunction with appropriate work force transformation, with non-medical professions' role development wherever possible. These proposals are fully aligned with that development and the increasing move to community based integrated medicine.

The increased use of competency-based curricula, as implied by the GMC consultation on Generic Professional Capabilities (GPCs), would allow much greater flexibility in the early years of training. Our proposal for the new Internal Medicine curriculum, would, for example, allow greater flexibility with the new GP curriculum.

As outlined, our focus is based primarily on the training of physicians to better meet current and emergent patient need. However, we also recognise the fact that an increasingly elderly population, with co-morbidities and chronic disease, has implications for non-physicianly specialties. Accordingly, we suggest that all specialties, as appropriate, receive better training in the basic principles of older peoples' care and the implications of polypharmacy and multimorbidity. In addition we believe there is the potential for the development of shared content across specialty assessments. For example we could integrate psychiatry questions in the MRCP(UK) or generate questions on older people for use in surgical exams. These specialties must be well represented in the early years of training. Such development would have the potential to influence and develop cross-specialty learning and care without necessarily having to have a formal period of training or a placement in a particular discipline. It still remains absolutely vital for the future care of patients within the NHS that all specialty training is supported and developed in parallel with increasing generalism.

Handling acute and emergency patients (questions 10-11)

Key to the discussions with the SACs has been the contribution in training to the acute take and the role all medical specialties in acute patient care. In the proposed model, all will contribute to the unselected take in the first three years of training. This needs to build on the acute internal medicine curriculum and ensure the skills in internal medicine are cross-linked to meet the needs of the acutely unwell patient for the relevant parts of the curriculum.

During specialty training most registrars will continue to train in supporting the acute medical take. This will be defined by patient need. The exact balance of which specialties will continue to contribute to the acute take (for at least one year, and often more) has yet to be defined.

There is a small number of specialties managed by JRCPTB which will continue to deliver non-acute, primarily outpatient-based services. We are keen to explore inter-College collaboration in this area, for example with Emergency Medicine.

Credentialing (questions 12-13)

Following extensive consultation with our SAC's as part of the Shape of Training Audit response, the strong view was that clinical credentials would *normally* be available to those on the Specialist Register (or GP register, as appropriate). In order for credentialing to work, we believe it should be seen as a positive step forward for those that have already obtained an appropriate level of competence (such as a CCT).

However; the GMC must ensure that the message surrounding the role of a credential is very clear, to patients, employers and doctors themselves. What must be avoided is any perception that a doctor, well-established in an area of practice in which a credential may be offered, is less-equipped to work in that area than a doctor with a credential. Any hierarchy (whether real or perceived) relating to CCT/Specialty recognition/Credentials must also be very clear.

During these SAC meetings credentials were viewed positively (subject to points outlined above) as an opportunity to increase the flexibility of post-CCT training and experience in a range of medical specialties both for physicians and, in some cases, other colleagues such as surgeons, paediatricians and GPs. Most SACs were able to identify areas of clinical practice which *could* be considered appropriate for a credential (for those with a CST in the specialty, as well as others). When considering the role of credentials in offering training cross-specialty there has been considerable intent in helping to develop post-CCT credentials in frailty in old age and community based acute medical care.

However, until the GMC publishes a response to the consultation and clearly indicates the way in which credentials will work it is difficult to fully know whether credentialing would be a suitable way for delivering certain specific competencies. Appendix 2 outlines the JRCPTB response to the GMC credentialing consultation.

Sub-specialty training (questions 14-15)

At present three sub-specialties sit within the JRCPTB portfolio; hepatology, metabolic medicine and stroke medicine. Discussions with SACs have suggested the following:

Hepatology: it is recognised that patient need is increasing in this area, for example with alcohol and non-alcohol related fatty liver disease, and so will inevitably result in on-going development of the service.

Metabolic Medicine: discussions have begun with chemical pathology to consider the most appropriate placement of this sub-specialty.

Stroke medicine: stroke medicine has always had crossover with other specialties, such as geriatric medicine, neurology and interventional radiology. Increasing patient need for interventional care will mean that discussions around this service will continue.

Possibilities involving the role of post-CST credentialing may be considered, appropriately, in all cases.

Academic training (question 16)

The proposals outlined are to ensure we meet the needs of the patients. However, to ensure we secure the future of health care and drive innovation and inquiry, we must recognise the importance of clinical academic medicine in securing a future health service that is fit for purpose. We recognise the vital need to strengthen academic training across all physicianly specialties. We would aim to further improve our co-working with our partners in NIHR across all clinical academic training pathways. In addition we would ensure improved academic training for all medical trainees via better and more rigorous assessment of research skills and knowledge via the Generic Professional Competencies and appropriate curricular reviews. Much research and development in the physician specialties has been, and still is, undertaken by non-academic track trainees. We would wish such trainees, where they have the ability, skills, aptitude and motivation, to continue to be able to apply to undertake research projects.

Greater flexibility of academic training pathways will be encouraged; to increase academic opportunities, while still enshrining achievement of clinical competencies for academic trainees.

It is not envisaged that there would be any significant alteration to the existing clinical academic training programme at present.

Length of training (questions 17- 19)

As outlined in the recent letter to the AoMRC from the Federation "*None of the work to date or indeed through the Shape of Training workshops suggested shortening of training nor indeed did the main principles within the Shape of Training report. The evidence base, in particular for dual training, does not provide any international model that could shorten training. For example, those comparable countries with dual training such as Australia and Ireland have a minimum of 7 year training programmes".* Accordingly the proposed model continues to support a programme length for dual training of (minimum) seven years after the two year foundation programme. We do not envisage any enthusiasm or role for single speciality accreditation in Internal Medicine alone.

SACs felt that to suggest a reduction in the length of training would have implications for patient safety as the skills and competences the service currently expects from the trained physician would not be possible. This undermines the very principles behind shape of training.

Most specialties agree that there ought to be a prescribed minimal length of training supported by approved competency based outcomes. As one SAC chair pointed out, we cannot lose sight of the fact that both undergraduate and postgraduate training of doctors is based on time as in many other industries and professions. It is a structure that all are familiar and comfortable with and permits employers to effectively manage the service.

However, trainees do inevitably vary in the speed with which they progress through training and, therefore, where appropriate, we have already introduced a mechanism for accelerated attainment of CCT/CST.

In addition JRCPTB would strongly support the ability, outlined in the original Shape of Training review, for trainees to be able to undertake opportunities outside of their specialty training programme. These could include leadership roles, research or training in an area outside of their specialty, which would all serve to strengthen the skill set of the future medical workforce.

Foundation and undergraduate training (questions 20-21)

There was consensus that the delivery of both undergraduate and Foundation Year training varies depending on the school/programme. Increasing practical supervised acute placements for undergraduates would be welcomed. It was also felt that additional acute medical experience would much better prepare doctors to enter training in one of the medical specialties.

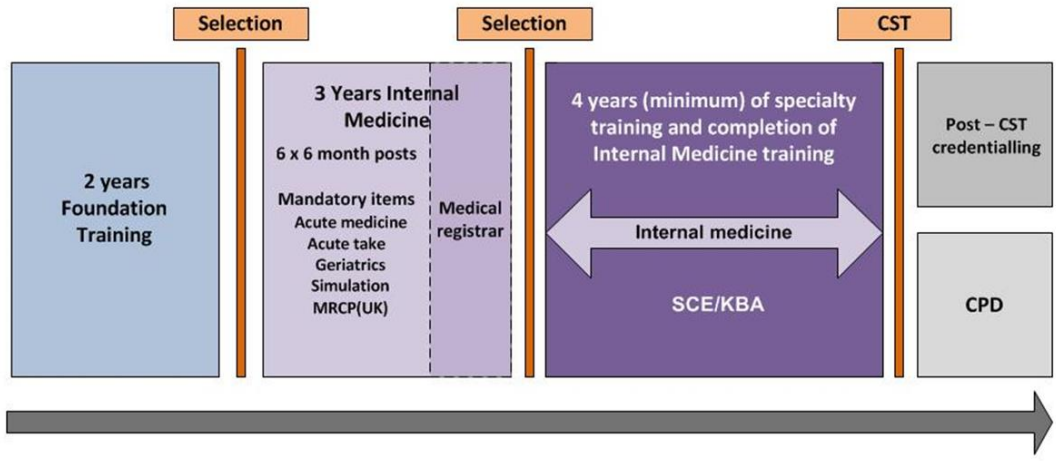
Amongst specialties delivering acute care in particular there is a firmly-held belief that the move towards more community-based experience in foundation years has reduced the ability for core medical trainees to deliver acute care confidently and safely. To better prepare for entry into specialty training (for acute specialties) the entire FY2 year would need to be acute care focussed including acute medicine. This would be seen as essential training and not to replace the necessary training in acute medicine within the latter part of specialty training.

So the proposed model *(figure 1)* assumes **increased** integrated community experience during Foundation years, then focus on hospital-based 'basic' Internal Medicine, especially acute care, for next three years, before development of integrated community skills in the four years of specialty training (as determined by the specialty).

Description (questions 22-23)

JRCPTB, on behalf of the Federation of Royal Colleges of Physicians, has suggested that an appropriate model for much physician training should consist of a minimum seven year (dual) training period after the initial two foundation years leading to a CST in a specialty and Internal Medicine *(figure 1)*. This is consistent with the European Standards for Postgraduate Medical Specialist Training (UEMS 2012/29 Internal Medicine) and with current developments in Internal Medicine in Europe. The seven years, starting from completion of foundation training, should consist of three years training in basic internal medicine during which increasing responsibility for the acute medical take would be experienced in year 3 and MRCP(UK) would be achieved by the end of this period. After these three years, there would be competitive entry into specialty training (combined with IM) for a usual minimum of four years. During this period, an indicative three years will be spent training for the CST specialty and a further year of internal medicine integrated flexibly within the specialty training to ensure that CST holders are competent to practice at post-CST consultant independent level.

Figure 1: The proposed model for training in physicianly specialties



We recognise that the details of the implementation of the proposed model will need to accommodate the range of physicianly specialties and the changing demands of the demographic of the trainee workforce in each specialty. The development of the flexible curriculum in internal medicine aligns with the increasingly flexible approach to workforce development exemplified in the Shape of Caring[1] Review. We believe a flexible approach is necessary to deliver a sustainable model for the training of physicians, agile enough to respond to meet evolving patient need.

We also note that the General Medical Council (GMC) is currently consulting on 'Generic Professional Capabilities (GPCs)'. These will require an extensive rewrite of all curricula and it will be essential to link this to the proposed changes to internal medicine. Indeed there is a huge synergy between an internal medicine curriculum and the expectation of GPCs.

Appendix 3 outlines the development of the curriculum in Internal Medline, which provides more detail on the proposed model, including the potential shift towards the use of an outcomes-based curriculum, underpinned by a more holistic assessment approach. Given the significance of any change to the way in which postgraduate medical training and education is delivered, we would expect to conduct pilots, and appropriately robust evaluation.

Finally there has been some discussion about the assessment strategy and this proposed flexible internal medicine curriculum. Our colleagues in MRCP(UK) have been fully involved in discussion and debate on what is a highly significant change. A new curriculum will need a change in assessment - and this work is yet to be done, but is likely to include the following:

- The potential for the blueprinting of examinations (that is the precise balance of content) to influence the direction of learning within a curriculum.
- The need to consider the total burden of assessment on all doctors, particularly given the likelihood that credentials will require assessment.
- The need to clarify whether the GMC expects the GPCs to be assessed in parallel to other specialty specific competencies (thus explicitly making them transferable to other specialties) or whether they are to be integrated into all competencies
- The need to consider the degree of difficulty (standard) and precise temporal placement of summative assessments within the training programme.
- The need to ensure that workplace sign off of competencies are deliverable, meaningful and truly complementary to the summative assessments.
- The need to consider the benefit of a shared language and format of assessments across broad specialties wherever possible, including shared common content in specialty examinations
- The need to consider and attempt to align the style and language of assessment in undergraduate, foundation and specialty training and perhaps revalidation.
- The most appropriate method of assessing the generic professional capabilities and internal medicine during specialty training.

Summary

In addition to considering the questions outlined in the original mapping exercise, we have also addressed the points raised subsequently by the GMC Shape Panel in which we were asked:

How the colleges' submissions address ensuring doctors who can provide safe emergency and acute care by the end of their postgraduate training.

- The proposed model has been designed to ensure that all trainee physicians are equipped to better manage and provide safe acute care throughout their training and beyond. All trainees will undertake a third year of 'Basic

[1] *Shape of Caring: A Review of the Future Education and Training of Registered Nurses and Care Assistants, Health Education England, March 2015*

Internal Medicine' which will enable further training in acute, unselected take to provide an essential building block for safe acute medical care. The inclusion of Competencies in Practice (CIPs) specifically related to acute care will also support this. The model has been subject to considerable debate, discussion and consultation in many different fora.

- Via SACs, specialties have demonstrated a willingness to contribute to acute medical care throughout their specialty training programmes.

How the college's submissions address developing a more flexible approach to training between specialties.

- The proposed move to competencies in practice and more outcome-based learning will encourage flexibility between specialties, particularly if other specialties adopt the same approach (as suggested by General Practice, for example).
- Broad Based Training (via CMT) and Acute Care Common Stem training programmes are both entry routes into ST2/3 specialties – broadening the flexibility in early years of training.

How the colleges' submissions address blurring the boundaries between primary and secondary care.

- As highlighted under 'Foundation and undergraduate training' we believe the proposed model presents the opportunity to blur the boundary between primary and secondary care across the length of postgraduate training i.e. that there will be increased integrated community experience in Foundation, then a focus on hospital-based Basic Internal Medicine, especially acute care, for next three years and then the development of integrated community skills in specialty training (as determined by the patient needs for the specialty).
- Future development of community-focussed CIPs within the specialty curricula.
- Development of post-CST credentials in partnership with RCGP and other Royal Colleges.

How the colleges' submissions address fostering lifelong learning including the possible role of credentials

- The Federation of the Royal College of Physicians already has one of the largest, most established CPD programmes in the world. This already affords us an ability to respond iteratively to both existing and emergent learning needs which will continue in the future.
- The role of credentialing in the education of physicians will need further consideration once the GMC has published their response to the recent consultation.