

Shape of Training: The story so far and the potential impact on Palliative Medicine

1. Introduction

The **Shape of Training Review** will have a profound impact on the medical profession, patient care and our specialty. The changes will affect all physicians working in the speciality, not just those involved in delivering education and training. It is now time for Palliative Medicine to consider the implications very closely and be clear about how we train junior doctors and deliver our service in the future.

To inform you in your thinking and our discussions this paper outlines the background and key concepts of the Review, and the evolving discussions taking place. Many areas remain vague and the information changes fairly frequently! A list of resources is at the end if you want to delve deeper.

Everyone in the specialty must contribute to the debate and be heard. Please take some time to read this document and then complete the attached questionnaire bearing in mind that many questions are extremely difficult to answer and that some may require certain knowledge about education, training and the curriculum.

2. Why did the Shape of Training review happen?

The role of doctors is changing rapidly against a backdrop of medical, technological and scientific advances, shifting demographics, changing healthcare systems and patient / public expectations. Independent reports on care include Francis, Neuberger and Berwick, and from the profession, "Hospitals on the Edge", "The Medical Registrar" and "Future Hospital: caring for medical patients". In 2012 the four UK governments established an independent review led by Professor David Greenaway, Vice-Chancellor of Nottingham University, to look at the changing needs of patients, health services and society, and the type of doctors that will be needed to provide high quality care in the future. The review was tasked with examining postgraduate medical education and training across the UK.

3. What were the key themes and recommendations in the Shape of Training Review final report

Key themes of the review were:

- What kind of doctors will patients need in 30 years' time?
- What balance will be needed between specialists and generalists?
- How can training be made more flexible to meet the changing needs of the health service and patients?
- How do these elements affect the content, length and end of training?

The Review concluded that we need a new way of training doctors to provide general care in broad specialty areas across a range of different settings. Nineteen recommendations included:

- Following broad specialty training, doctors will go on to train in more specialised areas where there are local patient and workforce needs.
- Medicine has to be a sustainable career with opportunities to change roles and specialties throughout doctors' careers.

- Full registration should move to the point of graduation from medical school, provided there are measures in place to demonstrate graduates meet the GMC's standards at the end of medical school.
- Implementation of these recommendations must be carefully planned on a UK wide basis to ensure minimum disruption to service.

4. What was the initial response to the Shape of Training Review

Following the review a joint position statement on “The Shape of Training Review” was published by the RCPL, RCPE, RCPSG, and the Joint Royal Colleges of Physicians Training Board (JRCPTB) supporting certain aspects of the Review including:

- Exploration of the balance between internal medicine and specialist medical care, and training in settings outside the hospital.
- Recognition of career-long training for doctors.
- Emphasis on support for doctors in training.

From subsequent discussions, a model evolved that would be underpinned by a new spiral curriculum in Internal Medicine. This would see a change to the way training is planned and delivered at both core and higher levels in most if not all, physician specialties (see Figure 1).

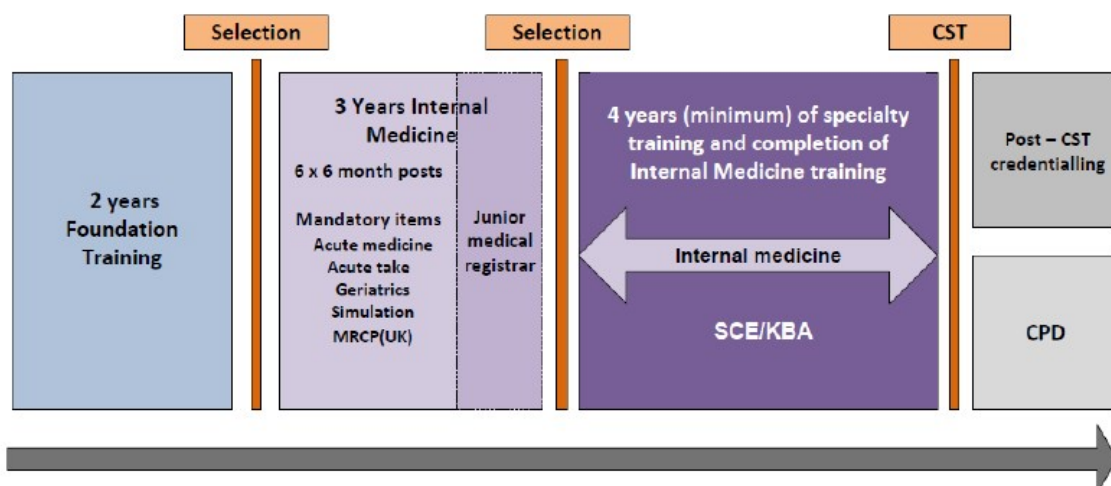


Figure 1

5. What would training in Internal Medicine look like?

There have been further discussions and some consensus on what could become key principles for future basic training in Internal Medicine. These include:

- 'Registrar' will describe a trainee in year 1-3 and 'Senior Registrar' for years 4-7.
- The new 3-year programme is not the existing CMT + 1 year. It should be an integrated internal medicine training programme, where competence and expertise (both clinical and non-clinical) is incremental.
- A focus should be found for each year, such as quality improvement or clinical leadership skill. In year 3 the focus must be on progress from readiness to competence in leading the acute take.
- Increased exposure to outpatient clinics is essential, but this may be 'front-loaded' in year 1 or 2 to balance staged exposure to this and acute environments.
- Procedural exposure should be increased with simulation competence vs. being able to practice independently, and graded throughout the programme.
- The selection process for higher training should take place at the end of this programme i.e. ST4. Trainees should not be required to apply for the 3rd year of the new programme in open competition.
- Completing MRCP by the end of year 2 will not be necessary; however, trainees must have at least attempted PACES in order to pass from year 2 into year 3.
- In year 3 trainees should spend a minimum of 6 months in a single site. 12 months would be preferred to ensure continuity in assessment of Internal Medicine in this year. MRCP would be an essential requirement for entry into ST4.

The plan is to develop the Internal Medicine curriculum for the entirety of the programme i.e. 'years 1-3' and '4-7'. This would enable definition of a core set of competences in Internal Medicine on top of which specialties could develop their own Internal Medicine components specific to the needs of their patients. It will be important that there is no duplication of the competences required for general Internal Medicine.

6. Where might we have concerns?

Year 4 of internal medicine training in specialty training is one of the key areas of debate. It is agreed that 'one size cannot fit all'.

For some, integration of internal medicine and the model appears straightforward. For others, whilst knowledge and skills in Internal Medicine are accepted as being important, supporting the acute take in ways other than managing unselected admissions seem a more likely requirement for the service than training. As it stands:

- The programme aims to ensure that the new consultant is sufficiently trained to support or lead the acute take (as required by the service).
- To maintain quality a trainee would have to have both an Internal Medicine and Specialty Training Programme Director to ensure that internal medicine training is adequate.
- Further consideration should be given to specific Internal Medicine assessment. It may be appropriate to introduce an SCE in internal medicine.
- Internal Medicine should be integrated throughout the programme, rather than being delivered in year 4, and then revisited at the end of year 7. This would ensure all trainees were able to effectively manage acute medical issues within their specialty area.
- Single or dual training / CCT / Curriculum: There are arguments for both a single CCT in 'specialty + Internal Medicine', delivered via a single curriculum, and for the need to maintain the distinction between the two (effectively dual-training).

However, for professional recognition, specialties may need to define standards of competence further to be reached in either the Internal Medicine or specialty elements of the programme. One possibility is a single spine encapsulating Internal Medicine and all generic competences, with a *separate* curriculum for the additional speciality specific competences.

7. What is credentialing?

Credentialing is: “a process which provides formal accreditation of attainment of competences (which includes knowledge, skills and performance) in a defined area of practice, at a level that provides confidence that the individual is fit to practise in that area in the context of effective clinical governance and supervision as appropriate to the credentialed level of practice”.

The GMC is working on a framework for credentialing stating that credentials will apply to defined areas of practice and be awarded to doctors who have shown sufficient competency in a defined area of practice. Skills developed by doctors while training during fellowships could be recognised through “credentialing”. The Shape of Training Review said that some specialty training, and all subspecialty training, will be acquired through credentialed programmes once doctors have completed their postgraduate training.

The GMC have suggested that credentialing could also be used as a mechanism to reduce the length of specialist training, because many specialties have ‘special interest’ programmes at the end of their training programme. They want specialties to look at whether some of specialty training could become credentials thus shortening training. However, it would need to be made clear that a CST holder didn’t have experience in those areas. Specialties need to look at their curriculum and decide how much of their special interest areas need to be covered in the curriculum.

8. What other issues have been highlighted?

8.1. There is a need for a better understanding of the future health landscape, with outcomes and workforce modelling

It is difficult to design training without understanding clearly what will be required in the future health service. Financial modelling and workforce planning should inform decision-making to avoid training people for roles for which there is no service demand.

8.2. Models that promote Internal Medicine without devaluation of the specialist knowledge needed for patient care

Improving training in Internal Medicine, and its attractiveness as a specialty, are important but not at the expense of compromising specialty training. Strengthening the links between Acute Medicine and Internal Medicine is also necessary to improve patient care and support training.

8.3. Robust structures for, and oversight of, post-CST training

Programmes must develop to deliver credentials that reflect advanced specialist training beyond a certificate of specialty training (CST), achieve competence based upon curricula, that are supervised, quality assured, funded, and managed to consistent and high standards nationally, whilst recognising that many will be driven by clinical needs identified in regional workforce plans.

8.4. An effective model for credentialing

This will take 5 to 10 years as legislation will be required. The Colleges are already developing post CCT fellowships. Accreditation could begin now and the APM should be at the heart of this process.

8.5. Mechanisms for accrediting good training environments

Good clinical environments should have national recognition and be accredited. Who would be responsible for this?

8.6. Opportunity to gain academic experience for all trainees

Some trainees develop research later in their careers. Flexibility should exist for trainees to engage in research at different points within their training years. Non-academic trainees should have the option to spend more than 1 year out-of-programme to undertake high-level research, such as an MD or PhD.

8.7. Supporting staff grade, specialty doctors and associate specialists (SAS doctors)

Adequate supervision, training and appraisal must not be restricted to those in formal training programmes, but extend to SAS doctors. The introduction of regional SAS educational advisors has been a positive development. With a move towards a 7-day service / on call / etc workforce planning should consider expanding the role and recruitment of SAS doctors supported by opportunity for fair competition for formal training programmes and credentials. However, given the experience, skills and often niche clinical roles that SAS doctors occupy, the certificate of eligibility for specialist registration (CESR) must be protected along with the opportunity for credentialing.

8.8. Understanding of the length of training needed across specialties

The minimum time to train as a consultant remains unchanged at 6 years. However, the current dual training model would reduce this from 7 to 6 years for all programmes. It is unrealistic to shorten the length of training without compromising the quality and competence of a CST-holder. The Colleges advocate a minimum of 7 years after foundation to gain dual accreditation of training in Internal Medicine and a medical specialty, with capability-based progression and assessment to determine the end point of training. Trainees reach a level of competence at different rates and should not have to practise independently as a consultant before they have the necessary experience and confidence to practice safely. The Colleges have suggested that the length of training is reviewed specialty by specialty.

8.9. Dual core accreditation for most specialties

Although there will be situations where single specialty accreditation is the agreed choice, the majority of trainees in bed-based specialties should be dual-accredited. Post-CST credentialing should be reserved for subspecialty training as determined by the specialties in order to avoid a number of unintended consequences and issues.

8.10. Optional year spent working in a related specialty or undertaking research or leadership and management work

An optional additional year out of specialist training within the time frame of 6 years could make it even more difficult to gain specialty competencies in the 6-year time period. The content of the year spent out of formal training should determine whether or not it should count towards the 6 years of training. However, the option to take time out of training for research for one or more years must be retained.

8.11. Future medical training must be piloted and phased

Implementation must be fully worked through over a number of years and piloted to ensure that the implications for patient care across the specialties are understood.

8.12. Interim solutions to address the current challenges in acute care

The view that these proposals will address the current problems in acute care is mistaken. The crisis is now, but the proposed changes at least five years away. There is a risk of a planning blight, which will delay the urgent changes that are necessary, while we await the full implementation of Shape of Training.

9. So what happens now?

The Shape of Training Steering Group (STSG) has endorsed the following general and specific proposals:

- Those aspects of the current training system that have been shown to work well and are fit for purpose should remain.
- Any significant changes to medical training should be consistent with the key principles outlined within the Greenaway report, and taken forward in a measured and incremental way to avoid service and training disruption.
- Any significant changes to medical training such as alterations to curricula must reflect the UK basis of medical training and be approved by the GMC.
- Groups should be developed in each country with appropriate stakeholder representation, with the remit to develop proposals as agreed by Ministers through the STSG, taking account of the different strategic priorities and requirements in each country; and to expand its membership to include representation from the BMA, employers, patients, doctors in training and Chairs of each country.

The next steps will focus on the following specific activities:

- Further work to describe how training can be more generic to meet the needs of patients. This will include a mapping exercise led by the Academy of Medical Royal Colleges and supported by the GMC to look at the extent to which Colleges have or can develop the generic components of their curricula.
- Measures to be scoped out, based on evidence collected through pilot studies, on how to further develop the careers of doctors who are outside formal postgraduate training and who are not consultants, such as SAS grade doctors.
- Measures to prepare doctors to work across the interface between primary, secondary care and the community with more flexibility in training between the sectors.
- The STSG will support the GMC as they develop and pilot credentialing, working with all stakeholders with an interest in this aspect of Shape of Training.

Specialties and the associated SACs now need to consider their response to the proposals and to a series of questions that have been circulated (see *APM questionnaire for further details of these questions*).

10. What are the issues for Palliative Medicine?

10.1. Impact on training

It remains unclear how much time would be spent working in Internal Medicine, and whether dual accreditation would become the norm. The length of specialty training is unclear, but if it remained at four years, trainees would have less time to achieve the required competencies. In turn this might also impact upon available experience in different settings. While improved Internal Medical knowledge and skills will be valuable in Palliative Care, specialty training should not be shortened to avoid a detrimental impact on the acquisition of specialist skills.

It may be the case that trainees coming through the broad based specialty training might have different motivation and commitment to the specialty, raising the possibility of doctors rotating through hospices who do not wish to work there. On the other hand, a broader range of junior doctors would be exposed to experience and training in Palliative Medicine, hopefully acquiring key skills and knowledge which may not otherwise not have happened.

There are pros and cons to Palliative Medicine trainees participating in acute take. Many patients admitted through the acute take have palliative care needs. Involving Palliative Medicine doctors in the acute take may encourage a more appropriate assessment of these patients not only by palliative care doctors doing the acute take, but also by modelling an alternative approach for doctors working alongside them. However there are challenges for our specialty in terms of our traditional access to training for candidates from non-MRCP backgrounds as they would not be able to lead an acute take. We also need to consider the impact on specialty on-call, and how this might balance with a commitment to acute take on-call.

10.2. Impact on workforce planning and recruitment

As a specialty, palliative medicine already endorses physicians working across care boundaries with roles in different settings to follow the needs of the patient, but few services are able to provide consultant delivered care 7 days/week at present. Careful and strategic planning will be needed to consider the implications of any extension to training to accommodate experience in General Internal Medicine, and also be creative in how difficulties in recruitment might be overcome, particularly outside London. Doctors with responsibilities in hospices and acute trusts could be expected to provide senior cover for one, and also share in the acute take at the other, which may be untenable. If this model were to be adopted it might be that the cost of the on call for registrars would need to be borne by the employing trusts (as it is in every other specialty) to allow specialist palliative care units to reinforce local specialty rotas.

10.3. Changes in the consultant role and how the specialty is defined

In the new system a CST holder would have different skills and experience compared to a CST holder who has undertaken credentialing and achieved additional competencies.

Could a consultant with a new style CST lead the MDT? If not would they be paid less? Would such posts be attractive for the independent sector that may be looking to reduce costs? Would a two tier system, detrimental to the specialty and the delivery of care, develop?

We will need to consider what would differentiate between the CST doctor and the credentialed specialist. There are potential challenges to Palliative Medicine as a specialty. Could future doctors in Palliative Medicine become general physicians with a special interest? We need to think carefully about possible consequences of a situation where end of life care is not supported by specialists. Of note, in the US there has been a shift away from generalists providing palliative care to the development of specialists.

As a specialty we need to articulate the knowledge and skills that define palliative care physicians now and the consultant CST holders of the future. We have begun to identify post CCT programmes such as Palliative Medicine in the context of renal disease, and this could be the approach to credentialing where further development and experience could provide senior expertise and leadership in a specific context. A SAC working group are reviewing the curriculum to consider whether there are any components that could be suitable for credentialing.

Finally as a specialty we may want to highlight the need for all specialists to have training and experience in primary and community care in order to better understand how we can work collaboratively across the different settings. This interface is likely to become progressively more blurred in the future.

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