CAMBRIDGE UNIVERSITY
Health Partners

Knowledge-based healthcare

Commentary on the recently published Shape of Training

Securing the future of excellent patient care

Final report of the independent review led by Professor David Greenaway

This important report was considered by the Board of Directors of Cambridge University Health Partners shortly after its publication, which felt that the report makes a number of useful recommendations. The Board supports the view that the training of the next generation of doctors in the UK needs to be responsive to the pressures on the health system brought about by an aging population many of whom have multiple co-morbidities and the increased prevalence of chronic health conditions. We would also agree that a far greater proportion of patient care could and should be provided closer to their homes in the community by physicians with a broad-based training. In order to achieve this there is a need to increase the numbers of doctors providing care to patients in a non-hospital setting and that there should be more emphasis on broad-based, generalist, post-graduate training so that doctors of the future are able to provide care to patients with a range of conditions and co-morbidities and reduce hospital admissions.

We are strongly supportive of both the 'apprenticeship model' of training, and an increase in the length of rotations, which will help foster team working and better supervision, with the caveat that there should be appropriate recognition for the time commitment of those delivering the training

However, the Board wishes to highlight the following for further consideration

1. The variation between medical schools is well described in the report. The risk of moving full registration to the point of graduation, is the likelihood that students may gain insufficient experience as an 'independent' practitioner to be considered as being fit to practice. This might mean the introduction of a national final exam, the implications of which would need careful consideration. Secondly, safeguards will need to be introduced to allow UK graduates priority to F1 posts over EU applicants to avoid significant unemployment of UK trained students and an increased attrition rate at this early stage of their career. Thirdly, students entering a four year graduate entry courses would not fulfil EU regulations as five years is required. Those with previous science qualifications may have this counted, but those without science backgrounds (who perform equally well) will be seriously disadvantaged.

2. We agree that it is vital that all doctors should have generic competencies which should be maintained as far as possible throughout their career. We also agree that competencies should ideally be acquired in a flexible way. However, increasing flexibility would encourage more frequent movement between programmes and/or institutions which will inevitably have implications for service delivery within Trusts unless trainees become largely supernumerary. Furthermore with a contracted training time outlined in the review, the ability to take one year

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out of clinical training (leadership, management) will have significant impact in gaining adequate clinical experience

3. The blurring of boundaries between community and secondary care is an interesting concept and supports the emphasis on training generalists particularly in the acute sector. Whilst the need for the change in emphasis in secondary care training is recognised, the current proposals represent an opportunity for a change in the way General Practitioners are trained and the type of service that they deliver. There is a move to increase GP training by a year and this could provide the basis of extending the role of General Practitioners which will strengthen the integration between primary and secondary care and enhance the attractiveness of the specialty.

4. Much more clarity is required as to what is regarded as a generalist, which may be more difficult to define in 'craft' specialities. Once defined, there would need to be careful consideration of the sustainability of generalists over a career lifetime, in order to avoid high attrition rates after the first decade of work.

5. High-quality health care systems involve delivery of high quality specialist care as well as generalist care. The provision of specialist medical and surgical care remains an important part of the care continuum and ensuring that patients have access to specialists when necessary continues to be essential. If we wish to 'Aspire for Excellence' a clearer articulation of how, under the proposed training model, specialist doctors will be able to develop and master their skills. Specialist advisory committees would want to ensure that trainees have adequate experience and competencies before being signed off, which will substantially increase the training time in some specialties if they are to do a four-to five year generalist training programme beforehand. The extension in training is likely to be even more profound for clinical academics which will further delay their ability to be appointed to senior academic positions.

6. Clarity will also be helpful on the funding of specialist training under the model proposed, in particular will this fall to individual Trusts to fund and how will consistency of approach be achieved. There is also the question of the balance between training and service provision to ensure both the value to the trainee and the organisation providing the training. Whilst the process by which specialist training programmes will be 'credentialed' is unclear, this could represent an opportunity for Universities as well as Royal Colleges to set up and approve innovative, high-quality programmes. Academic Health Sciences Centres could offer a significant contribution to achieving such programmes.

7. In terms of the effect on clinical academia, there are a number of proposals contained within the report which may affect academic development. An earlier CCT may reduce the clinical and academic experience of the doctor resulting in them being less competitive for

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research fellowships or grants, and less competent doctors. Restricting out of programme placements may adversely affect the training of many academics, as a major step on the career ladder is placement outside the host institution and even the country.

In addition, the award of a CCT before subspecialty training (credentialing) means that most academics will not be able to undertake advanced subspecialty training, as they will be expected to deliver consultant-led care in addition to undertaking research. If a trainee wants to be an academic in a subspecialty with significant practical skills, it would be very difficult to do that training and maintain an active research programme post CCT.

Before changes to the pathway for training tomorrow's doctors are finally implemented, serious consideration must be given to ensuring medicine remains a stimulating and rewarding career so that it continues to attract the very best individuals to the profession. To remain globally excellent, UK medicine must successfully address the increasing need for general medical care, with the very real need to provide the very best specialist care and clinical research.

The success of the proposed changes relies on establishing the detail. Much of this work will be undertaken by the implementation group(s) which will need to carefully evaluate the implications of proposed changes.

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