Shaping the Future Medical Workforce
Excellence in Medical Education

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Aims and Scope
The Academy of Medical Educators (AoME) was established in 2006. The main aspiration of the AoME is to improve clinical care through teaching excellence. *Excellence in Medical Education* has been designed with this aspiration in mind. The first five issues will focus on the AoME Professional Standards with invited expert reviews. Future issues will be based on specific educational themes with invitations to submit articles with a peer review process.

*Excellence in Medical Education* has been designed for the active and busy medical, dental and veterinary teacher. The aim is to highlight important educational topics, discuss challenging and controversial issues and stimulate debate. The series embraces 21st Century medical education with expert reviews, interviews and specialist articles. The series will provide an inspirational and thought provoking journey into the exciting field of medical education. We welcome articles and reviews for future issues so if you would like to contribute or comment please contact the Editor, Dr Vimmi Passi, at: vpassi@aol.com

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Welcome from the Editor

Dr Vimmi Passi,  
Editor of Excellence in Medical Education

Following the success of the first four issues, I am very pleased to welcome you to the fifth issue of Excellence in Medical Education, an exciting new educational product for the members of the Academy of Medical Educators (AoME). This series embraces 21st century medical education with expert reviews, interviews and specialist articles. It also provides an inspirational and thought provoking insight into the exciting field of medical education.

This fifth issue is a special issue focusing on our 5th Annual Academic Conference, Shaping the Future Medical Workforce. This issue begins with a welcome to the Conference from the former President of the Academy, Professor Sean Hilton. In this article, Professor Hilton describes the aims of the Academy, challenges ahead for medical educators and summarises the summary of the Academic Conference held on 23rd October 2013.

It is a great privilege to include a leading expert article from Professor David Greenaway on the Shape of Training. In this article Professor Greenaway highlights the important recommendations from the Shape of Training Review. It is a further privilege and pleasure to include the leading expert article by Professor Tony Weetman on the Role of the Medical School in Assuring the Best Doctors for the Future. In this paper, Professor Weetman highlights important national developments in the following five areas: selection into medical schools, getting the right balance in the curriculum, professionalism and fitness to practise, assessments and transition to Foundation Year One.

Shortly after the Shape of Training was published, Health Education England released Broadening the Foundation Programme Report. Professor Stuart effectively highlights the main recommendations from this report which cover supervision, breadth of placements and timeline for moving more placements into the community. Leading on, Professor Jacky Hayden presents an important and stimulating article on Broad Based Training – Lessons Learned Relevant to Implementing the Shape of Training Report. In this thoughtful provoking article, Professor Hayden highlights the background, changes and implications of Broad Based Training. Finally, I am very grateful to Mrs Julie Brown, Honorary CEO of the Academy for writing a very inspiring article on ‘Medical Educators: the Other Lost Tribe is Coming Home.’ In this paper, Julie Browne takes the reader on an exciting journey describing the establishment of the Academy in 2006 to the current work of the Academy with its charitable aim to improve patient care through teaching excellence.

It is proving to be another exciting and busy year for the Academy of Medical Educators. This year the Academy is hosting workshops at ASME in July 2014 and a Pre-Conference Workshop in AMEE in Milan in August 2014. Our national Academy ‘Recognising Teaching Excellence Workshops’ continue to be a great success. We look forward to meeting you to our 2014 AoME Annual Academic Meeting on October 22nd – ‘Education for Quality Improvement in Patient Care.’ We are really delighted to welcome our eminent keynote presenters for this event: Professor Iain Cameron, Professor Wendy Reid and Professor Martin Marshall.

Excellence in Medical Education has been an exciting new venture and I would like to thank all of our expert authors for their thought provoking and fascinating articles. It has been a great pleasure working with you all. We welcome articles and reviews for future issues, so if you would like to contribute or comment, please contact me at vpassi@aol.com.

1. The AoME Professional Standards

The Academy of Medical Educators (AoME) is a charitable organisation developed to advance medical education for the benefit of the public through:

A. The development of a curriculum and qualification system;
B. Undertaking research for the continuing development of medical education; and
C. The promotion and dissemination of best practice in medical education.

In order to achieve these objectives, the AoME’s Professional Standards have been produced. These Standards have been designed to provide the basis upon which a curriculum for medical educators can be developed. They act as a framework against which professional progression as an educator can be planned and measured. The Standards are a tool designed to assist medical educators to work towards excellence.

To be engaged in effective and appropriate professional development is an integral part of Membership and Fellowship of the AoME. The Standards aim to help clarify the professional characteristics that should be maintained and built on for the variety of roles undertaken by medical educators. The Professional Standards are divided into themes and each theme provides details of the knowledge, understanding and practice that underpin the roles of those involved in medical education.

The Standards may be used by organisations to identify the skills and competencies required of those who undertake or fulfil an educational role. Organisations may also use the Standards to develop and offer a framework for training and continuing professional development in support of medical education. The Standards could be considered when setting objectives in performance and appraisal and used for assessing the performance of individuals within organisations.

The Professional Standards are divided into core values of medical educators and five domains.
2. Welcome to the AoME Annual Academic Conference

Professor Sean Hilton

It was a great pleasure to welcome so many delegates to the AoME annual conference held on October 2013. In addition we had the pleasant anticipation of the 2013 Calman Lecture, given by Professor Ian Cumming, the Chief Executive of Health Education England and to round off the day, we had the President’s Reception.

2013 was an important year for medical education: with revalidation for the medical profession finally rolling out – and no doubt influencing thoughts about the same process for other healthcare professions- the implementation of the GMC’s standards for clinical trainers and educational supervisors also began. Raising standards for medical education and training is the AoME’s mission, and this process is helping us to professionalise the roles of educators and to put high quality education and training at the heart of patient centred care – one of my roles as AoME President is to promote our charitable aim of improving patient care through educational excellence.

However, the centre piece of the conference was the Shape of Training Review. Commissioned by the AoMRC, the GMC, MSC and the Home Nations’ Postgraduate Medical Education Bodies, the publication of Professor Greenaway’s review was eagerly awaited and we were delighted that he had agreed to give our opening address. Unfortunately, he was unable to attend on the day, but we are very grateful to him for providing the original article for this special edition of Excellence in Medical Education.

Aims of the Academy

Since before the Millennium, medical professionalism in all its aspects has had an increasing profile – perhaps because collectively we have lost sight of its centrality in the proceeding 30 years. Publications with professionalism in the title have grown 20 fold in the last 40 years. The proceeding 30 years. Publications with professionalism because collectively we have lost sight of its centrality in all its aspects has had an increasing profile – perhaps.

in benchmarking for the many organisations involved in medical and healthcare education. We are very pleased that the General Medical Council chose to utilise the Academy’s standards in describing its own standards for clinical and educational supervisors, another important implementation occurring during this year. Underpinning the standards are the Academy’s core values. Simply expressed, these are: Q&B R & I & S –

• Q= Quality of patient care is the overriding value
• B= Respect for learners, colleagues, patients and public
• I = Integrity – say what we mean and mean what we say about the place of medical education and training
• S= Scholarship – in all its aspects, from cutting edge educational research to reflections about our teaching and how to improve it.

Every Member and Fellow of the Academy makes a continuing commitment to these values, and this is required, regardless of any other achievement of merit. So, we stand as a small but growing organisation of around 500 members and 30 corporate partners as a registered charity, with a commitment to our aims and a commitment to working with like-minded organisations. It is not easy for a young organisation with limited resources, and our aspirations certainly outstrip our capacity right now. However, something we are getting better at is thinking about how to support our members, particularly junior members in developing and sustaining a career in medical education. We have a stimulating early careers working group, led by Jamie Read, and they are developing schemes for mentoring and for supporting senior medical students and junior doctors thrust into teaching and assessing roles.

Alongside AoME, I am also a board member of Medbiquitous, a north American based but internationally facing organisation that promotes improved education and training through shared standards for educational technologies to encourage interoperability and innovation (www.mediqitous.org). In his plenary address to the 2013 conference at John Hopkins in Baltimore, David Nichols, President of the American board of Paediatrics and incoming Chairman of Medbiquitous, spoke of the imperative to align more closely educational and clinical outcomes. For more than 20 years, we have had the Miller Triangle as a paradigm for the acquisition of clinical competence. In 2000 Cees van der Vleuten added a dimension of metacognition – particularly reflection and judgment – to create the Miller Pyramid. Professor Nicols argued that we should now be considering how to ‘top out’ – or at least add another layer to the pyramid, by inclusion of patient outcomes that indicate quality aspects of patient care and morbidity.

If we need to be persuaded of the importance of this, we need look no further than the publication in the UK in 2013 of the Francis Report into healthcare at Mid Staffordshire hospital. No aspect of healthcare provision can escape some of the responsibility for this distressing episode in NHS history. Although only 21 of 290 recommendations (7.2%) relate directly to education and training there is a clear requirement for educators and their regulators to play a stronger part in patient safety and patient care. Information shared and communication between them and other regulatory reports should be improved. Undergraduate students and tutors should provide feedback on safety and quality of care; and postgraduate training visits should aim to enhance patient safety and quality.

There are many challenges to address and time only allows me to give you an incomplete list as listed below, but the good thing is that there are many colleagues and likeminded organisations doing so, and some of those were represented by our conference speakers and amongst the audience.

Challenges to Meet: -

• Changing education and training across the UK
• Patient Centredness
• Learner Centredness
• Interprofessional Learning
• International and Technology Standards
• UK NHS versus devolving home nations
• Higher education sector
• Commissioning arrangements for education and training
• Single regulator of UG, PGT and revalidation ( CPD)
• Globalisation / Internationalisation

While the 2013 conference was focused on the Shape of Training report on postgraduate medical education and training, we held wide ranging discussions both in the plenary sessions and in the break out groups. We were delighted to welcome Candace Imison, Director of Policy at the King’s Fund, who illustrated a wider look at the NHS workforce with her talk – NHS and Social Care Workforce – Meeting Our Needs Now and in the Future? Professor Tony Weetman is an honorary fellow of the Academy and the outgoing Chair of the Medical Schools Council – a role he fulfilled with distinction from 2009-2013. He examined some of the implications of the Shape of Training for undergraduate education in the UK. Professor Peter Rubin, also a distinguished HonAcademEd, is Chairman of the UK General Medical Council. He shone his light on some issues to consider for Tomorrow’s Doctors 2020 – the 2014 entrants to medical school will be qualifying in 2020. At the end of the day we heard some interesting reflections from a panel of current medical students and junior doctors on what they heard and what they felt. It was a stimulating meeting and you can read much of the content in this issue of Excellence in Medical Education.
3. The Shape of Training

David Greenaway, Vice-Chancellor, University of Nottingham

1. Introduction

The Shape of Training is a comprehensive review of postgraduate medical education and training in the United Kingdom. It was commissioned by a Sponsoring Board which comprised the Academy of Medical Royal Colleges, Conference of Postgraduate Medical Education Deanseries, General Medical Council, Health Education England, Medical Schools Council, NHS Scotland, Wales Deanery and NIMDTA.

I was asked to lead this review and bring forward recommendations for changes to ensure we continue to train effective doctors who are fit to practice in the UK, provide high quality and safe care, and meet the needs of patients and service now and in the future.

2. Shaping the Review

One might begin by asking why a review was necessary in the first place.

Healthcare delivery is a very dynamic arena, for a number of reasons, chiefly demography and technological change. The former, in particular our rapidly ageing population, means doctors are treating more and more patients with chronic illness and multiple co-morbidities; the latter, especially the information and communications technology revolution, is opening up new opportunities for intervention and patient management.

Against this backcloth I was asked to review workforce needs in general and the balance between specialists and generalists in particular; the breadth and scope of training; tensions between training needs and service delivery; flexibility of training; and all with an uncompromising focus on patient needs.

Two things were obvious at the outset: first, in addition to the executive support provided by GMC and HEI, I needed the benefit of an Expert Advisory Group. I actually secured a group of high quality and committed experts with relative ease; a group which turned out to be absolutely invaluable. Second, I needed to consult widely across all four countries of the UK.

Between autumn 2012 and spring 2013, I and my colleagues conducted a range of seminars and workshops focused on the core themes of the review, and made a number of site visits across the UK. Through both we met doctors in training, employers, trainers, other health care professionals and patients. The evidence gathered through this comprehensive programme informed our call for written evidence which resulted in almost 400 responses. In turn, the analysis of those responses helped us frame principles and draft approaches to training, which formed the basis for 59 oral evidence sessions across the four countries.

Analysis of the evidence gathered from our (almost yearlong) consultation and engagement with key stakeholders, blended with our desk based research and contextual analysis distilled a number of key messages:

- Given the growing number of people with multiple co-morbidities, an ageing population, health inequalities and increasing patient expectations, patients and the public need more doctors capable of providing general care in broad specialties across a range of different settings.
- We will continue to need doctors who are trained in more specialised areas to meet local patient and workforce needs.
- Postgraduate training needs to adapt to prepare medical graduates to deliver safe and effective general care in broad specialties.
- Medicine has to be a sustainable career with opportunities for doctors to change roles and specialties throughout their careers.
- Local workforce and patient needs should drive opportunities to train in new specialties or to credential in specific areas.
- Doctors in academic training pathways need a training structure that is flexible enough to allow them to move in and out of clinical training while meeting the competencies and standards of that training.
- Our key task was to take these principles and design a new training structure to deliver a more appropriate balance of generalists and specialists, in a more flexible framework, to secure the future of excellent patient care; and to do so in a way that would not disrupt training or service.

3. Re-shaping Training

The framework for change which we recommended is summarised in the schematic below, its essential features are:

- Full registration should happen at the point of graduation from medical school. Measures will need to be put in place to make sure graduates are fit to work as fully registered doctors. They will also be restricted to working in approved training environments.
- As now, following graduation, doctors will undertake the two-year Foundation Programme. Doctors must have opportunities to support and follow patients through their entire care pathway, both during medical school and in the Foundation Programme.
- After the Foundation Programme, doctors will enter broad based specialty training. Specialties or areas of practice will be grouped together, characterised by patient care themes (such as women’s health, child health and mental health) and defined by the dynamic and interconnected relationships between the specialties. They will have common clinical objectives, set out in the specialty curricula. (How these patient care themes will bridge the boundary between hospital and community care needs to be considered further).
- Across all specialty training, doctors will develop generic capabilities that reinforce professionalism in their medical practice.
- Broad based specialty training, after Foundation Programme, will last between four and six years depending on specialty requirements (and on how individuals progress through the curricula).
- During postgraduate training, doctors should be given opportunities to spend up to a year in a related specialty or undertaking education, leadership or management work (similar to specialty fellowships). This year, which can be taken at any time during training, will allow them to gain wider experiences that will help them become more rounded individuals. It will be included in the timeframe of four to six years.
- When doctors want to change specialties, either within or between specialty groups, they will be able to transfer relevant competencies acquired in one specialty to their new area of practice, without having to repeat the same learning in the new specialty. This will include learning during the optional year and generic capabilities. By recognising previous learning and experiences, retraining in new areas should be shorter.
- Nationally funded clinical academic training will be a flexible training pathway. Doctors on this pathway will be able to focus their academic training in their academic or research area, while also undertaking broad based training. Time spent in academic experiences will be counted within training, but these doctors may occasionally take longer to reach the exit point of postgraduate training, if for instance they spend further time undertaking doctoral research studies. In exceptional circumstances, doctors in clinical academic training may be able to restrict their clinical practice to a narrow specialty, special interest or subspecialty area.
- The new exit point of postgraduate training will be the Certificate of Specialty Training (CST). It marks the point at which doctors are able to practise in their identified scope of practice, with no clinical supervision, while working in multi-professional teams.
- Most doctors will work in the general area of their broad specialty, based on patient and workforce needs throughout their careers. They will be expected to maintain and develop their skills in their specialty area and generic capabilities through continuing professional development (CPD) and to meet the requirements of credentialing. Learning through experience and reflection on their practice and patient outcomes will help give them the depth of knowledge and skills necessary to master their specialty area. Doctors will also have options at any point in their careers to develop their education, management and leadership roles.
- Doctors may want to enhance their career by gaining additional expertise in special interest areas and subspecialty training through formal and quality assured training programmes, leading to a credential in that area (credentialing). These programmes will be driven by patient and workforce needs and may be commissioned by employers as well as current postgraduate training organisations. These areas need to be approved and quality assured by the regulator to ensure appropriate standards and portability.

In sum, this framework will deliver a workforce with three broad levels of competence. First, doctors capable of providing safe and effective care for patients in emergency and acute situations, with some support; these will be doctors who have completed the Foundation Programme, but not yet achieved the CST. Second, doctors who have completed the CST, can make safe and competent judgements in broad clinical areas, provide leadership and manage patients with several problems across specialty areas. Third, doctors who are able to make safe and competent judgements and would be expected to provide general care in their broad specialty area, but have additionally acquired more in-depth specialty training in a narrower field of practice.
4. What Next?
Implementing these changes will deliver the trained doctors we need to meet rapidly changing patient needs and without disrupting careers or service delivery. But how soon, and what is required to ensure delivery?

During our extensive consultation, I was struck by the widespread recognition of the need for change and willingness to think about different ways of achieving this. Now that the Shape of Training report has been published, it is essential we build quickly on this appetite for change. That requires decisive action in establishing a UK-wide Delivery Group, with representation from Sponsoring Board organisations, the four UK Departments of Health and other patient and professional groups. The job of this Group would be to work through the details of what is required for each of my report’s recommendations. A number of those recommendations can be taken forward immediately; some will take two to five years to implement.

Shape of Training Model

The full Shape of Training report and its appendices can be downloaded at: http://www.shapeoftraining.co.uk/

Details of the Expert Advisory Group can be accessed at: www.shapeoftraining.co.uk/static/documents/content/Annexes_and_Appendices_final.pdf

4. The Role of the Medical School in Assuring the Best Doctors for the Future

Professor Anthony Weetman

In 1956, George Pickering wrote ‘It has been remarked by an intelligent observer from across the seas that no country has done less to implement them’ 1. Although this largely continued to be true for the next four decades, more recently there has been a radical shift as medical schools have responded vigorously to the many calls for improvement in undergraduate medical education, starting with the seminal publication of Tomorrow’s Doctors in 1993 2.

In this paper I will briefly describe national developments in the following five areas: selection into medical schools, getting the right balance in the curriculum, professionalism and fitness to practise, assessments and transition to FY1.

There have been two recent drivers for medical schools to address how they select students. Firstly, medicine has been singled out for criticism in a progress report on the Fair Access to Professional Careers initiative 1, particularly relating to access to work experience for pupils from lower socio-economic groups. This report has attracted ministerial attention and Dr Dan Poulter, Minister for Health, has asked for action. Secondly, research commissioned by the GMC has identified some important challenges for schools around their use of best practice in selection 4.

In response, the Medical Schools Council (MSC) has established a Selecting for Excellence Working Group 5 which is engaging with a wide variety of stakeholders to address the following areas by the end of 2014:

Widening Participation. How can medical schools increase the number of students successfully applying to medical schools from lower socio-economic backgrounds?

The Role of the Doctor. What makes a good doctor and how can medical schools select pupils who display these attributes?

Selection Methods. Medical schools use a variety of different selection methods - can this approach be justified and is there scope for schools to work together on selection?

Evidence Base. Building a data set that can be used to evaluate selection methods

The 2009 edition of Tomorrow’s Doctors 6 has taken into account recent changes that have impacted on medical schools: patient and employer expectations, more students, intense patient throughputs, a move away from old-style teaching based around ‘firms’, the need to enhance community-based medicine, and the increasing chronic disease burden.

Although patient safety and acceptability are paramount, the move to a more dedicated patient-centred training experience through assistantships is critical to addressing issues which have highlighted by the Francis, Berwick and Keogh reports. This development has been complemented by the publication of extensive advice from the GMC and MSC on professionalism and fitness to practise in relation to undergraduate medicine 7. This guidance has ensured that students have a clear set of professional behaviours that will be expected of them and medical schools have direction which enables them to make consistent decisions on fitness to practise cases.

The pros and cons of a national qualifying exam have been long-standing debate. Arguments in favour of this are that it offers uniformity of assessment with national minimum standards, public reassurance and sharing of resources between schools. On the other hand, an externally-imposed national exam might lead to an over-emphasis on factual knowledge unless clinical skills are also examined, which in turn greatly increases costs. Other concerns focus on the inevitable creation of league tables of medical schools, a reduction in the diversity of educational approaches across the UK and the potential for confusion between an assessment designed to test competence and an assessment that could be used as selection tool. In response to these challenges, the MSC has established the Medical Schools Council Assessment Alliance as a comprehensive endeavour by UK medical schools to share best practice in assessment and evolve a common pool of both knowledge-based and clinical assessments across the UK. The first phase of this work has been to produce a single best answer question...
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bank and an initial unpublished pilot of 13 schools using questions from this bank has shown no overall difference in passing standards. In addition the MSC has led on the new Selection into the Foundation Programme process and introduced a national situational judgement test as a method which allows assessment of students based on a set of professional attributes identified through a detailed analysis of the job of a newly qualified doctor 5.

The transition between an undergraduate and postgraduate in medicine is acute and inevitably some feel unprepared for it, with variation between doctors depending on their undergraduate school 15. This period is increasingly recognised as a ‘critically intense learning period... (which) can only happen in actual practice, therefore doctors can never be fully prepared in advance of a transition’ 11. The inherent risks to patients are obvious and medical schools must do all they can to maximise preparedness. In 2008 the particular areas of performance by newly qualified doctors that have been identified as a cause for concern are (i) lack of confidence and competence in clinical decision making, (ii) clinical procedures and prescribing, (iii) lack of understanding how the NHS works and (iv) standards of professionalism 15. The student internship period is critical to addressing many of these issues. Another major step forward has been the recent introduction of a UK-wide period of shadowing prior to FY1 and a survey of new graduates post-induction last year found that only 9% felt unprepared for their first foundation post: this compares favourably to 31% feeling unprepared in earlier cohorts 15.11.

Practically speaking, the ability to prescribe is the fundamental difference between an undergraduate and a postgraduate. An investigation into prescribing errors by foundation trainees in relation to their medical education found that FY1 doctors were no better or worse in passing standards. In addition the MSC has led on the new Selection into the Foundation Programme process and introduced a national situational judgement test as a method which allows assessment of students based on a set of professional attributes identified through a detailed analysis of the job of a newly qualified doctor 5.

UK medical schools’ recent achievements in medical education have been summarised in a recent MSC publication, which also includes the work that they have done on delivering benefits to the local community, values-based selection and widening participation, global and population health and inspiring future clinical academics 9. Given what has been accomplished in the 20 years since Tomorrow’s Doctors first seriously tackled a fossilised undergraduate curriculum in the UK, I am confident that the next decade will see medical schools produce even better and safer new doctors.

References
5. Broadening the Foundation Programme – a Long Time Coming?

Professor Stuart Carney

Shortly after Shape of Training was published, Health Education England released Broadening the Foundation Programme [1; 2]. This grappled with many of the same issues as Shape: the growing burden of long-term conditions, parity of esteem, integrated care, and the balance between generalists and specialists.

Although the original intention in England was that at least 80% of foundation doctors should rotate through a primary care placement, most foundation schools have only managed 55% [3]. The intended funding to increase the proportion of foundation doctors rotating through a primary care placement was not released in 2007/8. Undeterred Professor John Collins reaffirmed the importance of medical graduates contributing to care across traditional care boundaries, in his report Foundation for Excellence, which was published in 2011 [4]. He recommended that:

“The completion of the Foundation Programme should normally require trainees to complete a rotation in a community placement, e.g. community paediatrics, general practice or psychiatry.”

Health Education England was tasked with taking forward all thirty-three recommendations in Foundation for Excellence and now has a roadmap for providing a community or integrated placement for all foundation doctors starting in August 2017.

Agreement to increase the proportion of foundation doctors rotating through a community placement was not a foregone conclusion. Additional funding to provide more foundation placements in general practice is unlikely to be available and many clinical services are dependent on foundation doctors to provide patient-care.

Health Education England makes three recommendations in the report, Broadening the Foundation Programme (Table 1). These cover supervision, breadth of placements and the timeline for moving more placements into the community.

Table 1

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<th>Recommendation</th>
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<td>Recommendation 1</td>
<td>Educational supervisors should be assigned to foundation doctors for at least one year, so they can provide supervision for the whole of Foundation Stage 1 (F1), Foundation Stage 2 (F2), or both years.</td>
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<td>Recommendation 2</td>
<td>Foundation doctors should not rotate through a placement in the same specialty or specialty grouping more than once, unless this is required to enable them to meet the outcomes set out in the Curriculum. Any placements repeated in F2 must include opportunities to learn outside the traditional hospital setting.</td>
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| Recommendation 3 | a) At least 80 per cent of foundation doctors should undertake a community placement or an integrated placement from August 2015. 
b) All foundation doctors should undertake a community placement or an integrated placement from August 2017. It should be noted that both community and integrated placements are based in a community setting, and that an acute-based community-facing placement is not a substitute. |

It may seem odd that a recommendation was needed about educational supervision. While most schools allocate foundation doctors to an educational supervisor for a year, some have linked the role to clinical supervision and switched every placement. The latter was more common when foundation doctors rotated regularly across different sites. The role of the educational supervisor is to primarily to support and monitor learning. The educational supervisor also provides an end of year report. Consequently, as is typical in specialty training, education supervisors will be assigned to all foundation doctors for at least a year.

Supervision was one of the reasons cited by Professor John Collins for redistributing foundation posts - ‘to share the supervision of trainees among a wider number of supervisors’”[4]. He also recommended broadening the experiences “to ensure closer matching with current and future workforce requirements.”

Since the inception of the Foundation Programme, placements have been predominantly in medicine and surgery especially F1 [3]. This is not surprising as the provisionally registered house officer year originally required completion of at least three months in medicine and surgery. But foundation doctors often play a critical role in service delivery. While there have been improvements, many of the tasks discharged by foundation doctors are repetitive and have little educational value. Strategies to redistribute these tasks and reduce the pressures on foundation doctors, including the appointment of Physicians Associates, will take a number of years to bear fruit. Meanwhile, the heavy demands on medical and surgical services may, in part explain the lower levels of reported foundation doctor satisfaction in comparison to other specialties [5]. It is hoped that by ensuring that foundation doctors rotate through a range of different specialties, this will improve supervision, help test career hypotheses and enhance their capabilities.

Broadening the Foundation Programme expanded the proposal of community a community placement for all to include integrated placements. While there is no universally accepted definition of an integrated placement, the report proposes that is:

“a four- to six-month placement with a named clinical supervisor, primarily based in a community setting, which crosses traditional care boundaries and supports the development of capabilities in the care of patients along a care pathway.”

Many clinical services are developing more integrated models of care, which transcend typical boundaries. Diabetics, care of the elderly and asthma are emerging areas for a more integrated approach to care. Mental health has a long tradition of providing care in a range of different settings in partnership with general practice. By not confining the recommendation to community placements, the report should not stifle innovation. It should allow local education providers and foundation schools to develop new types of foundation placement.

The challenge of realising these ambitions should not be underestimated. The report comes at a time of virtually “flat-cash” funding and increasing patient demand. However, almost ten years after the original ambition, we need to broaden the foundation experience and ensure that our foundation doctors are pluripotential and better able to respond to changing patient needs.

References
6. Broad Based Training – Lessons learned relevant to implementing the Shape of Training Report

Professor Jacky Hayden

Background to Broad Based Training

Broad based training is a core training programme, approved by the General Medical Council (GMC), that can contribute to specialist training and certificate of completion of training in any of the four parent specialties, namely, medicine, general practice, paediatrics and psychiatry. Broad based training consists of experience in each of the four specialties over a two year period; a trainee who completes broad based training successfully can progress to run through training, entering at level 2, in general practice or paediatrics or can complete core training in psychiatry or medicine, again entering at level 2.

Broad based training was introduced to enable doctors who wanted a broad base to their early specialty training so that they were better equipped to deliver care to patients either as a general practitioner with a greater depth of specialist knowledge or as a consultant in a specialty which has been traditionally taught in hospital, such as surgery (which future is likely to be more community based) with a greater understanding of human behaviour and development and experience of delivering care in a community setting. Some of the applicants were already aware that the four separate specialties were not the best fit for their career choice and the programme gave them the opportunity to experience a broader range of opportunities.

The first cohort of forty-three trainees commenced the broad based curriculum in August 2013; a second cohort has been recruited to commence in August 2014. Evaluation is therefore on going and it is difficult to predict the overall impact of a broader beginning to specialty training on this small cohort of doctors at this early stage. The pilot programme was approved by the GMC for two cohorts with an agreement to a rigorous evaluation.

The first cohort has already completed preliminary feedback, through an initial questionnaire, a meeting of trainees and interviews with the programme and as part of the formal evaluation, which is being conducted by Cardiff University.

There are themes associated with arranging the programme and ensuring the overall aims that have implications for the implementation of the Shape of Training.

The Challenges faced in the first nine months

The four parent medical royal colleges, working together as a single group, developed the curriculum. However, innovation was limited by the need to ensure that each trainee would be able to enter any one of the parent specialties. This had the potential to compromise the fluidity and complexity of delivering a training programme that was intended to develop a more holistic approach to patient care. For example each of the parent specialties needed to be confident that selection to the programme and the assessment framework was comparable with that of the trainees progressing through conventional training and that the trainees moving from broad based training to each of the four specialties would be able to work as a second year core trainee. The only other programme that is accredited for entry to any of four specialty programmes is Acute Care on Demand training. However the difference in this programme is that most trainees elect their parent specialty at recruitment.

In order to achieve a continuous programme, as opposed to four separate specialties, the trainees work for 90% of their time in one specialty and 10% in another specialty. At the end of two years the experience will comprise 100% in each of the four specialties. This has brought its own difficulties, some parts of the country have amalgamated the 10% into a two-week block, others have recognised the time as a day in two weeks and others have identified half a day a week. Whichever is chosen creates logistical difficulties of accommodating rotas and maximising educational activity.

When the programme was launched, it was agreed that there should be specific teaching for the broad based curriculum.

At the first meeting of the trainees and trainers a tension had already been identified as to whether the trainees should be attending broad based teaching, specialty teaching or both.

The Implications for future medical workforce

The Shape of Training Report was commissioned to identify some of the issues the medical profession faces in developing doctors who are able to provide medical care in an NHS which has developed to meet patient needs. The report and the leadership within the NHS has identified the need for doctors who are sufficiently broad in their thinking that they are able to manage illness in patients within a physical, psychological and social framework, providing care for patients with complex comorbidities, to gain a greater understanding of the management of patients with long-term conditions and the acute care of patients who have existing long-term illness. Mulley et al have described what they term ‘the silent misdiagnosis’ in which patients’ preferences for the management of their conditions is disregarded in the interests of accurate diagnosis and ‘text book’ management. However, if we are to achieve the aspirations of the Shape of Training, the medical profession will need to work across the current medical royal college structures so that we are able to agree a more general curriculum that crosses the traditional boundaries of specialties within medicine. We have achieved this previously when the foundation curriculum was developed. In addition, recruitment and selection processes need to be established which are specific to the broad theme, rather than trying to accommodate the individual components of the individual college selection processes.

Developing a more generic approach to training will be facilitated if some of the structural aspects are considered. For example selection to each of the proposed broad themes is likely to cross traditional boundaries and will require sharing of expertise and experience, with selectors seeking assurance that candidates have the ability to cope with uncertainty and be comfortable in a complex environment. The medical profession is comfortable with using electronic portfolios to demonstrate progression. However, other than the foundation portfolio, the electronic documents have been developed as college specific instruments. The variation of the four e-portfolios in the broad based specialties was sufficient to warrant a bespoke e-portfolio that can carry the collection of information into any of the four parent specialties.

As we implement the Shape of Training, the existing e-portfolios are unlikely to need adaptation or re-composition so that they shift emphasis to demonstration of a broader range of skills. Greater emphasis may need to be placed on demonstrating the medical leadership competences.

The nature of the workplace experience and assessment will also need review. Experience with the broad based curriculum has shown that the development of a generalist is much more than the combination of the individual specialties. Each of the proposed broad themes will need a defined skills set which in turn will require a broader range of experiences, with most focusing more on ambulatory patients whose illness is managed mainly in the community. This will create a tension unless the provision of care by a trained workforce 24/7 is addressed. Perhaps more importantly the future generalist will need a modified approach to learning how to manage risk and cope with uncertainty. Broad based training has provided the opportunity for young specialist trainees to work across the four different but related specialties. Most importantly trainees value the time to discuss in a peer group what they have experienced and observed.

Implementing broad based training has crystallised some of the tensions between service and training and amplified some of the cultural differences between the four specialties. There has always been a tension between delivering service with current trainees and ensuring that they have the opportunity to learn how best to deliver service in future years. The need for parity with conventional trainees, for example in out of hours experience, has exaggerated the tension, and resulted in a shift of emphasis in the programme from learning about care of patients with chronic co-morbidities to working on the acute pathway. The learning for Shape of Training may lie in the use of the proposed time out of training, which might be used for sabbaticals and professional development but could mean that every doctor will contribute to providing care in the acute pathway during their training years. Delivering a more community based medical workforce will be facilitated if clinical commissioning groups (CCGs) and provider trusts are able to work together towards a common culture of safe patient-focused care.

One of the planks of Modernising Medical Careers was the development of explicit, accredited college courses that would enable doctors to develop their expertise outside of the current medical royal college structures so that we are able to agree a more general curriculum that crosses the traditional boundaries of specialties. There has always been a tension between delivering service with current trainees and ensuring that they have the opportunity to learn how best to deliver service in future years. The need for parity with conventional trainees, for example in out of hours experience, has exaggerated the tension, and resulted in a shift of emphasis in the programme from learning about care of patients with chronic co-morbidities to working on the acute pathway. The learning for Shape of Training may lie in the use of the proposed time out of training, which might be used for sabbaticals and professional development but could mean that every doctor will contribute to providing care in the acute pathway during their training years. Delivering a more community based medical workforce will be facilitated if clinical commissioning groups (CCGs) and provider trusts are able to work together towards a common culture of safe patient-focused care.
programme has encouraged the four specialty leads to reflect on the competence and culture of the training community and has challenged some of the more traditional approaches to delivering training. Implementing the Shape of Training will be more effective if our faculty of consultant and GP educators challenge some of the approaches to learning and develop a more facilitative, learner centred style. This should result in the graduates of our programmes being more patient centred.

Conclusion

Introducing the broad based training programme in advance of the Shape of Training Review has given a unique opportunity to consider some of the barriers and opportunities we are likely to encounter as we introduce a more themed approach to specialty training. The most challenging of all has been to work across the four colleges in a way which ensures their commitment and adherence to what we are delivering.

Acknowledgement

I am grateful to Tracey Lakinson and Jo Brown for their energy and enthusiasm in establishing the programme.

References


7. Medical Educators: The Other ‘Lost Tribe’ is Coming Home

Julie Browne Honorary CEO AoME

Medical educators: the other ‘lost tribe’ is coming home

In the eight years of its short existence the Academy of Medical Educators has already survived through two Governments, the London Olympics, the Queen’s Diamond Jubilee, droughts, storms, floods and a global banking crisis, and even though it is not yet into double figures, it can at least claim the honour of being older than both Twitter and Prince George.

Since 2006, the Academy has racked up five different office moves, three Presidents, six annual conferences, five Calman Lectures, well over a hundred workshops, seminars and educational meetings – but we haven’t actually been counting – five issues of its journal Excellence in Medical Education, and over 1,000 applicants for Membership and Fellowship through its Recognition Scheme. Despite all these internal changes it has never swerved from its fundamental vision, which is to work for the improvement of patient care through fostering and promoting excellence in medical education.

Like all young and aspiring organisations the Academy has set itself some very ambitious targets, and in so doing it has achieved a great deal. As a consequence of the rapid pace of change and development, it has also had its ups and downs, particularly in terms of its finances and infrastructure: but we believe it has got over what Jane Austen calls the ‘most trying age’. The Academy is in good shape to face the challenges of the future.

It will need to be.

In the last two decades there have been a number of seismic upheavals in the way that medical education is organised, regulated and structured both at postgraduate and undergraduate level in the UK, and most importantly, in the way that it is perceived and understood. The pace of change looks set to continue and the Academy’s members will inevitably be on the front line, so let us consider what has been going on and where we are going next.

Medical education is in a period of upheaval that arguably began in, or about, 1993, the year that the first edition of Tomorrow’s Doctors was published and the year the Calman Report on postgraduate training emerged. In the final decades of the 20th century, a number of key figures drew attention to the poor state of postgraduate training in the UK. Notably Calman1 and Donaldson2 called for the introduction of more structure into specialty training designed to sweep away the old ‘lost tribes’ of Pre-registration House Officers and Senior House Officer, of whom it was said: “Nobody knows what they do in hospitals or has a clear idea what skills they should be learning. Nobody is responsible for them and they suffer from having a poor career structure and inadequate training”.

Organisational responses to the problems caused by poor career structures and haphazard approaches to training began to appear across all organisations involved in postgraduate medical education: the General Medical Council (GMC), the Royal Colleges, the National Health Service (NHS) through the Department of Health, the Deaneries and a wide array of other stakeholders all responded to the need for reform with a number of initiatives that explicitly aimed to improve the conditions for doctors in training. There was a new emphasis on curricula and standards, underpinned by quality assurance frameworks to ensure that all parties understood what was expected. Some of these structural changes have had an enormous impact: the Foundation Programme was introduced in 2005 and the Modernising Medical Careers specialty training programme came into existence in 2007, clearing the way for smoother and swifter progress towards completion of training (CCT), offering a broader range of experience and training to assist in career selection and progress, and making explicit expectations of what junior doctors need to learn and be assessed upon in order to pass through the various stages in their training. The merger of the Postgraduate Medical Education and Training Board and the GMC in 2010 to create a single regulator, the introduction of the GMC’s Quality Assurance of Basic Medical Education (QABME) process in 2010, the continued restructuring of local health authorities and trusts, changes to national employment contracts and the way the NHS itself is structured and funded have caused ripples – and occasionally tidal waves - throughout medical education at all levels.

If medical trainees were getting a raw deal out of the UK’s medical education system during the last two decades of the 20th century, however, so were their supervisors and trainers. It was not explicit to anyone, let alone to the teachers themselves, what students were expected to learn, or how, or when, or to what standard. Organisational, structural
advertisements and role specifications; they are proving a valuable tool for appraisals and revalidation; courses for medical educators are increasingly being mapped against them; and for the first time, all medical educators have an authoritative and rigorously designed resource to help them plan their continuing professional development, a framework against which they can report and reflect on their progress, and a formal scheme within which they can submit their portfolio for recognition and feedback from their peers in medical education.

All of these projects have been accompanied by the steady, day-to-day work that the Academy does through its volunteer members: accrediting courses; recognising and celebrating excellent medical educators through its affiliate programmes and annual prizes; supporting organisations to develop their teaching faculty; creating and enhancing links and partnerships both in the UK and internationally; promoting and developing research and evidence in medical education; mentoring, advising and encouraging its members; arranging conferences, workshops and networking opportunities; developing educational resources and a quarterly journal, and all the other things that a small-to-medium size membership organisation would be expected to do on a very restricted budget.

But in terms of influence, the Academy punches well above its weight, and we will continue our drive to embed the Professional Standards further into medical, dental and veterinary training – and more importantly, to assert the role of the clinical teacher, with damaging effects to patient care, are actually starting to be recognised and appreciated in organisational terms.

One of the most important tools for recognising and appreciating the role of the medical educator is a set of clear standards for medical educators, agreed by the profession itself and also by regulators, patients and the public. The Academy is proud of its work in developing its Professional Standards for Medical Educators, a document that was 18 months in the making but which has gained considerable currency and influence in the six years since its publication and is now adopted nationally and internationally as a definitive statement of what medical educators at all levels, clinical and non-clinical, should know, believe and do. Moreover, thanks to the behind-the-scenes work the Academy has done among the UK regulators, we have the beginnings of a national recognition and approval scheme for educational and clinical supervisors in secondary care and for those who supervise the progress of medical students in clinical settings and on placements.

These initiatives have had knock-on effects: the Academy’s Professional Standards are finding their way into job

References
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