

AUKUH response to the consultation on the Tooke Inquiry

AUKUH welcomes the Tooke Report and commends the Panel on its high quality – particularly given the short timescale within which it was produced. AUKUH members' responses to the recommendations follow. However, a group of seven Chief Executives from across England convened to provide additional comments from the perspective of university hospitals.

1. Students

Governance issues make the return of student locums unlikely. However closer working with Medical Schools so that F1 doctors arrive with accredited 'competency passports' could speed induction and allow more rapid acquisition of responsibility.

2. Foundation Year One

Trainees need incentives to strive for excellence. If the computer adaptive ranking exam is to take place at Medical School, additional OSCEs and/or structured interviews should be considered to aid selection into core training.

3. Core

The development of additional Masters programmes during core training was supported, however funding streams must be identified and made available. It should be noted that some Masters programmes are already available, for example the Masters in Child Health at UCL.

4. Trust Registrars

AUKUH members saw little use for such a cadre of staff in tertiary centres. It was felt that in DGHS there was more of a need for this role and that individuals in this post would be characterised by excellent diagnostic skills and the widest possible range of generic skills. AUKUH members in contrast were looking to provide consultant delivered care 24/7 in A&E, O&G, ICU, Anaesthetics and Paediatrics with CCT holders available 9-5, five days a week in all other specialties. In addition members found the suggested name unhelpful and put forward Hospitalists or In-Hospital GPs as alternatives.

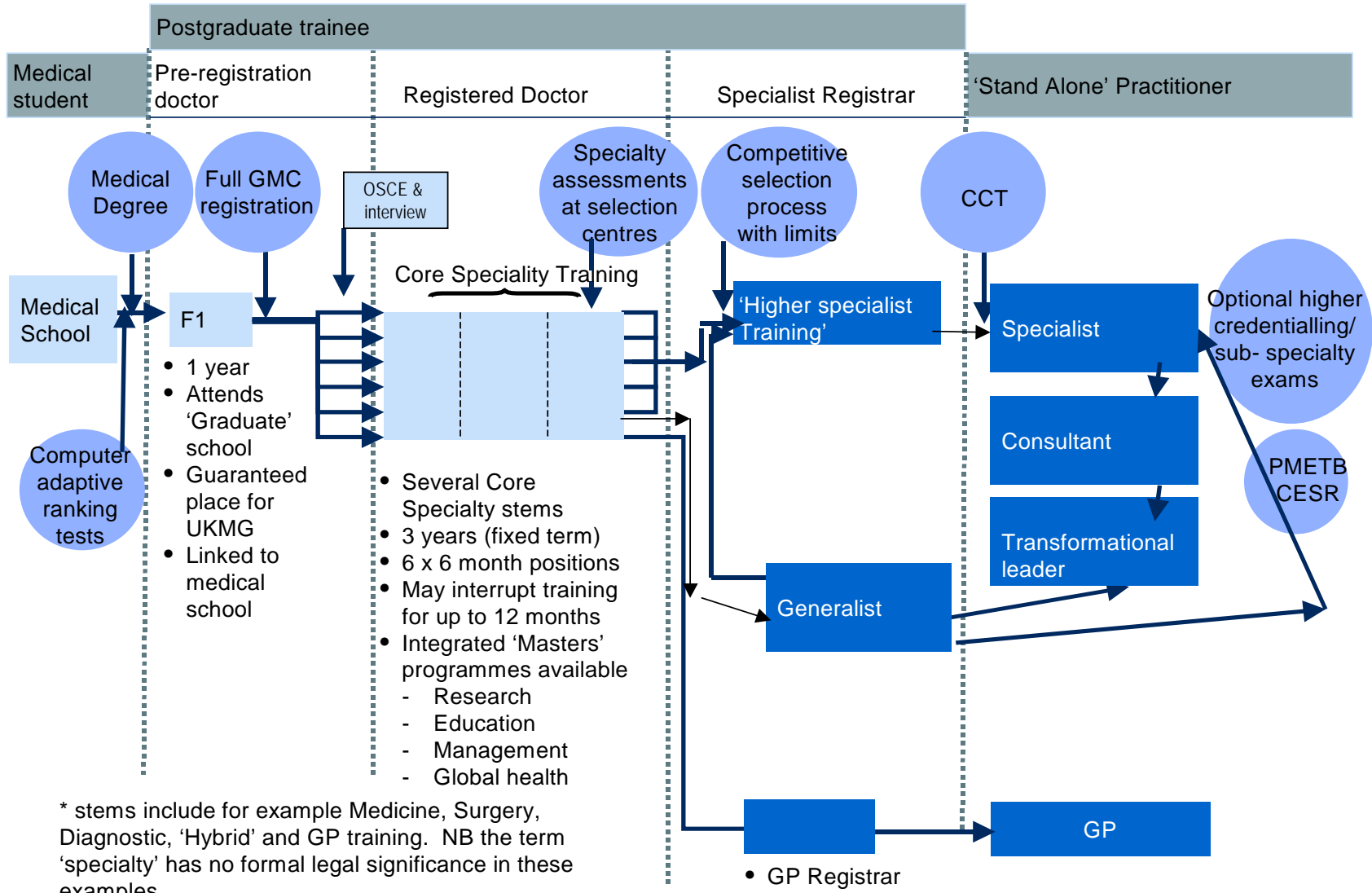
5. Specialist Care

There is a dissonance between the aspirations of trainees and the profession for ever greater sub-specialisation – and the needs of service. In many areas service would prefer skilled generalists yet financial rewards push staff towards sub-specialisation.

The flow chart of the proposed career pathway in the Report again reinforced the expectation that the greatest kudos would come from promotion to the consultant role. It is therefore suggested that the right hand side of the diagram be modified, as in the figure below, to give equal status to specialists, consultants, GP Principals and Transformational Leadership roles – with the possibility of moving into the latter from all routes – both specialist and generalist.

Patient care can only benefit from greater clinical involvement in management and this must be nurtured and encouraged.

Postgraduate training – AUKUH recommendations



The Role of the Doctor

Recommendation 5

There needs to be a common shared understanding of the roles of the doctor in the contemporary healthcare team. Such clarity must extend to the service contribution of the doctor in training, the certificated specialist, the GP and the consultant. Such issues need to be urgently considered by key stakeholders and public consensus reached before the end of 2008. Education and training need to support the development of the redefined roles.

Agree. AUKUH strongly agrees that it would be helpful to have a tightly focused review of the role the doctor plays within the healthcare team. This is of particular relevance in the context of the European Working Time Directive (EWTD) and the development of advanced roles in other areas of the workforce. It is important that the review leads to clear and workable outcomes and that once defined, the role of the doctor is articulated consistently throughout undergraduate and postgraduate training.

Recommendation 9

At a local level Trusts, Universities and the SHA should forge functional links to optimise the health:education sector partnership. As key budget holders SHA Chief Executives should have the creation of collaborative links between local Health and Education providers as one of their key annual appraisal targets.

Strong working relationships between the health and education sectors are critical to ensuring that recruitment processes work effectively and that service is able to influence decision-making. However AUKUH feels that this recommendation must be linked to clear, measurable outcomes if it is to make a difference.

Workforce Planning

Recommendation 12

DH Workforce should urgently review its medical workforce advisory machinery to ensure that it receives integrated and independent advice on medical workforce issues to inform/complement SHA and local deliberations. Both national and devolved workstreams must be adequately resourced. The medical workforce advisory machinery should also take account of national policies impacting on the workforce such as the shift of more care to the community.

Regional workforce plans should be subject to a national oversight and scrutiny advisory committee with service, professional and employer representation. Such oversight should encourage local responsiveness and acknowledge issues facing the devolved administrations whilst ensuring national consistency on roles and standards.

Agree. It is important that service is involved in workforce planning and that there is an interaction between local and national scales.

Recommendation 14

The content of higher specialty training and the numbers of positions will be informed by dialogue between the Colleges, employers, and medical workforce advisory machinery to allow finer tuning of the nature of the specialist workforce to reflect rapidly evolving technical advances and the locus of care.

Agree.

Recommendation 15

Explicit policies should be urgently developed and implemented to manage the transitional 'bulge', caused by the integration of eligible doctors into the new scheme, with appropriate credit for prior competency assessed experience.

Agree.

Recommendation 16

DH should recognise the burgeoning supply of medical graduates it has commissioned and make explicit its plans for the optimal use of their skills for the benefit of patients. It is recommended that sufficient numbers of Core Specialty training posts (see Recommendation 33) should be made available to accommodate doctors successfully completing FY1 and the use of commissioning funds for this purpose should be monitored.

Agree. It is important that there are an adequate number of posts available, however trainees must aspire to excellence rather than competency and must be both employable and competitive.

Medical professional engagement

Recommendation 19

There should be enhanced opportunities for training in medical management during postgraduate training years to fuel an increase in clinically qualified managers and an awareness of the interdependency of clinicians and managers in the pursuit of optimal healthcare.

Agree. At present it is difficult for doctors in management to have credibility with their clinical colleagues without high-level clinical experience. It is important that management is seen as a viable career path for doctors. Nevertheless, time given to training in medical management must be carefully balanced with the need for clinical training and service provision.

Recommendation 20

Doctors in training should be better represented in the management structures of Trusts to ensure that they better understand service pressures and priorities and Trusts better appreciate their service role and training needs.

Agree. See comments to recommendation 19.

The commissioning and management of postgraduate medical education and training

Recommendation 21

A suitably qualified Director level lead for medical education within DH should be identified and act as the reference point for interactions with the medical profession including postgraduate Deans. The relationship and accountability of this lead to the following should be explicit: CMO, DH Head of Workforce, NHS Medical Director, and medical educational leads within devolved administrations.

Agree in principle. Medical education and accountability at government level is important but greater clarity about the exact remit and responsibilities of this role is required.

Recommendation 22

Recognising i) the importance of linking workforce supply and demand, ii) the very recent devolution of workforce commissioning function to SHAs in England, we recommend that this situation prevails for the moment for initial Postgraduate Medical Training subject to the forging of closer links at all levels with the Higher Education sector. A formal review of the compliance with Service Level Agreements between DH and the SHAs relating to commissioning training and the functionality of the arrangements should be undertaken in 2008/9. Any deficiencies should prompt urgent consideration of a National Institute for Health Education (as outlined in Recommendation 12) assuming the commissioning function.

AUKUH supports consideration of a National Institute for Health Education. This consideration must take into account fund flow management.

Recommendation 23

Funding flows for postgraduate medical education and training should accurately reflect training requirements and the contributions of service and academia. The current MPET Review should lead to a clearer contractual basis that recognises the service contribution of trainees and the resources required for training.

Agree.

Recommendation 27

To incentivise Trusts to give education and training sufficient priority the Healthcare Commission's Core Standards should be reviewed to encompass education and research.

Education is already contained within the Healthcare Commission's Core Standards. There are difficulties in measuring research given the range of organisation types within the NHS and the differential levels of engagement with research.

Recommendation 28

Responsibility for the local delivery of postgraduate medical education and training should form part of the explicit remit of Medical Directors of Trusts. Part of that responsibility should include regular reporting to Trust Boards on the issue.

AUKUH supports the development of opportunities for postgraduate medical education and training to be raised at a senior level, however members feel that this is not necessarily a matter for Trust Boards.

Recommendation 29

Training implications relating to revisions in postgraduate medical education and training need to be reflected in appropriate staff development as well as job plans and related resources. Compliance with these requirements should form part of the Core Standards.

AUKUH does not support this proposal and believes that these areas are already covered within the Healthcare Commission's core standards.

Streamline regulation

Recommendation 30

PMETB should be assimilated in a regulatory structure within GMC that oversees the continuum of undergraduate and postgraduate medical education and training, continuing professional development, quality assurance and enhancement. The greater resources of the GMC would ensure that the improvements that are needed in postgraduate medical education will be achieved more swiftly and efficiently.

AUKUH supports the principle of greater clarity and streamlining of regulation of undergraduate and postgraduate medical education. However we do have concerns over the accountability arrangements, particularly the issue of employer engagement, and for this reason we do not agree that the GMC is the right body to oversee postgraduate medical education and training. Any change must take into account the needs of service.

The structure of postgraduate medical training

Recommendation 31

Under the Medical Act, Universities already have responsibility with regard to FY1. By breaking the linkage with FY2, it will be possible to guarantee an FY1 position in the new graduate's local Foundation School subject to prevailing local selection processes. The linkage between FY1 and FY2 should cease for 2009 graduates.

In general we support this recommendation although some members are concerned that there has not been enough time to demonstrate the effectiveness of the foundation programme. Flexibility in training is important and core specialty training must be generic to allow trainees to move between 'branches' if necessary.

Recommendation 32

FY1 should be reviewed to ensure that i) harmonisation with year 5 is optimised; ii) the curriculum more clearly embraces the principles of chronic disease management as well as acute care; iii) competency assessments are standardised and robust. In future, doctors in this role should be called Pre-Registration Doctors.

Agree.

Recommendation 33

Foundation Year 2 should be abolished as it stands but incorporated as the first year of Core Specialty Training. The current commitment to FY2 GP placements should continue as part of Core Specialty Training and developed further as resources permit. Doctors in Core Specialty Training should be called Registered Doctors.

Agree.

Recommendation 34

At the end of FY1 doctors will be selected into one of a small number of broad based specialty stems: e.g. medical disciplines, surgical disciplines, family medicine, etc. During transition, 'run-through' training could be made available after the first year of Core, for certain specialties and/or geographies that are less popular than others. Core Specialty Training will typically take three years and will evolve with time to encompass six six-month positions. Care will be taken during transition to ensure the curricula already agreed with PMETB are delivered and the appropriate knowledge, skills, attitudes and behaviours are acquired in an appropriately supervised environment.

It is essential that service be included in the development of core curricula. Bodies developing the curricula should have greater accountability to service needs.

AUKUH agrees that placements should be six months. The current four-month rotations are too short and longer placements will improve training and quality.

Recommendation 35

For those doctors who do not know to which Core Specialty to commit at the end of FY1 there will be the capacity to take up to 2 years in hybrid rotations allowing experience in four main Core areas. Experience in the subsequently selected Core area will count towards the completion of Core Specialty training subject to successful competency assessment.

In principle AUKUH supports the flexibility that this recommendation would allow for, however the practicalities of implementing this scheme may be difficult.

Recommendation 36

Colleges should work together with the Regulator and service to devise modularised curricula for Specialist Training to aid flexibility/transferability. They should also devise common short-listing and selection processes that have been standardised across the country to allow sharing of assessments between Deaneries. This work should be completed within two years.

It is important that service is also involved in this work. Curricula need to reflect the needs of employers and selection process must be acceptable to those who will offer contracts of employment to doctors in training.

Recommendation 37

Satisfactory completion of assessments of knowledge, skills, attitudes and behaviours will allow eligibility for

i) selection into Trust Registrar positions in the relevant area or

ii) selection into Higher Specialist Training.

Doctors in Higher Specialist Training will be known as Specialist Registrars, those selected into General Practice specialty training will be known as GP Registrars (equivalent to ST3 and beyond).

Agree. The title 'Trust Registrar' may need to be revised to avoid confusion.

The 'end products' of the training pathway, illustrated in the diagram within the report, should be refined to include a more flexible range of options and prevent a two-tier Trust Registrar/Higher Specialist Training system. There should be an illustration that medical graduates have a range of opportunities within the health service and could, for example, reach a high level in research, clinical leadership or clinical practice. Different pathways should be available to reach these outcomes.

Recommendation 38

The newly named Trust Registrar position (formerly termed Staff Grade) must be destigmatised and contract negotiations rapidly concluded. The advantages of the grade (accrual of experience in chosen area of practice, consistent team environment) need to be made clear. Trust Registrars should have access to training and CPD opportunities. They should be eligible for a reasonable limited number of applications to Higher Specialist Training positions according to the normal mechanisms and also to acquisition of CCT through the Article 14 route.

Agree. It is important to establish these posts as valued and an acceptable choice rather than a position of last resort.

Recommendation 43

Successful completion of Higher Specialty Training as confirmed by assessments of knowledge, skills and behaviours will lead to a CCT. Higher specialist exams, where appropriate, administered by the Royal Colleges, may be used to test experience and broader knowledge of the specialty and allow for credentialing of subspecialty expertise gained post CCT and aid selection to consultant positions.

Agree.

Recommendation 45

The length of training in General Practice should be extended to five years, bringing it in line with specialty training and the other developed European countries.

Agree.