Educating for the Workforce of the Future – The Dept of Health View

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Is the view from Whitehall different?
Others view of the DH?

Conspiracy or chaos theories:

• Cost cutting
• Disempowering doctors
• A “sub-consultant” grade
• Devaluing training
• Incompetence
Another view

- Financial climate
- Best use of public money
- Fair distribution
- Multiprofessional workforce
- Service and patients needs first
What does the future look like?

Demand

• Changes in science, demographics, morbidity and patient expectations

Supply

• Changes in composition of workforce, lifestyle expectations, shape and duration of training
Elderly population

- Healthy enough to be at home
- Increasing survival with co-morbidities
- Don’t like hospitals
- Don’t like to travel
- Want continuity of doctor
Patients expect:

- To be seen sooner
- Latest treatment
- To be seen by a consultant or fully trained doctor
- IT literacy
Patients will have:

IT literacy – personal iPhone profile/diagnosis

DNA profile?
End of life decisions and cultural change

Societal and individual attitude to quality of life and personal beliefs

- euthanasia
- termination
- consanguineous marriage
- disability
Public Health

LIFESTYLE ISSUES

Alcohol

Obesity
Global Health

- Pandemic flu
- Climate change
- Recession
- Conflict
Supply

- Feminised medical workforce
- More ethnic mix
- More social class mix
- Different working patterns—family friendly, LTFT
- Geography most important in influencing career
Supply

- Better trained, less experienced
- Less likely to do research
- Inter-professional skill sharing
- Reduced budgets
Repeat

Reduced budgets (MPET)
So?

Need more generalists:

- Reduce multiple referrals
- Diagnose and manage co-morbidities
- Manage care closer to home
- Reduce acute referrals
- Reduce length of stay
- Cost efficient?
Is that more GPs?

Yes but also:
• Need general physicians
• Need general surgeons
• If DGHs are to survive
Do we still need specialists?

Yes but:

- Must work in MDTs
- Must be able to work in “integrated care” out of hospitals
- Currently over-producing
  - Trainees in excess of specialty needs
  - Doctors whose skills are not wanted
What does this mean for training?

• 50% of future trainees will be GPs
• Informed career choice early
• Balanced undergraduate training
• Value generalism in training
• Promote academe
Where did MMC leave us?

- National recruitment
- Shorter duration of training
- 2 year foundation
- Run-through – but some specialties subsequently decoupled
- FTSTAs
- Other routes to specialist registration
Foundation Programme

2 years
(FY1, FY2)

2 year Core training for Uncoupled Specialities (CT1, CT2)

4 or 5 year Speciality Training (ST2 – ST6/8)

CCT for entry to the Specialist Register

Consultant (total time in Training: 8-10 years)

6 or 7 year run-through Speciality Training (ST1 – ST6/8)

2 year General Practice Vocational Scheme (ST1, ST2)

1 year training As GP registrar

CCT for entry To the GP register

GP (total time in Training: 5 years)
What did PMETB do for us?

• Defined curricula
• Defined assessment
• Quality assurance frameworks
• Fewer (but more consistent?) visits
• Article 14/CESR approval
• Trainee and trainer surveys
So what needs fixing?

- Recruitment and selection
- Routes for the undecided
- Flexibility for the change of heart
- Evaluation of the F1 and F2 years
- Time for acquisition of skills
The Tooke Report

FINAL REPORT OF THE INDEPENDENT INQUIRY INTO MODERNISING MEDICAL CAREERS

PROFESSOR SIR JOHN TOOKE

ASPIRING TO EXCELLENCE
A High Quality Workforce

ourNHS our future
Selection

Credentialing

New specialities

Foundation Programme

2 years

Selection

Overall review

Shadowing

Workforce planning

2 year Core training for Uncoupled Specialities (CT1, CT2)

4 or 5 year Speciality Training (ST2 0 ST6/8)

CCT for entry to the Specialist Register

Consultant (total time in Training: 8-10 years)

Accreditation of supervisors

6 or 7 year run-through Speciality Training (ST1 – ST6/8)

Leadership

Workforce planning

2 year General Practice Vocational Scheme (ST1, ST2)

1 year training As GP registrar

CCT for entry To the GP register

GP (total time in Training: 5 years)

Extension of training

Credentialing

48 hour Quality Accreditation of supervisors

Use of simulation

Commissioning quality

Workforce planning

Broad based entry

48 hour Quality Accreditation of supervisors

Use of simulation

Commissioning quality
Selection into Foundation

- Will be challenged in future by UK, EU and non-EU applicants
- Current white space section and med school quartiles unsatisfactory
- Develop robust, fair structure and process
Recruitment

• Mainly national – central or by speciality – College and/or Deanery
• Working with Colleges and BMA/JDC
• Computer failures have occurred:
  – Temporary
  – Notified
  – Fixed
Selection into specialist training

- Evaluation of pilots of selection processes
- Computer assessed testing
Credentialing

• A mark of output rather than input
• Recognition for SASGs
• Areas of expertise e.g. forensic medicine

PMETB
General Medical Council

DH Department of Health
English Deans

- Speciality training numbers
- Recruitment and selection
- International training
Academy of Medical Educators

Accreditation of educational supervisors
Education Commissioning for Quality

- Proposal to add specific metrics for commissioning
- Commissioners can reward good teaching providers or address poor ones
- Medical Programme Board TFG
...and then came EWTD
Time's Up
1 August 2004
A guide on the EWTD for junior doctors
Working time Regulation

• Is law from Aug 2009
• Is health and safety regulation
• A derogation to 56 hours until 2011 has been granted to a small proportion of rotas
• DH and AoMRC and Medical Programme Board working together
Quality of Training in 48hr WTD

• Task and Finish Group of Medical Programme Board:

  Quality of Training in
  Reduced Working Time Environment
Review of Quality of Training in 48hr WTD

Request to MEE from Secretary of State

• MEE Review
  – Independent chair – Sir John Temple
  – Expert group
  – written and oral evidence

• PMETB Panel
Evaluation of Foundation

• Prof John Collins
• Surgeon from New Zealand
• Currently in Oxford

• Expert panel
• Taking evidence
• Report May/June next year
Meeting of the Workforce Planning Team
• Arms Length Body

• Tenders taken

• Successful group will be announced imminently
Women and medicine
THE FUTURE

A report prepared on behalf of the Royal College of Physicians

June 2009

Royal College of Physicians
Women doctors: making a difference

Report of the Chair of the
National Working Group on Women in Medicine

Presented to Sir Liam Donaldson,
Chief Medical Officer

October 2009
Fig 3.1 Intake to UK medical schools by gender, 1960–2007
Source: NHS WRT, UGC returns and UCAS acceptances (2006* and 2007*).
MEE membership

- Academy of Medical Royal Colleges
- BMA and Junior Doctors’ Committee
- GMC/PMETB
- NHS Employers/NHS Confederation
- SHA workforce/SHA CEOs
- Patients
- Medical Schools Council
MEE membership

- Chair of English Deans
- Academy of Medical Sciences
- HCS/Dentist/Pharmacists
- British Dental Association
- One non-medical Dean
- Federation for Healthcare Science
- Royal Pharmaceutical Society
- DME
• Coherent professional voice on education and training
• Coordination of changes to postgraduate training pathway
• Integration of service and professional perspectives
A national strategy for simulation in training

- Undergraduate and PG
- Multidisciplinary
- Building on good practice
- Includes CMO’s recommendations
- Recognising current financial climate
CMO’s Report: Key Recommendations

Simulation based training should:
• be fully integrated within clinical training
• be valued and adequately resourced by the NHS
• have expert clinical facilitators to deliver high quality training

And:
• A national centre for simulation techniques should be established
Scope and Purpose

Availability and use of simulation facilities accessible to NHS staff in England

• What current facilities are available,
• How they are most effectively used
• Identify opportunities to share good practice
• How it is improving training quality
• How it is improving patient care
Approach to the project

- Literature Review
- Advice from expert Panel
- Specific questionnaires to target groups
- Web-based survey
- 2 stakeholder workshops
- Site visits
- Report to inform national strategy
How to get simulation into training?
How will training be different?

- Education filled hours
- Larger “cells” fewer hours
- Use of simulation
  - Procedures
  - Communications
  - Emergencies
How will training be different?

- More graduate students
- Final undergraduate year – shadowing, student assistantships, better transition
- Student debt a factor in job choice
Extending duration of training?

• Case for craft specialties and procedural skills
• Case for General Practice?
• Hybrid training schemes?
• Broad based entry schemes?
BUT

• Drift back to the perpetual trainee?
• Based on what evidence?
• Financial implications......
• Need to define principles
Health Innovation and Education Clusters

• 17 HIECs awarded
• Managed educational networks
• High quality care through better trained clinicians
• Faster translation and adoption of research and innovation
Thank you