Royal College of Physicians

Setting higher standards

# Future Forum, phase two: Education and training

## Royal College of Physicians' response

10 October 2011

## Summary of the RCP's response

**Structures**

- *All* postgraduate medical education should be nationally planned, led by Health Education England (HEE) working with royal colleges, etc, with the number of trainee placements for medical specialties set at a national level.
- Postgraduate deaneries must be retained and be made accountable to HEE.
- Postgraduate deaneries must maintain sufficient independence, control and autonomy to undertake effective quality management. Funding should flow directly to deaneries, medical schools and other Higher Education Institutions (HEIs) from the national commissioner, HEE. Hosting arrangements for deaneries could be determined locally, but routes of accountability and funding should be common across the system.
- For postgraduate medical education, Local Education and Training Boards (LETBs) should provide information and advice to HEE.
- The Centre for Workforce Intelligence (CfWI) should undertake the long term modelling of the workforce under the direction of HEE, in close liaison with the RCP and the medical specialties.
- HEE could play an important role for in overseeing workforce planning 'from cradle to grave', creating a smooth continuum of medical education from undergraduates to postgraduates.

**Incentives**

- The RCP supports the concept of an NHS training levy paid by all providers.
- Measuring, publishing and incentivising quality of education and training is vital, but new proposals must be piloted and subject to proper prospective academic study.

**Health reforms**

- The Health and Social Care Bill 2011 should: give the Secretary of State a duty for the education and training of the healthcare workforce (clause 1); give the NHS Commissioning Board and Clinical Commissioning Groups a duty to promote education and training and write this into contracts (clauses 20 and 22), and; ensure that the provision of education and training is a mandatory condition of being licensed by Monitor to provide to the NHS (clause 93).

**Provision of training**

- Different professions have different requirements and *multi-professional education* at the undergraduate level has not been demonstrated to have any impact or saving (except where there are strong shared needs and knowledge).
- In the service field there are opportunities for the *multidisciplinary training* (eg for stroke services) of consultants, physiotherapists, nursing and pharmacy staff. *Inter-professional learning* for areas of the curriculum such as leadership and management, and for team building, is important.
- There needs to be stronger leadership of, and responsibility for, training the whole acute team.

**Medical careers**

- Acute hospitals need a workforce appropriately trained to deal with current demographics. We need to assess whether the current balance between physicians trained in a speciality and those trained in general internal medicine and/or geriatric medicine is right. The options for specialisation later in training should be fully considered, with greater flexibility for joint/modular training and a broader base of generalist skills gathered across a broader range of settings.
- There needs to be greater flexibility in medical career paths.
- There is now an urgent need to review rotas and the structure of the entire medical team to ensure that medical in-patients receive direct input from consultant physicians seven days a week.

**Time for work that contributes to the wider NHS**

- This includes time for work that contributes to the wider NHS, including college work. Doctors must have time for Continuing Professional Development (CPD) and Supporting Professional Activities (SPA), which ultimately benefits patients by helping doctors develop their skills, train the next generation of doctors, improve clinical standards, and foster innovation and advances in knowledge and treatment.

## 1. About the Royal College of Physicians (RCP)

The Royal College of Physicians (RCP) plays a leading role in the delivery of high quality patient care by setting standards of medical practice and promoting clinical excellence. As an independent body representing over 25,000 fellows and members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare.

The RCP plays a number of specific roles in relation to the education, training and development of the medical workforce in the UK:

- The RCP's education and training department is committed to supporting physicians through training and education, from registration to retirement. We do this through our excellent programmes of education, assessment, training and development. We also take a leading role in planning for revalidation.
- The RCP, with the Joint Royal Colleges of Physicians Training Board (JRCPTB), designs and develops curricula and assessment methods for postgraduate core and specialty medical education, in agreement with the General Medical Council (GMC).
- We work with JRCPTB and the deaneries to deliver the Core Medical Training (CMT) recruitment programme. This is a centralised recruitment process for trainees and, more recently, higher specialists. The national programme provides an effective and economical mechanism for handling selection and recruitment.
- Royal colleges and deaneries work together to deliver deanery-based schools of medicine and create and effective visiting processes for quality management. Over the last three years, heads of school have become an enormous source of workforce knowledge and expertise at a regional level.
- Our well-developed and highly experienced and respected Medical Workforce Unit provides expert advice on workforce planning and intelligence, with strong links with the Centre for Workforce Intelligence, the medical specialties, deaneries and local trusts. The unit also undertakes a number of specific projects, and is currently exploring the role of the medical registrar.
- The RCP is also currently exploring the role of generalism in the acute sector, as well as issues such as mentoring for new consultants and the 'sub-/ junior consultant' grade.

## 2. Introduction

The RCP welcomes further analysis of this topic by the Future Forum and the opportunity to help shape a future system of education and training that meets the needs or patients now and in the future. This is an opportunity to develop a system of education and training that is flexible; has the right balance of responsibilities and accountabilities; ensures effective local partnerships, achieves patient, public, professional and provider engagement and; crucially, improves quality of education and training, including methods for assessing quality.

Any new system must recognise the complexity of medical education and training. If we get education and training structures wrong, there is a risk of damage to the long term sustainability of the health service, with a detrimental impact on patient care. Training and education must be not threatened by the increasing service pressures resulting from efficiency savings or concurrent reforms to the health service.

Our response focuses on medical education and training, and provides further detail of: how we believe the system should be structured; the health service reforms; funding flows, outcomes and incentives; inter-professional training; workforce demands, including generalism and the need to provide 24 hour care; workforce intelligence; academic medicine and research, and; the public health workforce.

## 3. Recommended model for education and training structures

Medicine must be nationally planned and commissioned. Training the medical workforce is expensive and the right balance must be achieved between specialties and regions. This requires constant national supervision and intervention. These themes are explored in some detail in the RCP's response to Developing the healthcare workforce, which is included as an annex to this response together with the independent submission from our Trainees' Committee.

To protect the integrity of medical education and training, the RCP recommends the following model:

### National leadership and planning

- A*ll* postgraduate medical education should be nationally planned, led by Health Education England (HEE) working closely with the postgraduate deans, the medical royal colleges, the Centre for Workforce Intelligence (CfWI), etc. Training must consider both service needs and the whole pathway of medical school to specialism, often 15 years or more.
- The number of trainee placements for medical specialties should be set at a national level, with scope for flexibility in local implementation. HEE should be responsible for approving local plans and have sufficient powers to take action where necessary.

### Postgraduate deaneries

- Postgraduate deaneries undertake crucial functions that cannot be delivered effectively elsewhere in the system, including independent quality and trainee management; they must be retained. We welcome the recognition of both the Future Forum and the government of importance of postgraduate deaneries.
- Postgraduate deaneries should be made accountable to HEE at a national level, and postgraduate deans should continue to be accountable to the General Medical Council (GMC) for the delivery of the postgraduate medical curriculum and professionally accountable to HEE.
- Postgraduate and undergraduate deans must be the 'responsible officer' for quality management of medical education.
- Funding should flow directly to deaneries, medical schools and other Higher Education Institutions from the national commissioner – HEE for postgraduate medical education.
- Local hosting arrangements for postgraduate deaneries should be set up following the abolition of Strategic Health Authorities (SHAs) in 2013. These could be hosted within universities, as an independent body hosted by a trust, or in sub-national HEE structures, depending on local needs and relationships. However, the routes of accountability (to HEE) and funding (from HEE) should be common across the system.

### Local Education and Training Boards (LETBs)

- For postgraduate medical education, Local Education and Training Boards (LETBs) should provide information and advice to the national commissioner (HEE). It is vital that local and service needs are understood in national planning, and different parts of the country clearly have different needs. This information must influence the national commissioning programme if it is to make sense at a regional level.
- LETBs should involve a broad range of partners and be inclusive in their membership, including Higher Education Institutions alongside providers.
- The heads of deanery-based schools of medicine (a joint initiative with the royal colleges) are one of the most powerful sources of workforce expertise locally and at a regional level and should support LETBs, acting as a conduit of information back to HEE.
- However, the postgraduate deans, accountable to HEE and GMC, must retain financial and quality control of training, holding service providers to account when necessary.

## 4. Planning and delivering medical education and training

The RCP believes that medicine *must* be nationally planned and commissioned. The RCP's patient and carer network also strongly supports national planning of medical education; moving away from a system of national planning will risk building a system that is not equitable for patients.

All medical workforce planning needs national oversight to ensure that collated plans are coherent and in line with national strategies and horizon scanning. Training must consider both service needs and the whole pathway of medical school to specialism, often 15 years or more. Training the medical workforce is expensive, and the right balance must be achieved between specialties. Experience tells us that this requires constant national supervision and intervention. This is most obviously the case for smaller specialties, but it is clear that planning for all medical specialties, such as cardiology, requires long term vision. Recent improvements in, for example, cardiovascular care were made in part due to a strong national vision and strategy.

Medical education is for the whole of the UK, with a single UK regulator, the General Medical Council (GMC). The GMC has legal responsibility for signing off national curricula (developed by the royal colleges) and in relation to European law, with deaneries accountable to the GMC for the delivery of national curricula.

The relationships between Health Education England (HEE), General Medical Council (GMC) and the royal colleges at a national level, designing curricula and their delivery, will therefore be crucial. As will strong links with the devolved nations. Clear lines of responsibility and accountability will be needed, as well as a culture of knowledge-sharing and collaborative working that avoids conflicts of interest.

There also needs to be more focus on the continuity of education from undergraduate medical schools to postgraduate level and later career development in primary and secondary care.

### 4.1 National planning

#### Role of Health Education England

The national planning process for a*ll* postgraduate medical education should led by Health Education England (HEE), working closely with the medical royal colleges, the Centre for Workforce Intelligence (CfWI), etc.

The number of trainee placements for medical specialties should be set at a national level, with some scope for flexibility for local implementation. HEE should be responsible for approving local plans and have sufficient powers to take meaningful action where necessary.

#### Structure of Health Education England (HEE)

HEE must retain strong professional ownership and influence. The RCP strongly recommends the retention of the Medical Education England's Medical Programme Board, which supports an inter-professional approach.

The professional advisory boards and MEE's Programme Boards should be absorbed into HEE's structure. This will ensure continuity throughout and beyond the period of transition. The Medical Programme Board will advise the main HEE Board on the development of their respective education and training arrangements and on workforce planning matters. It – together with the other programme boards –will play an essential role in scrutinising the local plans of provider networks and drawing attention, for instance, to any issues that may not be in the overall national interest of the right workforce supply.

The RCP recommends that the Medical Programme Board carry out the functions originally described in the Tooke report[1], namely:

- hold the ring-fenced budget for medical education and training for England
- define the principles underpinning postgraduate medical education and training (PGMET)
- act as the professional interface between policy development and implementation on matters relating to PGMET
- develop a national perspective on training numbers for medicine working within the revised medical workforce advisory machinery (now the CfWI)
- ensure that policy and professional and service perspectives are integrated in the construct of PGMET curricula and advise the regulator on the resultant synthesis
- coordinate coherent advice to government on matters relating to medical education
- promote the national cohesion of postgraduate deanery activities
- scrutinise medical education and training functions of the Local Education and Training Boards (LETBs), facilitating demand led solutions whilst ensuring maintenance of a national perspective is maintained
- commission certain subspecialty medical training
- act as the governance body for future changes in PGMET
- work with equivalent bodies in the devolved administrations, thereby promoting UK wide cohesion of PGMET whilst facilitating local interpretation consistent with the underpinning principles.

There must also be lay involvement at a strategic level within HEE.

## 4.2 Local management and delivery

Postgraduate deaneries undertake crucial functions that cannot be delivered as effectively elsewhere in the system - including independent quality management function and trainee management - and must be retained. We welcome both the Future Forum's and the government's recognition of the importance of postgraduate deaneries.

There has been growing partnership at regional level between royal colleges, deaneries and medical schools through the development of specialty schools. Developing academic training partnerships need to be fostered and enhanced.

### Postgraduate deaneries

Postgraduate deaneries should be made accountable to HEE at a national level, and continue to be accountable to the General Medical Council (GMC) for the delivery of the postgraduate medical curriculum. Postgraduate and undergraduate deans must be the 'responsible officer' for quality management of medical education.

Funding should flow directly to deaneries, medical schools and other Higher Education Institutions from the national commissioner – HEE for postgraduate medical education.

Local hosting arrangements for postgraduate deaneries will need to be set up following the abolition of Strategic Health Authorities (SHAs) in 2013. There are a number of potential models for the hosting of

[1] Professor Sir John Tooke. *Aspiring to Excellence: Final Report of the Independent Inquiry into Modernising Medical Careers*. MMC Inquiry, January 2008. Final Report of the Independent Inquiry into Modernising Medical Careers

postgraduate deaneries, including as an autonomous, independent body hosted within universities, a teaching trust, academic healthcare centre or in sub-national HEE or NHS Commissioning Board structures. Hosting arrangements could be determined locally depending on local needs and relationships. However, the routes of accountability (to HEE) and funding (from HEE) should be common across the system, and postgraduate deaneries must maintain sufficient independence, control and autonomy to undertake their quality management functions effectively.

Royal colleges and deaneries have worked together recently to deliver deanery-based schools to create and effective visiting processes. Over the last three years, heads of school have become an enormous source of workforce knowledge and expertise at a regional level. They understand where the trainees are, they know the service pressures and they know the workforce undertaking the training. They should be one of the most powerful sources of local workforce expertise at a regional level to support local education and training boards in the future.

### Local Education and Training Boards (LETBs)

It is vital that local needs are understood, and that providers are engaged in education and training. This information must influence the national commissioning programme if it is to make sense at a regional level. It is widely understood that it has been difficult to engage local education providers in either national or local workforce planning.

Local Education and Training Boards (LETBs) should provide information and advice to the national commissioner (HEE). In relation to postgraduate medical education, their role should be to *advise* the national commissioner, as well as acting to bring together the local health and social care community. In medicine, local needs tend to focus on months to a year. Training, however, must consider the whole pathway of medical school to specialism – often 15 years or more. There are already examples of inter-professional educational bodies, such as deaneries, being hosted outside Strategic Health Authorities helping to develop strategy and inform local delivery. We would advise learning from these non-bureaucratic solutions and can provide examples on request.

Local Education and Training Boards:

- must be reflective of local communities and inclusive in their membership – including universities, postgraduate deaneries, social services, public health, dental and pharmacy, as well as strong lay involvement.
- serve an appropriate population base - able to reflect local need, whilst being large enough to get economies of scale. In some parts of the country this may reflect catchment population, in others it may reflect the realities of natural geography
- must have clear lines of accountability, reporting and responsibility
- should play an advisory role in relation to postgraduate medical education and training.

The deanery will be accountable for quality management at a local level and must therefore be separate from the LETB (and answerable to the regulators and HEE – see above).

There needs to be greater clarity on the arrangements for ensuring that providers participate in LETBs. *Developing the healthcare workforce* suggested that Monitor is likely to have a role in ensuring provider participation in LETBs. There needs to be a clearer vision of the sanctions and action that will be available if providers do not participate. Likewise, there must be clear guidelines setting out what *meaningful* participation will look like.

## 4.3 Funding flows

**For education and training**
Funding should flow directly from the national commissioner to deaneries, medical schools and other Higher Education Institutions. This follows the argument for national commissioning and ensures that as far as possible funds allocated centrally for education reach regional education bodies intact and are not, for example, siphoned off for service.

*If*, against the RCP's strong advice, LETBs are to commission any aspects of medical and training, there must be strong contractual arrangements with HEE. Contracts/ Service Level Agreements (SLAs) must stipulate clear trainee numbers (ie per speciality), ring-fenced funding. These arrangements, together with meetings and reporting, must be open and transparent, and HEE (through the deans) must have strong powers to hold LETBs to account if they do not deliver.

**From providers (training levy)**
The RCP supports the concept of an NHS training levy paid by all providers, including providers to the NHS, directly to HEE. This should include those providers who do not provide NHS services, but do use NHS trained staff, ie the independent sector.

The definition of a 'provider' has implications for occupational medicine. The RCP is aware that colleagues from our Faculty of Occupational Medicine have responded in more detail on this issue. It is clear that a number of issues must be considered so that the levy and payment system ensure the ongoing viability of training in occupational medicine, without introducing disincentives to occupational health service provision by employers, a distortion of the market, or unnecessary bureaucracy and burdens for the NHS.

**To providers (training tariff)**
The RCP supports the review of the Multi Professional Education and Training (MPET) budget and agrees that the current system should be reformed. Currently, the link between the quality and quantity of education and training, and the funding that pays for it, is weak. There are insufficient incentives for excellence, and inadequate, or non-existent, penalties for failing education providers. There must also be sufficient incentives to ensure that education and training are improved when outcomes are shown to be poor. It seems sensible to replace this with a tariff system, but – as highlighted above – this will be difficult to get right. The tariff must provide sufficient incentive to offer training. This must consider the *full* costs of training, including supervision and contributions to standards settings, for these are historically missed from calculations. We recommend that a gradual approach be taken in order to ensure that individual organisations are not destabilised.

The RCP suggests that HEE consider adopting a system of financial incentives for quality similar to the Commissioning for Quality and Innovation (CQUIN) payment system used within service commissioning. Full tariff price for education and training in certain areas should only be payable on demonstration of appropriate levels of quality.

See also: section 5.2 on incentivising quality.

# 5. Managing, measuring and improving quality

## 5.1 Quality management

Postgraduate and undergraduate deans must be the 'responsible officer' for quality management of medical education. The GMC has a clear structure for holding deaneries accountable at a local/regional education training board level to ensure quality management, while individual providers undertake

quality control. This is a strong and logical system that combines understanding of service pressures at a regional level and proper external scrutiny.

Most would agree that visiting with enhanced externality is at the core of local postgraduate quality management. It is crucial that quality management looks at supervision and training, and has the teeth to withdraw funding and trainees. Postgraduate deaneries must maintain sufficient independence and autonomy to undertake their quality management functions effectively, and should therefore not be part of LETBs (although the dean would sit on these boards).

Visiting also has the potential to pick up on wider safety and quality issues, which can be discussed/ monitored/ acted upon/ referred to regulators, as appropriate. It is important that any changes to structures take account of the findings and recommendations from the Public Inquiry into Mid Staffordshire NHS Trust, due to report towards the end of the year. Visiting needs to be backed up by objective outcomes related to trainee experiences, trainer perceptions and employer satisfaction (see section 6.2).

It is crucial that there is lay involvement in quality management and visiting, and open publication. The RCP's Patient and Carer Network has emphasised that the important work postgraduate deaneries have done in relation to lay involvement should not be lost.

### 5.2 Measuring and incentivising quality outcomes

There has been much debate about metrics to support the development of medical education (or as a financial incentive). Measuring, publishing and incentivising quality is vital but new proposals must be piloted and subject to academic scrutiny, and proper prospective academic study. The evidence so far is that genuine outcome metrics for medical education are complex and not worked through. Any evaluative framework will need to be simple, sufficiently rigorous for comparative analysis and sustainable to permit comparisons over extended period (particularly when taking account of duration of training). The RCP should be involved in developing this evaluative framework.

## 6. National intelligence

### 6.1 Measuring, planning and modelling the healthcare workforce

The history of medical workforce planning is not good and the RCP strongly believes that *'there is a need for more consistent, high quality workforce information to provide the foundation for local and national workforce planning'*.[2] Attempts to plan the medical workforce in recent years have been hampered by the lack of reliable information about the numbers and location of doctors in training[3]. The RCP supports the further development of CfWI and the promotion of more integrated ways of working. There is a clear role for a coordinated national workforce planning, such as avoiding the historic over – and under – supply of trained specialists. The RCP funds a Medical Workforce Unit that surveys hospital physicians.

We recommend that CfWI be tasked with long term modelling of the workforce under the direction of HEE. This must be a national process and should involve close liaison with the RCP and the medical specialties. It will take some time for the CfWI to provide useful guidance on *major* specialties, and it should be noted that many of the 62 specialties are small and planning requires sophisticated professional knowledge. Specialties will all require planning at national level, and the data and expertise

[2] Department of Health. *Liberating the NHS: Developing the healthcare workforce: A consultation on proposals*. 2010. Paragraph 3.19, p 26. Liberating the NHS: Developing the healthcare workforce: A consultation on proposals 2010

[3] At present, the size of an individual workforce is decided based on the prediction of its needs by a specialty (as outlined in 'Consultant Physicians Working With Patients'[3]), the number of training posts decided by the Medical Education England (MEE) Medical Programme Board, the Workforce Availability Policy and Programme Implementation Group (WAPPIG), the deaneries and the local finances of trusts. Centre for Workforce Intelligence advises the Programme Board and WAPPIG, and was hoped to be a facilitator in the planning process.

to do this are currently lacking. The RCP can provide a range of support and is already closely working with the CfWI to develop such models; the RCP must continue to be involved in this process[4].

For workforce planning, we need to know the distribution and training level of all trainees – this is currently unknown[5]. This situation must be urgently remedied by the concerted action of the medical royal colleges, deaneries and the GMC, with the data being shared with CfWI.

CfWI should continue its work with the RCP to redefine how the current medical workforce is measured. This means moving away from traditional measures of 'full time equivalents' and towards 'programmed activities', in keeping with the changes to the consultant contract and individual job plans. This should be based on the data already collected by the medical royal colleges and CfWI should continue to seek their support and expertise.

HEE and the LETBs will need a continued source of high quality information about professional workforce matters, and will need to develop a close working relationship with the CfWI. The RCP agrees that all providers to the NHS should be required to provide workforce data. Transparency and openness must apply to all areas.

### 6.2 Planning and medical schools

There is currently a disconnect between medical school places, especially in regard to the regional distribution of medical schools, and NHS workforce planning. At present, there is an over-production of students; we welcome work being undertaken by the Health and Education National Strategic Exchange (HENSE), with CfWI, to model ways to reduce the number of students. CfWI is currently working with the RCP's Medical Workforce Unit on this from the point of view of medical specialty long-term modelling. However, there needs to be a body with sufficient power to enforce changes across the UK: HEE could play an important role for in overseeing that workforce planning is 'from cradle to grave'.

## 7. Health service reforms

The provision of high quality education and training must be a key consideration, not just for providers, but for those that commission their services. The RCP believes that the Health and Social Care Bill 2011 and health service reforms could be further strengthened to ensure that education and training and the future workforce is protected. We recommend:

- The Secretary of State is given a duty for the education and training of the healthcare workforce, including the medical profession, as part of his duty to secure the provision of comprehensive health services (**clause 1**). We are pleased that the government's response to the original Future Forum report committed to this, and await this amendment to the face of the Bill.
- The NHS Commissioning Board and Clinical Commissioning Groups be given a duty to promote education and training (**clauses 20 and 22**), and for this to be a mandatory part of commissioning contracts for all qualified providers.
- All providers will have to be licensed by Monitor; the provision of education and training should be a mandatory licence condition (**clause 93**), with only certain explicit exceptions.

[4] In addition to our Medical Workforce Unit, which can continue to advise CfWI on numbers and measurement, we also have a well-developed regional system embedded in the Schools of Medicine and hospital trusts. This is well-placed to facilitate the provision of expert advice on medical specialties to any localised workforce planning functions.

[5] The medical Royal Colleges collated data on trainee numbers until 2005 when responsibilities for approving training shifted to the Postgraduate Medical Education Training Board (PMETB). PMETB chose to focus on programme approval, rather than posts, and centrally held data have therefore since deteriorated.

## 8. Academic medicine and research

Academic research and development in medicine must be supported by links between deaneries and medical schools. Postgraduate deans need academic linkages and training must continue to support research during training, not just focus on service. This is one facet of the growing need to ensure a continuum of medical education from undergraduates to postgraduates.

Clinical academic medicine is of great importance to UK plc, but is currently threatened for a number of reasons:

- higher fees will discourage intercalated degrees
- reduced NHS bursaries will limit widening access
- the NHS Outcomes Framework requires no commitment to research and education
- a focus on local issues would endanger the bigger picture, particularly for the smaller specialties
- there is a risk of creating chasms between training in the different nations

The RCP is committed to supporting healthcare innovation in the NHS. Without a healthy cadre of clinical academics, innovation, efficiency and productivity will all stall.

The RCP has produced two recent reports outlining how academic training could be improved. These documents – *Coordinating academic training for physicians* and *The NHS academic vision: training the physicians to deliver it* – are included as an annex to this response.

See also: section 9.4 on CPD and SPA time.

## 9. Delivery and content of education and training

### 9.1 Inter-professional training

There should be improved inter-professional education, and there is a role of LETBs in ensuring this happens. It is widely understood that developing clinical leadership, team working and a real focus on improving patient care is fundamental for the NHS. Thus improving quality also requires much more innovative inter-professional education at undergraduate, postgraduate and post Completion of Core Training (CCT) level, increasing as clinical teams work together in practice.

This is not, however, the same as multidisciplinary/multi-professional education. Multi-professional education at the undergraduate level, other than for groups requiring the same scientific basis to their studies or where there are certain shared needs, has not been demonstrated to have any impact or saving, for the different professions have different requirements. Trainee medical specialists have particular education needs. These would not be met in multidisciplinary training sessions. All medical students need time to understand the unique demands and requirements of their own profession in order to contribute effectively to integrated team work for optimal patient care. Once students have acquired confidence in the special contribution of their own profession, then they can more readily appreciate the skills and talents of others and can come together to create effective, well functioning teams.

In the service field there are obvious opportunities for the multidisciplinary training (eg for stroke services) of consultants, physiotherapists, nursing and pharmacy staff for the purposes of continuing professional development. Likewise, *inter-professional* learning for areas of the curriculum such as

leadership and management, and for team building, is important and should be developed across the whole of healthcare education.

There must also be clear differentiation between early training and education (and associated workforce planning) up to consultant level, and later Continuing Professional Development and 'training' for consultants.

There needs to be stronger leadership of, and responsibility for, the training of the whole team within hospitals.

### 9.2 Curricula

There is a growing need to ensure that there is a smooth continuum of medical education from undergraduates to postgraduates, with stronger links between undergraduate and postgraduate curricula.

The RCP, with the Joint Royal Colleges of Physicians Training Board (JRCPTB), designs and develops curricula and assessment methods for postgraduate core and specialty medical education, in agreement with the General Medical Council (GMC).

The needs and future needs of the service should be considered (see section 10 on changing workforce demands and requirements), as should the evolving nature of medical professionalism as patient expectations and demographics change. Doctors must be equipped to deliver what the service – and patients – need. However, there must be differentiation between service planning and delivery, and the content of the curricula. The content of medical curricula cannot become short-term issues for trusts, but must be professionally-led.

### 9.4 Time for work that contributes to development and the wider NHS

The RCP particularly welcomed the Future Forum's previous recommendation that there be recognition of the importance of time for training and work that contributes to the wider NHS, including college work, such as curriculum development, training and the development of clinical standards.

Time for Continuing Professional Development (CPD) and Supporting Professional Activities (SPA) ultimately benefits patients by helping doctors develop their skills and train the next generation of doctors, by improving clinical standards, and by fostering innovation and advances in knowledge and treatment. However, increasing service pressures are already impacting on this time. To lessen these pressures the RCP believes it is crucial to renegotiate the New Deal for trainees as soon as possible, and part of the European Working Time Directive.

**Continuing professional development** (CPD)

Given the current financial climate, we are concerned that the transfer of continuing professional development (CPD) funding from the multi-professional education and training (MPET) budget to local employers may result in a local squeeze.

CPD has always been important, but is now more formalised in a legal framework through the process of revalidation. It is critical that employers continue to fund – with time and finance – support for CPD. While consultants' CPD needs should take account of local service provision, it important that consultants who can demonstrate clear needs are given time to undertake these activities and academic development.

**Supporting Professional Activities** (SPA)

Academic and research development has traditionally been encouraged through the flexibilities of the consultant contract. Against a backdrop of increasing service pressures, it is crucial that job plans allow adequate Supporting Professional Activities (SPA) time in order to ensure there is time for education, training and, for many, also research.

**Clinical Excellence Awards** (CEAs)
Reward for significant academic and research development has often occurred through Clinical Excellence Awards. It is essential that this system continues to reward and encourage those that make effort over and above their day job; this particularly affects academic and research development.

### 9.5 Other issues

**Involvement of trainees**
There should be greater involvement of trainees in their training and its design. There must be sufficient time allowed for both trainers and trainees for teaching. Both clinical supervision and continuity of training are crucial. The lack of senior input out of hours adversely affects the supervision and training of junior doctors (see section 10.2 on consultant-delivered services and out-of-hours care).

**Super-specialty training**
The RCP also notes that currently there is no formalised education and accreditation for super-specialty after Completion of Core Training (CCT). The introduction of this has the potential to improve outcomes and reduce costs, and could be explored.

## 10. Changing workforce demands and requirements

The medical workforce must meet the need – and future need – of patients. Demographics and future health needs (inputs) must be considered and mapped, enabling the production of future generation of doctors able to meet these needs (outputs). The challenges associated with providing high quality care for the increasing number of patients with co-morbidities and complex needs must be considered in the planning of the workforce and in the design of the medical curricula (see section 9.1), career pathway and training provision. Likewise, the aim must be to provide patients with high quality, efficient and effective care 24 hours a day and across specialties, wards and settings. This will necessitate changes to the way we plan and deliver education and training, and the content of training and education programmes.

There needs to be greater pressure on the service to deliver on Sir John Temple's report[6], recreating a consultant-provided service with education and training delivered as part of the service.

In addition, the RCP is also exploring issues such as mentoring for new consultants and the issue of the "sub-/ junior consultant" grade.

### 10.1 Generalism

The RCP is exploring how it can bolster the level of generalist skills in the acute sector – we would be happy to share further details of this work with the Future Forum as it progresses. We also recently responded to the Royal College of General Practitioners and Health Foundation Commission on

[6] Sir John Temple. *Time for training*. Medical Education England. London: 2010. Time for training, Medical Education England

Generalism, which focussed on generalist skills in primary care – a copy of our response is included as an annex to this paper. In addition, our Medical Workforce Unit is currently exploring the role of the medical registrar – again, we can provide the Future Forum with further information.

We need to assess whether the current balance between physicians trained in a speciality and those trained in general internal medicine and/or geriatric medicine is right. Acute hospitals need a workforce appropriately trained to deal with the acute medical intake and aftercare of these patients. This means looking at who is best placed to look after the increasing number of complex patients who do not neatly fit within a single speciality. Generalist skills must be valued.

Future training programmes should look to develop generalist skills in the primary and secondary care workforce. Joint training opportunities and rotations between general practice and general medicine should be explored. Robust consideration should be given to whether we need to develop a general internal medicine curriculum that better fosters diagnostic talent. There should be increased incentives for those working in or *considering* working in a more general field, as well as more flexibility for doctors in training.

The options for specialisation later in training should be fully considered, with greater flexibility for joint/ modular training and a broader base of generalist skills gathered across a broader range of settings (see also: section 10.1 on flexibility in medical career paths).

### 10.2 Flexibility of medical career paths and training

There needs to be greater flexibility in medical career paths. The medical specialty workforce needs to be more flexible to the needs of the NHS, and trainees need to be able to move between specialities more readily to facilitate this (see also: section 10.1 on generalism).

There should also be flexibility (including in existing deaneries) for doctors to move from one specialty or region to another to meeting training needs. This could be hindered by increasing the amount of local planning. HEE could provide oversight of this and work with partners to ensure that curricula are not overly restrictive.

The opportunity to fast track training in a second specialty without having to start again at the bottom should be further explored. The current system of moving from a consultant post to a training post if changing career path is particularly problematic for specialties to which people tend to come to later in their careers, such as occupational medicine.

There should be greater flexibility in the time allowed for out-of-programme activities, with notice, including research and work overseas. This is an important part of the development for future doctors.

### 10.3 Consultant-delivered services and the expanded physician role

The RCP has long advocated consultant-delivered care and the provision of better out-of-hours care for hospital patients. We believe the mounting evidence of sub-standard care delivered to patients who are admitted to hospital during these times is related to the difficulties in providing sufficient input to these patients from consultants. The lack of senior input at these times also adversely affects the supervision and training of junior doctors.

Many hospitals have developed new ways of working that increase the contribution of consultant physicians to the routine care of patients outside normal working hours; this is not always accurately

reflected in job plans and there remain difficulties in balancing the demands of elective and emergency work for the consultant physician workforce. Traditional patterns of work for consultant physicians limit input from consultants to the care of patients admitted outside normal working hours and to those who remain in hospital at weekends and bank holidays.

The RCP believes that there is now an urgent need to review rotas and the structure of the entire medical team to ensure that medical inpatients receive direct input from consultant physicians on a seven day a week basis. We recognise that it may take some time to achieve the service redesign that may be required and that other specialties and support services (including diagnostics) will need to adopt seven day working practices if the full benefits of additional physician input are to be realised. The RCP statement on care of medical patients out of hours in 2010 advocated:

- Hospitals undertaking the admission of acutely ill medical patients should have a consultant physician on-site for at least 12 hours per day, seven days per week, at times related to peak admission periods. The consultant should have no other duties scheduled during this period
- While much of the work of the consultant physician will be on the acute medical unit, provision should be made for a daily consultant visit to all medical wards. In many hospitals this will require input from more than one physician
- Job plans will need to reflect correctly the extra work undertaken by consultant physicians and must include arrangements to ensure adequate rest

The RCP also advocates greater involvement of physicians in other areas, such as surgical wards and in care homes.

## 11. Public health workforce

Public health workforce planning must be integrated and conducted alongside the rest of the healthcare professions. It is essential that the public health workforce strategy includes an appreciation of the wealth of public health work that is delivered outside of the NHS system. There should also be mechanisms established to ensure that planning for the public health workforce takes into account the whole public health workforce and not just those that are employed within an NHS setting.

It is essential that public health input and understanding is firmly embedded into HEE and local education and training boards, with specialist advice from Public Health England. These requirements must be fed into the local education and training boards in a collective way. There is a clear role for local Directors of Public Health, who must have chief officer status within local authorities.

Training must continue to be delivered across a range of training environments, including clinical commissioning groups (with support from local consultants as they are being established) and local authorities.

The RCP also believes that statutory regulation of the public health profession should be introduced.

## Supplementary documents:

- RCP response, Developing the healthcare workforce
- Independent response from the RCP trainees committee, Developing the healthcare workforce.
- RCP working party report, *Coordinating academic training for physicians*
- RCP working party report, *The NHS academic vision: training the physicians to deliver it*
- RCP response to the RCGP/ Health Foundation Commission on Generalism
- RCP statement on care of medical patients out of hours

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