Shape of Training BGS Trainees Weekend Spring 2019

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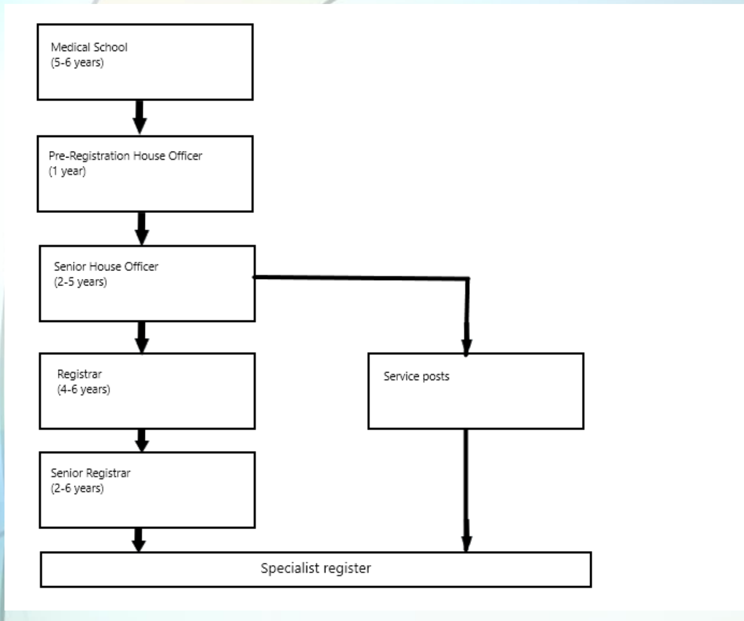
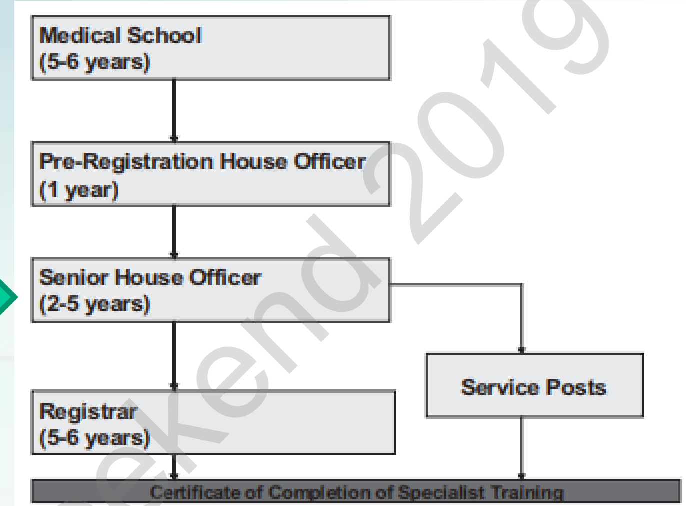
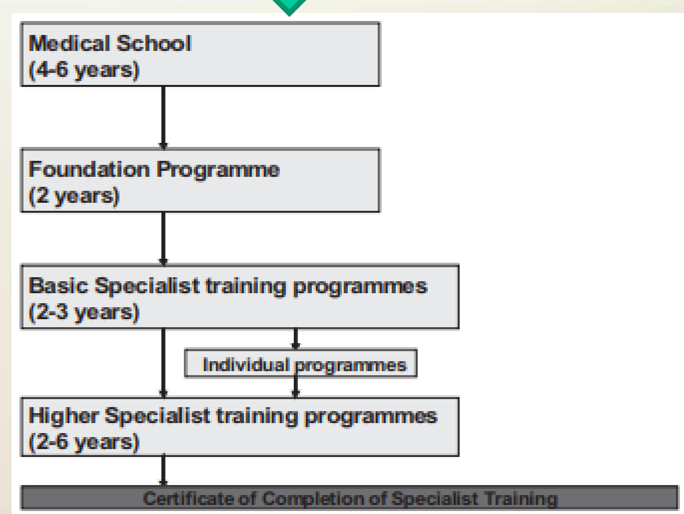
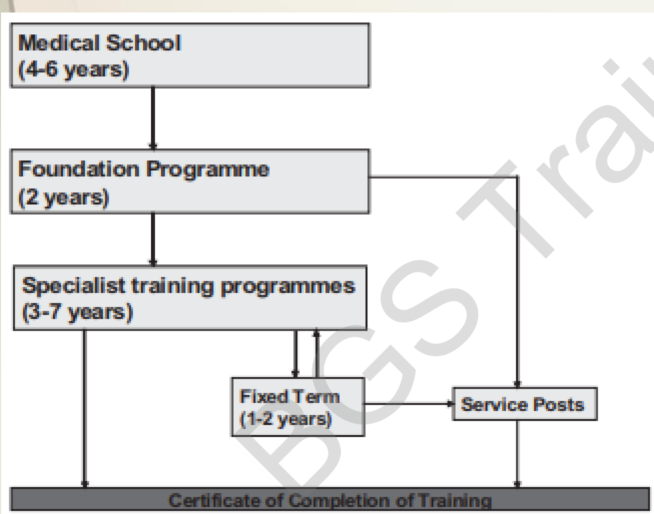
Background for the cynical

- “The lost tribes of SHOs”
- “Unfinished business” 2002
- Widespread deficits in NHS 2004-5 leading to SHAs withdrawing funding for training posts.
- Modernising medical careers 2006-7


Medical School
(5-6 years)
Pre-Registration House Officer
(1 year)
Senior House Officer
(2-5 years)
Registrar
(4-6 years)
Service posts
Senior Registrar
(2-6 years)
Specialist register


Medical School
(5-6 years)
Pre-Registration House Officer
(1 year)
Senior House Officer
(2-5 years)
Service Posts
Registrar
(5-6 years)
Certificate of Completion of Specialist Training


Medical School
(4-6 years)
Foundation Programme
(2 years)
Basic Specialist training programmes
(2-3 years)
Individual programmes
Higher Specialist training programmes
(2-6 years)
Certificate of Completion of Specialist Training


Medical School
(4-6 years)
Foundation Programme
(2 years)
Specialist training programmes
(3-7 years)
Fixed Term
(1-2 years)
Service Posts
Certificate of Completion of Training

“Things... can only get better...”

- Core medical training
- Growth of the single organ specialities
- EWTD
- “Hospitals on the edge” 2015

Why do we need to change?

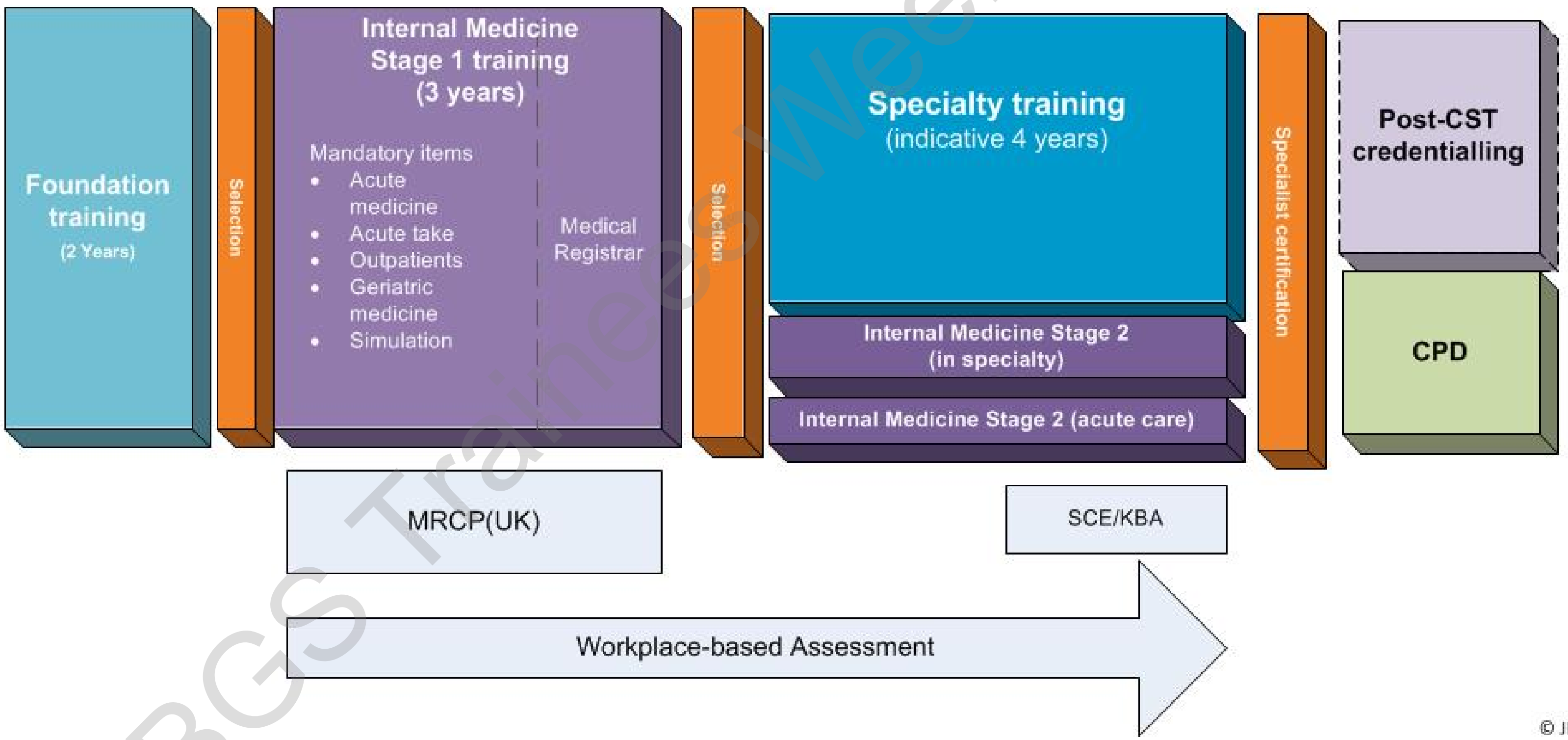
- Generalist care for ageing population with multiple comorbidities
- Still need to train specialists but fewer of them
- Postgraduate training needs to adapt to prepare medical graduates to deliver safe and effective general care in broad specialties.
- Medicine has to be a sustainable career with opportunities 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.

Proposed outline model for physician training

Internal medicine (IM) training is divided into two stages. All physicians will undertake IM stage 1 training and contribute fully to the unselected acute take in the first three years of training. Stage 1 and 2 IM training will contain all the Generic Professional Capabilities (GPCs).

Following successful appointment to a specialty training programme, doctors in training will undertake one of the following routes:

Completion of specialty training + IM Stage 2 (in specialty) = CST in specialty
or
Completion of specialty training + IM Stage 2 (in specialty) + IM Stage 2 (acute care) = CST in specialty AND CST in IM



IM 4 and beyond….

- What does it mean for us?
- All Group One specialties will dual-accredit
  - Specialty + IM
  - GMC Generic Professional Capabilities can only be acquired with full IM training

- Transition arrangements not yet clear…..
- But from 2021 we will have no ST3 trainees
  - Trainees will enter HST at ST4
  - The programme will consist of 12 months IM and 36 months geriatric medicine

New IM Curriculum

Approved by the GMC in December 2017

- GMC generic professional capabilities
- Knowledge and skills required to manage patients presenting with a wide range of medical symptoms and conditions
- Emphasis on diagnostic reasoning, managing uncertainty, dealing with co-morbidities and recognising when specialty opinion or care is required

Focuses on learning outcomes through the achievement of capabilities in practice (CiPs)

Assessment strategy

Capabilities in Practice (CiPs)

'A unit of professional practice identified as a task or responsibility to be entrusted to a learner to execute unsupervised once sufficient competence has been demonstrated'

In the literature referred to as Entrustable Professional Activities (EPAs)

Assessment of generic CiPs

Assessment made by the ES using

Global assessment anchor statements

- Below expectations for this year of training; may not meet the requirements for critical progression point
- Meeting expectations for this year of training; expected to progress to next stage of training
- Above expectations for this year of training; expected to progress to next stage of training

Assessment tools – remain the same

Supervised Learning Events (SLEs):

- Acute Care Assessment Tool (ACAT)
- Case-Based Discussions (CbD)
- Mini-Clinical Evaluation Exercise (mini-CEX)

WPBAs:

- Direct Observation of Procedural Skills (DOPS) - formative
- Multi-Source Feedback (MSF)
- Patient Survey (PS)
- Quality Improvement Project Assessment Tool (QIPAT)
- Teaching Observation (TO)

Supervisor reports:

- Multiple Consultant Report (MCR)
- Educational Supervisor Report (ESR)

Internal medicine stage 1 will normally be a three year programme that will include mandatory training in geriatric medicine, intensive care, outpatients and ambulatory care.

Internal Medicine curriculum 2018 (page 3)

https://www.jrcptb.org.uk/sites/default/files/Internal Medicine stage 1 curriculum FINAL 221217.pdf

Geriatric medicine

With an increasing elderly population it is essential that all trainees in IM have adequate exposure to and experience of geriatric medicine. It is felt that a four month attachment to a team led by a consultant geriatrician during the training programme is an absolute minimum.

Internal Medicine curriculum 2018 (page 33)

https://www.jrcptb.org.uk/sites/default/files/Internal Medicine stage 1 curriculum FINAL 221217.pdf

5.5 Outline grid of levels expected for Internal Medicine specialty capabilities in practice (CiPs)

Levels to be achieved by critical progression points

Level descriptors
Level 1: Entrusted to observe only – no execution
Level 2: Entrusted to act with direct supervision
Level 3: Entrusted to act with indirect supervision
Level 4: Entrusted to act unsupervised

	Internal Medicine Stage 1				Selection	Internal Medicine Stage 2 + Specialty				CCT
Specialty CiP	IM1	IM2	CRITICAL PROGRESSION POINT	IM3	CRITICAL PROGRESSION POINT	ST4	ST5	ST6	ST7	CRITICAL PROGRESSION POINT
Managing an acute unselected take		3		3					4	
Managing an acute specialty-related take		2		2			3		4	
Providing continuity of care to medical in-patients		3		3					4	
Managing outpatients with long term conditions		2		3					4	
Managing medical problems in patients in other specialties and special cases		2		3					4	
Managing an MDT including discharge planning		2		3					4	
Delivering effective resuscitation and managing the deteriorating patient		3		4					4	
Managing end of life and applying palliative care skills		2		3					4	

Geriatric Medicine Curriculum

- Purpose statement October 2018
- Only allowed 8 CiPs – mapped to more detailed syllabus
- The fate of stroke medicine
- “No optional grids”
- Curriculum has to be risk assessed for equality and diversity

A. Capability in practice (CiP) leading to a 'trusted decision'	B. Descriptor (key observable activities, tasks and behaviours)	C. Evidence	D. Relevant competencies from the current specialty curriculum
1. Performing a comprehensive assessment of an older person, including mood and cognition, gait, nutrition and fitness for surgery in an in-patient, out-patient or community setting	• Demonstrates the ability to take a comprehensive history incorporating physical, social, cognitive and functional elements • Demonstrates the ability to communicate effectively with patients from diverse backgrounds and with special communication needs such as hearing, visual and speech impairments and confusion and mental health issues • Demonstrates diagnostic skills – particularly in the context of complex multisystem pathologies and associated social and psychological issues • Demonstrates the ability to perform functional status evaluation • Demonstrates the ability to use CGA to develop individualised management plans • Champions the value of CGA	CbD Mini CEX SCE ACAT MCR MSF	• Knowledge of factors influencing health status in older people, and measures employed in measuring this • Models and concepts of frailty • Evidence base for CGA • Awareness and recognition of age discrimination within healthcare systems and strategies to combat this • Knowledge of the range of agencies that can provide care and support, how they can be accessed, and financial support available • Is familiar with safeguarding legislation and actions needed when caring for vulnerable adults

So what happens now?

- Use of existing Geriatric Medicine NTNs to support development of IM3 posts?
- “Flavours for service” – stroke, POPs, continence etc
- Develop robust IM geriatric medicine training posts
- Push development of undergraduate curriculum