

MMC PROGRAMME BOARD TASK & FINISH GROUP ON QUALITY

**Maintaining Quality of Training in a Reduced Training Opportunity
Environment**

Chaired by: Dr Ian Wilson

Recommendations to the MMC Programme Board
January 2009

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1 Summary of Key Recommendations

	Section Ref
Recommendations for Minsters	
A The Department of Health should make the measurement of quality of training provided by Local Education Providers (LEPs) part of the remit of the Care Quality Commission. Further work is needed to develop benchmarking standards that are consistent, useful for different organisations and purposes, and robust enough to be used as part of an organisation’s overall performance rating.	3.5.2 4.1.2 4.1.3
B The DH must require that PCTs/commissioners of services ensure that the impact on training and education is factored into service reviews and built into business development/continuity plans by providers, and that appraisal of education opportunities forms part of all service level agreements.	5.1.2
C The DH review of funding mechanisms for postgraduate medical training must consider mechanisms specifically designed to incentivise high quality training provision. Captured within this should be provision for placements where trainees’ contributions to service provision is necessarily limited (e.g. F1). Elements of funding for training and education should be clearly identified within budgets. There should be explicit and clear tracking of those funds. The DH should explore the option of a differential tariff / supplement for training cases. Extra funding must offset entirely the additional cost of training.	3.3.2(c) 5.1.3
D Further work must be undertaken by the Department of Health with Deaneries, Royal Colleges, NACT, BMA & employers to provide guidance over the time and balance of duties required to properly undertake the various training, education and monitoring roles required.	3.5.5
Recommendations for Regulators and Royal Colleges	
E Where there is objective evidence that competences and skills are not typically achieved within current expected duration of training consideration must be given to lengthening the indicative duration of training programmes, though as a last resort – the primary focus being on improving quality of, and access to, training opportunities.	3.4.2
F Further work should be undertaken by PMETB, Deaneries and employers regarding the training, accreditation and assessment/monitoring of trainers.	3.5.5
G PMETB and Royal Colleges must make robust recommendations for monitorable standards for the different elements contributing to learning: education, training, and consolidating experience. Curricula should ensure that confidence to safely and appropriately use clinical and other skills is core to training.	3.1 3.3.1
Recommendations for Deaneries & SHAs	
H Where, despite best efforts, access to training opportunities has been insufficient to reasonably allow attainment of competencies consideration must be given to lengthening the duration of training for individuals without detriment to the trainee concerned. This must be recognised in the frameworks for delivery of training.	3.4.1

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|---|--|-------------------------|
| I | Learning Delivery Agreements between SHAs/Deaneries and Local Education Providers must contain specific, measurable objectives for training quality (for example, planned regular time for discussion between a trainee and their named supervisor whether training opportunity matrices have been kept up to date, whether trainees are accessing teaching sessions, access to study leave, etcetera, developed in consultation with PMETB and other training system stakeholders). | 5.1.1 |
| J | Deaneries/SHAs should be proactive in assuring themselves of “value for money” for their investment in training; tools for this should be developed by SHAs with the Department of Health with a framework that ensures consistency with existing systems and data, and with proposed monitoring by the CQC. | 3.1
4.1.1 |
| | <ul style="list-style-type: none"> SHA Chief Executives should have overall responsibility for ensuring that there are effective processes for monitoring and scrutinising the oversight and provision of training within LEPs, measured as part of their organisational objectives. Postgraduate deans must have oversight and overall responsibility for monitoring and scrutinising LEPs and making changes where necessary. In each LEP the Chief Executive must hold overall responsibility for ensuring a process for the management, monitoring, delivery and reporting of outcomes and standards of training. | 4.1.2
4.1.2
4.1.2 |
| K | SHAs and deaneries must consider mechanisms to give trainees greater influence over the location of their training based on evidence of quality of training as well as their training requirements. | 5.1.3 |
| L | Deans and Employers should develop templates for “training opportunity matrices”. These would be populated by LEPs working with Deans and Training Programme Directors for local/regional use to make training opportunities clear and accessible. Trainees must be proactive in seeking and utilising all learning opportunities. | 3.3.2(b)
3.5.1 |

Recommendations for Local Education Providers

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|---|---|----------------|
| M | Local Education Providers (LEP) must acknowledge and emphasise the need for their medical staff to teach and train, ensuring that trainers and trainees have sufficient, accessible time in their job plans for training and educational leadership roles. LEPs must consider the various types of teaching and training required in a doctor’s development including Education, training, and experience. | 3.5.5
3.5.6 |
| N | A planning group must be established in each LEP to consider innovative approaches to maintain quality of training in the light of reduced training opportunities. These must have Board level leadership, with senior doctors, finance and HR managers and a range of clinicians, including trainees, involved in delivering healthcare. | 3.3.2(a) |
| O | The roles and responsibilities of trainers must be supported through time and resource. The importance of high quality in training should be recognised and rewarded through local mechanisms including Clinical Excellence Awards schemes. | |
| P | Employers should tailor clinical sessions to allow for training when scheduling these. LEPs should work with commissioners of care and IT experts to develop methods of identifying patients whose care may be suitable to support training opportunities. This would allow appropriate and efficient allocation to “training lists / clinics” with better use of time and resource, as well as recognising impact on throughput. | 3.3.2(c) |

2 Introduction

2.1 Background

The Modernising Medical Careers (MMC) Programme is not only about career pathways but is also about improving training standards through better structured and managed training programmes to enable trainees to achieve excellence as well as competence.

Changes in the structure and the environment in which training and education are delivered, along with reductions in overall hours worked, have created challenges in ensuring that quality of training and the standards of those exiting training programmes are maintained.

2.2 Remit

The MMC Programme Board created a short life Task and Finish Group (TFG) to look at issues involved in maintaining and improving quality of training in the context of reduced training opportunities, and to make recommendations to the Board for actions and commissioning of further work.

2.3 Membership

Dr Ian Wilson	MMC Programme Board (Chairman of T&F group)
Dr Anne Thornberry	AoMRC/RCoA
Dr Deborah Kendall	NHS North West
Professor Humphrey Hodgson	AoMRC
Professor Roy Pounder	AoMRC
Mrs Patricia Le Rolland	PMETB
Dr Paul Flynn	Consultant/CCSC
Dr Peter Maguire	BMA EWTD Group
Mr Conor Marron	Surgical Trainee/JDC
Dr Tom Dolphin	JDC
Mr Graham Saunders	NHS Employers
Ms Raj Bhamber	NHS Employers
Miss Wendy Reid	Postgraduate Dean
Dr Elizabeth Spencer	NACT
Mr Tim Lund	DH
Mr Steve Buggle	MMC Operations Manager

2.4 Process

With such a wide potential remit the group identified three key strategic areas on which to concentrate:

- Access to training & education opportunities
- Measuring Standards of Training
- Incentives to Train

The emphasis of this document has necessarily been framed around the hospital sector. However many of these principles will translate into other training environments. The language is also, in places, based on English models. However the principles should be universal in application.

3 Access to Training and Education Opportunities

The purpose of Calman, and subsequently MMC, reforms was to structure training to maintain and enhance quality and standards, whilst streamlining career and training pathways to meet those standards. Professor Sir John Tooke recommends “outcome focussed medical education”¹. These directions of travel in postgraduate medical education are underpinned by the assessment of competences rather than simply time served.

Much is assumed about the quality and standard of trainees and those achieving CCT compared with their forebears². However there is a relative deficit of objective evidence in this regard. The group re-emphasises the MMC Programme Board assertion that the outcomes of training and the award of CCT should ensure that training produces doctors who are capable, competent and confident.

3.1 Outcome of Training

Specific details will vary between specialties and will necessarily take account of outcomes from the “Role of the Doctor” as well as developments in training (e.g. management and leadership generic skills, or transferable competencies) being taken forward by the Academy of Medical Royal Colleges.

Anecdotally it is reported that some employers consider new CCT holders to have competence (in their knowledge, skills, behaviours and attitudes), but not confidence (to deliver their competences). Such a situation might represent sub-optimal value for the investment in training made by purchasers of training (ie Deaneries / SHAs); confidence to safely and appropriately use clinical and other competences is itself a core competency and should be developed and assessed as part of a training and education curriculum leading to the award of a CCT

Curricula should ensure that confidence to safely and appropriately use clinical and other skills is core to training. **Recommendation G**

Deaneries/SHAs should be proactive in seeking to assure themselves of “value for money” for their investment in training; tools for them to do this must be developed by SHAs in discussion with the Department of Health. **Recommendation J**

¹ Aspiring to Excellence. Final report of the independent inquiry into Modernising Medical Careers. ©MMC Enquiry 2008

² BMJ 06Dec 2008

3.2 Reduced Access to Training Opportunities

Reduced hours and pressures of service provision may be only part of the picture, with any number of factors or perverse incentives affecting trainees' access to high quality training. Some of these will be universal, however any process to improve training must include consideration of local factors.

Box 1. Examples of factors restricting access to training opportunities

- Reduced and reducing hours (EWTD)
 - Delivery of service in context of reduced trainee hours not always well planned by Trusts; often rely on hoping to appoint middle-grade doctors, who are not always available anymore
 - Service re-design may be more appropriate, but implementation of this approach is variable
- Provider (trust) “productivity” drivers
 - Service delivery requirements
 - Meeting access targets (eg 18 week target)
 - Time for trainers to train
 - Loss of Empowerment
 - Trainers not feeling empowered to prioritise training due to other demands overriding training needs
- Diversion of clinical cases to ISTCs and similar
 - Evidence of impact may be useful eg Brighton / Southampton, Trauma & Orthopaedics
- Too many trainees for the opportunities available
 - Varies between hospitals
 - May reflect mal-distribution of trainees
 - Conflict between workforce planning and training opportunities
 - Some hospitals may have reduced numbers of trainees because of a reduction in the number of procedures available for training
- Loss of concept of “training list”
 - Time pressures: “productivity drives”, targets, need to finish lists on time
 - Waiting list management (ie allocation of cases often no longer done by consultant/trainer, so limited possibility to create a “training list”)
 - Very different approaches taken by NHS employing organisations
- Validity /application of in-training assessment
- Understanding and engagement of trainers, trainees, and trusts

3.3 Job Plan for Specialty Registrars

Some Royal Colleges/Specialty Associations already specify minimum average weekly time that trainees should spend in training. This may be an estimated minimum period needed to achieve CCT-level skills for that specialty. Given continuing downward pressures on time and training opportunities it may be necessary to reconsider and specify:

- Time elements: the balance of different aspects of training and time at
- Improving training opportunities
 - delivery of training
 - balance with demands of service
- Duration of Training
 - the minimum average weekly training time
 - the number of years over which training should typically be deliverable (see section 3.4.2)

3.3.1 Time Elements

Reducing working hours have emphasised the need to focus trainees' time on activities relevant to training. This focus has removed many inappropriate tasks, and allowed innovative approaches to reduce inefficiency. However there are reports that this change in balance may have also caused some confusion between different elements of training, and those elements of service delivery that are essential to training, through consolidation of skills and the gaining of confidence.

Clarity of the roles of different time-elements of training and their relative contributions may help with developing recommendations for delivery of the training programme, and monitoring of local education providers.

Education:	Usually set away from the workplace e.g. courses, lectures, clinical skills labs, seminars etc.
Training:	Learning through working with supervision. Observing more senior staff, being observed and feedback.
Experience:	Providing appropriate service and supervising/teaching more junior staff consolidates learning and increases confidence. Typically through less-proximally / indirectly supervised practice.

The balance between these elements will vary between specialties and at different times throughout training. However all elements should be recognised as having a valid contribution to the attainment and development of skills and competences – and of confidence to use these.

PMETB and Royal Colleges must make robust recommendations for monitorable standards for the different elements contributing to learning: education, training, and consolidating experience. **Recommendation G**

Royal Colleges should develop recommendations within their curriculae regarding standards for, and balance of, these different elements taking into account overall length of training. These recommendations should be sufficiently robust to allow monitoring of providers of training and to offer ways for providers to raise standards.

Specialty Registrars job plans should acknowledge the contributions of these different elements to gaining and consolidating competencies and experience.

3.3.2 Training Opportunities

(a) Trainee Availability

It is widely accepted that most of the learning opportunities for junior doctors take place within the normal working day, the more so for “craft” specialities such as surgery and anaesthesia^{3 4 5 6}. It therefore makes sense to match the workforce distribution to both demand and opportunity; this would not *necessarily* be trainees only, as it is good practice that consultants are involved to oversee and train using the opportunities available at those times.

Innovative approaches to managing routine and service-delivery tasks may be being used to reduce hours for EWTD compliance. Such approaches may also be useful to release trainees to attend training and educational opportunities⁷. Examples of these approaches can be found on the Working Time Directive 2009 page of the Healthcare Workforce Portal⁸

Some specialties are moving towards having more elements of service delivery by consultants. If there are opportunities for active training during such times it may be appropriate to roster trainees at these times also; if not, the trainees could instead be rostered to be available at different, more educationally useful, periods. The same principles apply to allocating non-training grades for service provision to protect training grade doctors from losing out on training-time by excessive service provision.

Box 2: Matching availability to opportunity

If the early Monday evening is busy, for instance, ensure there is appropriate cover by people who can benefit from the training opportunities that may arise.

Similarly if the Wednesday afternoon has little educational activity, that may be time to have fewer trainees working, perhaps only a “skeleton service” at the same level as would be provided at the weekend.

A planning group must be established in each LEP to consider innovative approaches to

³ Joint Royal College of Anaesthetists and Royal College of Surgeons of England WTD 2009 Project. Implications and Practical Suggestions to Achieve Compliance. Nov 2008

⁴ Nicholas Horrocks MSc and Roy Pounder MD, DSc, FRCP. Designing safer rotas for junior doctors in the 48-hour week. Royal College of Physicians.

⁵ Working Time Directive 2009: Meeting the Challenge in Surgery. Royal College of Surgeons of England. June 2008.

⁶ Royal College of Anaesthetists. Working time directive 2009 and shift working: way forward for anaesthetic services, training, doctor and patient safety. Royal College of Anaesthetists: June 2007.

⁷ Working Time Directive 2009 – Education Briefing. National Workforce Projects and the National Association of Clinical Tutors. April 2007

⁸ www.healthcareworkforce.nhs.uk

maintain quality of training in the light of reduced training opportunities. These must have Board level leadership, with senior doctors, finance and HR managers and a range of clinicians, including trainees, involved in delivering healthcare. **Recommendation N**

(b) Mapping of training opportunities

Most Local Education Providers (LEPs) will have an intrinsic knowledge of the variety of training opportunities that they can provide. However these may not be acknowledged in a co-ordinated way at regional/deanery level, be clearly mapped against curricula, or be updated as opportunities change.

A local or regional “training opportunity matrix” would map such curriculum requirements against those providers able to deliver high quality training in that clinical area. This would not only allow appropriate allocation of trainees to posts by deaneries, but would also allow LEPs to concentrate availability of trainees to appropriate times of the day or week, helping rotas to balance training and service-provision needs.

Deans and Employers should develop templates for “training opportunity matrices”. These would be populated by LEPs working with Deans and Training Programme Directors for local/regional use to make training opportunities clear and accessible. **Recommendation L**

A model for this approach should be developed at a national level by representatives of deans, employers and trainees.

Research by the University of Sheffield into the impact of the EWTD on medical training found that many trainees do not recognise and capitalise on informal learning opportunities that arise as part of service delivery⁹. Using a curriculum and training opportunity matrix trainees would be better able to map their own training requirements within clinical attachments or make best use of their training time by seeking out opportunities beyond their base hospital.

Trainees must be proactive in seeking and utilising all learning opportunities.
Recommendation L

Training departments who have their clinical and educational activities planned into the medium and long term will likely be better able to match rotas and availability of trainees to such opportunities, and to plan or re-schedule service requirements accordingly.

(c) Organising training opportunities

Clinical sessions designated for training require careful matching of trainee skill, case-mix, volume of activity, and time. Organisation of clinics and operating lists/treatment sessions is increasingly delegated to centralised bookings offices. Consequently there is limited opportunity to design a training session around the skills of an individual trainee.

⁹ Drs Kath Farrell, Jayne Clarke & Helena Davies, Professors Fiona Patterson & Nigel Bax. Impact of the EWTD on Postgraduate Medical Education. University of Sheffield. September 2008

Pressures to maximise case throughput such as waiting time targets, financial and other pressures, mean that the concept of a planned “training list”, clinic or round, is less common than it may once have been.

Employers should tailor clinical sessions to allow for training when scheduling these. **Recommendation P**

Further work should be done to provide guidance for employers on adjustment of trainer workload to allow for training responsibilities during clinical sessions.

To ensure that training opportunities are provided either as distinct sessions or within sessions there needs to be clinician input into the choice of patients for sessions. Ideally this would be by a senior clinician choosing the case-mix directly. It seems unlikely that the trend towards centralisation will reverse and so options for coding patients’ suitability for training sessions should be considered and developed, so that when patients are first allocated for a treatment or procedure, for example, their care pathway can be assigned a code to indicate that provision of care could be provided by an appropriately skilled trainee.

LEPs should work with commissioners of care and IT experts to develop methods of identifying patients whose care may be suitable to support training opportunities. This would allow appropriate and efficient allocation to “training lists / clinics” with better use of time and resource, as well as recognising impact on throughput. **Recommendation P**

A balance is needed between the need to treat the maximum number of cases and the need to train. This may require specific acknowledgement of additional time-per-case by setting a different tariff payable for cases or lists run as training opportunities. The precedent for this exists in Wave Two ISTCs which had two different tariffs depending whether trainees were involved. (see also section 5.1.3)

The DH should explore the option of a differential tariff / supplement for training cases. Extra funding must offset entirely the additional cost of training. **Recommendation C**

3.4 Duration of Training

The length of training specified for individual curricula is *indicative* rather than an absolute that cannot be exceeded, and European regulation specifies a *minimum* period. Calman and MMC both intended a move towards competency-based assessment of progression towards CCT; these principles are endorsed by – and are the subject of recommendations in – the independent inquiry into Modernising Medical Careers².

3.4.1 Individual Training Programmes

It is unclear whether assessment processes are yet sufficiently sensitive to adjust the duration of individual training against achievement of competences. However as there is downward pressure on time at work and consequently time in aspects of training, these issues become increasingly important considerations both for trainees and for those responsible for the delivery of curricula, workplace based assessments and ARCP/RITAs.

All training programmes must, therefore, have mechanisms to proactively manage genuinely under-performing trainees who are unlikely to achieve CCT standard within a reasonable maximum time frame, giving due recognition to the reasons for under-performance.

Where, despite best efforts, access to training opportunities has been insufficient to reasonably allow attainment of competencies consideration must be given to lengthening the duration of training for individuals without detriment to the trainee concerned. This must be recognised in the frameworks for delivery of training. **Recommendation H**

Assessment and transferability of skills is central to appropriate career management in these circumstances.

It is, however, noted that a key principle of MMC (restated by the MMC Programme Board) is that training should not be unduly prolonged.

3.4.2 Whole Curricula

Successive programmes for the reform of post-graduate training have led to reductions in the minimum overall duration of training programmes for most specialties. During this time average hours of duty per week have steadily reduced driven both by UK contractual arrangements and European legislation on working hours.¹⁰ Other issues affecting training opportunities have been considered above.

Some Royal Colleges have documented changes in the overall time that trainees have had exposure to training or experience opportunities during a training programme.¹¹

Where there is objective evidence that competences and skills are not typically achieved within current expected duration of training consideration must be given to lengthening the indicative duration of training programmes, though as a last resort – the primary focus being on improving quality of, and access to, training opportunities. **Recommendation E**

3.5 Ownership of Training

3.5.1 Trainees

There is a balance to be struck between strict adherence to training requirements and educational freedom in medical training. Reforms of undergraduate medical education mean that an increasing number of trainees are used to that greater degree of freedom. The new ST programmes require the trainee to have a great sense of ownership and responsibility for their learning to ensure the appropriate collection of evidence in the portfolio to enable progression into the next year of training at the ARCP meeting. Supervisors should be available to guide progress with the use of educational plan for each post, including opportunities to achieve agreed goals and regular supervision against progress with structured feedback. If available opportunities are not utilised and goals not met then progression cannot occur.

Trainees must proactively seek and utilise all available learning opportunities to ensure training progression. **Recommendation L**

¹⁰ Reports of the Review Body on Doctors and Dentists Remuneration. Office of Manpower Economics

¹¹ Association of Surgeons in Training (ASiT) survey 2008

3.5.2 Educational Governance in NHS Provider Organisations

Introducing Education Governance in provider organisations ensures that the Chief Executive has a built-in responsibility to deliver high quality training and education of all staff. Monitoring organisations' performance against accepted and useful measures must not only ensure that education governance is central to providers' strategic objectives but helps to develop and improve standards.

The provision of appropriate education and training resources, along with the achievement of specific targets for training of doctors needs to be incorporated into Trust assessment and 'Star Rating' procedures, giving clarity to those Trusts who show initiative and drive to establish good training resources as part of their global assessment.

The Department of Health should make the measurement of quality of training provided by Local Education Providers (LEPs) part of the remit of the Care Quality Commission. Further work is needed to develop benchmarking standards that are consistent, useful for different organisations and purposes, and robust enough to be used as part of an organisation's overall performance rating. **Recommendation A**

Consultant job plans need to be flexible enough to allow teaching to take place outside of the 9-5 period.

Consultant supervision of emergency admissions in the out of hours period is a very rich source of training and feedback for juniors. There should be more incentive for provision of this type of support to juniors (also improving patient care and safety).

Deaneries should ensure that trainees are placed in units where they can get the best training rather than following historical placement patterns.

As money follows trainees, departments should be encouraged to set up more training lists, clinics and ward rounds by specifically targeting the money to allow extra consultant time to provide training.

3.5.3 Empowerment of the Educational Contract and Learning Agreement

Currently it would appear that many rotas are reconfigured with little regard for any educational impact. European working time legislation and New Deal compliance are typically the main drivers for change, with education often a tertiary concern.

There already exists some evidence of templates for 'model' rotas that demonstrate the weekly experience that any individual trainee should receive (see Box 3). This has obviously been lost with the reduction of hours, and many trainees will be falling well short of this experience per week.

Box 3: Surgery

In 2000 a weekly timetable was compiled by the SAC in General Surgery stipulating that the working week should have 3 Operative and 1 Procedural Session per week (4 operative where the specialty does not have a procedural session), 2 outpatient sessions, 1 research/audit session, 1 teaching session, 1 admin session, and 1 flexible session per week

It would appear that Training Committees and Postgraduate Deans are finding it hard to enforce educational requirements within the weekly working template that trainees are often presented with, and indeed have little knowledge of what the working week is for many of the posts that they govern.

Recommended streams of work to follow are considered in Boxes 4 and 5

Box 4: Issues for trainers

- Identify a model weekly rota template, which would be defined by the specialty.
- Rotas would be examined during the ARCP and RITA processes to ensure that the minimum educational component is being fulfilled.
- Rota changes would need to demonstrate how *each* trainee on the rota will obtain the minimum amount of experience stipulated by the specialty, with targeted training where necessary.
- Where the minimum educational requirements are not met, then there should be consideration of punitive action.

Box 5: Issues for trainees

- The trainee learning agreement should make the trainee aware of the number of sessions available to them and their responsibility to fulfil these criteria.
- The learning agreement should be a two way process of allowing the trainee to determine sessional commitments that they would need to fulfil, whilst also providing in-depth information of what sessions are available.
- Current lack of knowledge of structure of jobs, and poor rota design contribute to poor sessional figures.
- Reasons for the learning agreement not being fulfilled must be fully justified and explained by the trainee.

3.5.4 Education and Training Resource Analysis and Review

In recognising that there will be ‘down time’ within the working week, the provision of *useful* educational and training resources needs to be evaluated in order that all time spent within the workplace can be adequately utilised. Maximising the use of this time is imperative in ensuring that the impact of reduced hours and other limiting factors are lessened.

At present it would appear that there are insufficiently robust systems in place to inspect, evaluate, and insist upon education and training resource availability within provider organisations (trusts etc), and no specialty standard to which these are compared. Often standard educational resources are underutilised by trainees as they are not fit for purpose or needs.

Box 6:
The example in the North West of the development of Surgical Skills labs within theatre complexes in the North West is one model that may be of use to explore and translated to other specialties.

Specialties should determine the minimum provider-based (trust) educational and training resources that should be made available to trainees in that specialty. Some resources are already available though provision is variable and needs to be further enhanced, appropriately funded, and robustly monitored. Educational supervisors and trusts must work to ensure the most effective use of time within the working week using these resources.

The administration and effective utilisation of educational resources will require educational supervision, again strengthening the need and role of accredited trainers with job-planned time to supervise skills sessions at provider organisation (eg trust) level, and also the teaching and training time for more senior trainees to cascade teaching and learning to more junior trainees.

3.5.5 Accreditation and Recognition of Training Time

Raising the profile of and enthusiasm for training is essential both to encouraging participation and excellence in existing trainers, and in order to re-engage those who have become disenfranchised.

Local Education Providers (LEP) must acknowledge and emphasise the need for their medical staff to teach and train, ensuring that trainers and trainees have sufficient, accessible time in their job plans for training and educational leadership roles. **Recommendation M**

The MMC reforms require robust clinical and educational supervision to ensure that the curriculum and assessment frameworks are delivered and clearly documented. There are broadly four levels at which trainers will operate within a local education provider:

Active	Specific training activity (e.g. bedside teaching, observing practice with feedback, workbased assessment, exam practice, lecture/seminar); WPBA; time additional to scheduled clinical activities is required to allow formal training to take place alongside provision of care (as this often takes longer than the same activity where there is no training) e.g. training lists, training rounds, registrar clinics, etc.
Intrinsic	Use of clinical activity to provide observational training opportunity within provision of care (e.g. business ward round)
Trainee Administration	Supervisors reports, appraisal; 360, supervising audit/research, pastoral support especially if issues identified; other administrative work relating to individual trainees
Programme Organisation	Department/LEP oversight of and quality control of training programme; co-ordination of training opportunities; informing and supporting other trainers including multiprofessional team

Further work must be undertaken by the Department of Health with Deaneries, Royal Colleges, NACT, BMA & employers to provide guidance over the time and balance of duties required to properly undertake the various training, education and monitoring roles required. **Recommendation D**

Trainers must clearly understand their specific roles and responsibilities and may require additional training to help them “walk the talk”, teach at multiple levels dependent on learners’ needs, let trainee “have a go” within the context of patient safety, coach the struggling trainee, etc.

Further work should be undertaken by PMETB, Deaneries and employers regarding the training, accreditation and assessment/monitoring of trainers **Recommendation F** and the time required to properly undertake the various training roles. This will assist with monitoring trainer performance

3.5.6 Time to train

Dedicated time, dependent on role, must be clearly stated and reviewed within job plans both in timetables and objectives.

There should be clear connection between trainers’ responsibilities for educational governance and clinical directors’ requirements for ensuring clinical governance - particularly with the Care Quality Commission (CQC). As systems have changed a realistic reappraisal of the training and time required to undertake these different roles, particularly for educational supervisors and tutors, should be undertaken.

Other organisations which train trainees (for example in Public Health or Occupational Medicine) will have different contracts and governance arrangements, but even so there must be adequate time allowed in their working week for training as identified above.

Reviews of trainees’ progress have tended to be driven by the need to complete the requirements for annual Deanery assessments. This can mean that specific needs may be identified too late to be address in that post.

Planned regular time for discussion between a trainee and their named supervisor should be a minimum standard. Trainers should build regular progress reviews into both their job plan and their schedule.

Local Education Providers (LEP) must acknowledge and emphasise the need for their medical staff to teach and train, ensuring that trainers and trainees have sufficient, accessible time in their job plans for training and educational leadership roles. LEPs must consider the various types of teaching and training required in a doctor’s development including Education, training, and experience. **Recommendation M**

4 Measuring Standards of Training

PMETB sets standards for training, standards for deaneries, and also approves the curricula and assessment systems against specific national standards.

The Royal Colleges set out the requirements for trainees to achieve by the development of curricula and assessment systems for their specialties and sub specialties.

PMETB expects that deaneries and Royal Colleges will work together to manage the quality of training, and work with LEPs to control that quality. The mechanisms for assuring these requirements are met have evolved over time. Questions have been raised whether processes are sufficiently robust to fully manage an under-performing trainee. Further reassurance may be needed that new processes are able to assess “confidence” as a core competence (see above).

Current assessment methods encourage achievement of a minimum standard and do not act as an encouragement to trainees to go beyond this and achieve excellence. Colleges should explore means of recognising excellence in training and this could also be useful for prospective employers.

Standards for achievement of competences are set by the existence of curricula and assessment systems for trainees to achieve in order to move to the next stage of, or to complete, training.

There are a few objective measurements for provision and delivery of medical education and training but much of the work undertaken is presently qualitative. As commissioners of training and education invest considerable sums of public money in post-graduate training it is likely that they will, as they themselves come under increased scrutiny, wish to assure themselves that their investment represents good value for money and that the doctors are fit for purpose.

- What standards exist;
- How do they manage training;
- How can they be structured so that they manage training effectively

4.1.1 Levels of Monitoring

There are a number of structures for national (PMETB regulation and Royal College requirements and guidance) and/or regional standards and matrices (e.g. Deanery quality systems for educational governance; deanery SLAs with LEPs; learning delivery agreements between SHAs and LEPs). It is less clear at local or individual level. Clarity of which standards apply and at which levels, and ownership thereof is important to efficacy.

Any standards must fit “SMART” criteria (Specific, Measurable, Achievable, Reliable/Realistic, Tracked/Timed) if they are to be useful and if those that need to apply them are to take

ownership and collect information. There is a balance between measuring impressive concepts and data fields and measuring what can practically be measured.

Deaneries/SHAs should be proactive in assuring themselves of “value for money” for their investment in training; tools for this should be developed by SHAs with the Department of Health with a framework that ensures consistency with existing systems and data, and with proposed monitoring by the CQC. **Recommendation J**

A clear structure for standards and matrices needs to be developed and applied at different levels:

- National – mostly achieved in relation to threshold standards but needs to consolidate; need to develop recognition of excellence; accreditation of trainers is the next key development
- Regional – significant achievements but needs consistent implementation
- Local – yet to be achieved but work by NACT-UK
- Individual – yet to be achieved

4.1.2 Responsibilities

Responsibilities for standards should be clear at each level with specified roles and responsibilities for measurement, management, delivery & reporting.

The widest ownership of standards at a cultural and institutional level would be assured by making training quality measures part of the ratings system for the new Care Quality Commission.

The Department of Health should make the measurement of quality of training provided by Local Education Providers (LEPs) part of the remit of the Care Quality Commission **Recommendation A**

under both Quality of Care and Use of Resource. This would require the Department of Health to agree to this in principle whilst appropriate metrics were developed and piloted.

Responsibilities for day-to-day oversight and delivery will include the Trainee, trainers, educational supervisors, managers within local education providers (e.g. Trusts) as well as those organisations responsible for monitoring the performance of LEPs i.e. deaneries and SHAs. Whilst it is appropriate to delegate the day-to-day aspects of managing training it is important that oversight and responsibility rests with an individual with sufficient authority to instruct and effect change within an organisation.

SHA Chief Executives should have overall responsibility for ensuring that there are effective processes for monitoring and scrutinising the oversight and provision of training within LEPs, measured as part of their organisational objectives.

Postgraduate deans must have oversight and overall responsibility for monitoring and scrutinising LEPs and making changes where necessary.

In each LEP the Chief Executive must hold overall responsibility for ensuring a process for the management, monitoring, delivery and reporting of outcomes and standards of training.

Recommendation J

4.1.3 Standards for Measurements

Quality measures should be consistent and useful to trainees, trainers, employers and Deaneries/SHAs.

Quality data must be designed to be shared appropriately between and within the identified levels without causing un-necessary additional bureaucracy or “translation”.

The approach should also allow, for example, organisations to use data for internal purposes such as for appraisal or their own quality improvement systems, as well as for reporting to regulating or performance managing organisations.

Measurement matrices and standards information need to be further developed and should flow in a relevant and open form between all four identified levels. One example already in use is the annual PMETB, with COPMED, surveys of trainees and PMETB trainers – the results of which are available at all four levels

Box 7: Transferability of measures.

Supervision scores currently measured by PMETB are accepted by the National Health Service Litigation Authority (NHSLA)

Quality Assurance Outcomes currently measured by PMETB are accepted by the Healthcare Commission (HC) as being sufficiently robust and of a format to be useful for their ratings.

Outcomes from PMETB surveys are already published and accessible although they may need to be presented in a more user-friendly format.

Measures need to ascertain delivery in real terms and could include:

Organisations	Trainees	Trainers
Audit actual clinical opportunities <ul style="list-style-type: none"> e.g number of teaching clinics, ward rounds per unit, provider organisation or Trust 	Audit of ARCPs/RITAs Audit and analysis of Multisource Feedback (MSF) and other workplace based assessment (WPBA) Feedback forms from trainees <ul style="list-style-type: none"> specialty specific and deanery level PMETB/ CoPMeD Annual Trainee Survey	Audit of SPAs <ul style="list-style-type: none"> uses categories Feedback <ul style="list-style-type: none"> peer review DMEs Ongoing measurement essential Time allocated for training... and used Efficacy <ul style="list-style-type: none"> measures could include trainee feedback PMETB/ CoPMeD Annual Trainer Survey

Further work is needed to develop benchmarking standards that are consistent, useful for different organisations and purposes, and robust enough to be used as part of an organisation's overall performance rating. **Recommendation A**

Organisations that design standards for training, for example CQC, PMETB, DH, should take this recommendation forward developing metrics that can, wherever possible, be used by other regulators to measure achievement of quality targets .

Resources are needed to both initiate and sustain these quality measures at all four levels but particularly at local level. This is urgently needed to incentivise training in acute settings and to ensure educational and training resources are contemporary and fit for purpose.

5 Incentives to Deliver Quality Standards

Encouraging ownership of quality and standards at the several levels required will need drivers and incentives. These incentives should be targeted at:

- Deaneries/SHAs
- Commissioners of service (PCTs)
- Local Education Providers
- Training departments
- Individual trainers
- Trainees

5.1.1 Deaneries/SHAs

The setting, monitoring and maintenance of standards should already be core to the culture of these organisations. Maintaining these priorities will be essential as organisational structures and responsibilities change. Measuring success in these roles is essential to ensuring and supporting these roles.

Learning Delivery Agreements between SHAs/Deaneries and Local Education Providers must contain specific, measurable objectives for training quality (for example, planned regular time for discussion between a trainee and their named supervisor whether training opportunity matrices have been kept up to date, whether trainees are accessing teaching sessions, access to study leave, etcetera, developed in consultation with PMETB and other training system stakeholders). **Recommendation I**

Further work should be commissioned (for example from an economist) regarding specific incentives to maintain standards for monitoring organisations, aimed at all levels (SHA/Deanery, employer, individual trainers and trainees)

5.1.2 Commissioners of service

When new services are developed, or existing services redesigned, they must meet requirements and conditions, both fiscal and qualitative, set by the commissioners who are

funding it. Increasingly, existing services will come under such scrutiny to assess value for money, and compliance with standards and conditions of funding. If training and educational elements are not given sufficient consideration and due weighting by commissioners these elements risk being sidelined or diminished to reduce costs in order to compete in a market.

Education and training should be treated by the NHS as being part of the cost of care, rather than an externality as it is at present.

Ensuring that commissioning processes require providers to consider (and calculate the cost of) training and education obligations and that they have appropriate standards and measurements is both an incentive to existing providers to continue training and may assist in ensuring training is delivered where there is a multi-provider environment (where competition over costs might otherwise disadvantage service providers who choose or are required to provide training).

Commissioning organisations and those monitoring them will need processes to ensure that education is high on their agenda, with mechanisms for development and commissioning processes to include educational opportunity/options appraisal.

The DH must require that PCTs/commissioners of services ensure that the impact on training and education is factored into service reviews and built into business development/continuity plans by providers, and that appraisal of education opportunities forms part of all service level agreements [with clear triggers for review of services where necessary]. **Recommendation B**

Where funding for service follows patient flows, and as care-quality (and thus training) metrics become part of the Payment by Results structure, those elements of funding intended for education and training activities will need clear identification and tracking for audit.

Elements of funding for training and education should be acknowledged within funding arrangements with explicit tracking of use of funds for provision of training or education (e.g. post-disbursal ring-fencing with audit trailing).

Recommendation C calls for the DH to explore the option of a differential tariff for training cases. It is important to avoid introducing an incentive for commissioners of care to send patients to providers that do not train and are thus able to apply a lower tariff. This would be a disincentive for all parties to train doctors.

A way of avoiding this could be to ensure that the non-salary component of MADEL funding (presently disbursed to provider organisations to compensate for the additional costs of training - facilities, diminished patient throughput, etc) is instead routed to accompany revenue for completing cases used for training. This means that LEPs investing in training will attract this additional funding and commissioners of care will not be “out of pocket”. The extra funding must offset entirely the additional cost of training.

The review of funding for postgraduate medical education must include examination of incentives and perverse incentives, and the best pathway for funds to flow to optimise this.

5.1.3 Employers

Recruitment and retention of the best consultants is likely to be enhanced by ensuring that training and education are core, supported objectives.

Employers do gain both credibility and expertise from providing high quality training and having high quality trainees. Employers will also wish to get value for any investment they put in and should engage actively in recruitment processes.

As part of staff development, LEPs should be mindful of the need for their employees to be able to train others – e.g. through provision of Training for Trainers courses.

These positive incentives are complemented by sanctions for poorly performing organisations such as removal of training status where an organisation is not providing sufficient support for training departments, or collecting and acting on quality / monitoring data. Trainees may also, if given more influence over where they are attached for training, influence this process.

SHAs and deaneries must consider mechanisms to give trainees greater influence over the location of their training based on evidence of quality of training as well as their training requirements. **Recommendation K**

The cost/benefit of having trainees is not clear under current funding arrangements with training at F1 level a significant cost to an organisation. In a market system it may be necessary for commissioners of training to insist on provision of F1 training by organisations as a “loss leader” for having other levels of trainee, or to adjust the funding arrangements for such trainees appropriately.

The DH review of funding mechanisms for postgraduate medical training must consider mechanisms specifically designed to incentivise high quality training provision. Captured within this should be provision for placements where trainees’ contributions to service provision is necessarily limited (e.g. F1). **Recommendation C**

5.1.4 Training departments (including GP Practices and non-NHS organisations)

Provision of training and education should be supported and co-ordinated at a specialty departmental level by a named trainer(s) who should have input into departmental clinical management systems, being influential but remaining independent (noting that their role to ensure and manage quality training may create tensions with management structures).

Recognition, reward and support for the role of the clinical tutor/DME, responsible for programme organisation and oversight of local delivery.

Training departments should have systems to monitor standards of training and to offer support, and if necessary remove trainees, where standards are poor.

Training departments must provide the required learning opportunities appropriate to the curriculum.

Sufficient time and resource should be provided for those co-ordinating and delivering training to undertake their roles, through job planning and other processes.

Positive incentives may include departmental/team training accreditation or “kite-marking”.

5.1.5 Individual Trainers

Positive incentives are more likely to have impact than negative sanctions. Whilst these may be useful they may not engage all trainers, and there needs to be suitable incentives and drivers to embrace the training culture.

- Recognition of time, and hence funding of time, for training - robustly evaluated and enforced.
- The time taken to deliver training within procedural sessions should be reflected with providers’ operational planning.

Box 8: Positive Incentives

Training excellence awards for individual trainers may be promoted locally to encourage and develop high quality and innovation in training.

Whilst encouraging and rewarding good practice and innovation, systems must build in measures to identify and remedy poor quality training and trainers so that interventions can be made to improve quality or, if necessary, remove training from their role.

- Evidence on quality to support annual appraisal, revalidation & CEAs
- Job planning and objectives
- Positive development and investment (e.g. Expert Trainer)
- Regular accredited trainer education
- Departmental monitoring of quality performance
- Awards/prizes (trainer of the year; local/regional/specialty etc)
- Time for training and relevant administration, as described above
- A full understanding of the curriculum, its requirements, and what constitute good opportunities to provide education and training will make trainers feel more positive about their role
- Properly-structured and -resourced teaching and training sessions are often rewarding in themselves; without the stress of trying to squeeze it into tight budgets and busy days, many doctors very much enjoy teaching.

Box 9: Lessons from General Practice

- In General Practice, there are regular training practice reaccrreditation meetings so that trainers are assessed and kept up to date.
- GPs are sometimes given an entire session purely for training (e.g. seeing a series of patients with the trainee, which is slowed by all the educational discussions, but this is allowed for)
- Regular GP trainer workshops locally with a supportive network
- There are annual deanery led GP trainers' meetings that allow input into the system (generating more of a sense of ownership).

Many of the above incentives appear elsewhere either explicitly or as consequences of other recommendations.

The local Clinical Excellence Awards (CEA) panels should include the Director of Medical Education/Clinical Tutor or a deputy wherever possible, to balance the scales and give more prominence to training within consideration of CEAs.

5.1.6 Individual Trainees

Training might be considered to be an incentive in itself, as it leads to career progression. However, the longterm goal is often not seen because trainees cannot raise their gaze to see beyond the end of the current post.

Careers guidance to help them plan where they're going with their careers (not just choosing a specialty), and having a defined life goal makes it easier to have a sense of heading somewhere, rather than drifting through.

Careers guidance that addresses not just choice of specialty but ongoing career development plans and goals should be made available to all trainees on a recurrent basis.

Having regular educational review meetings (e.g. monthly as suggested earlier) makes life easier as the job becomes more about training towards a goal and not just providing service; it also means that training/teaching will be more focussed as the trainee will more often remember to maximise their use of the training opportunity in front of them.

Inclusion of trainees in management meetings (as happens in GP) gives trainees more insight into the system; having an understanding of the context of service can give a fresh perspective on what can otherwise be a daily grind, following a plan without always knowing the bigger picture.

Trainees should be included in departmental and hospital management meetings wherever possible.

6 Conclusions & Next Steps

The task and finish group was firmly of the view that high quality education and training should be treated by the NHS as being part of the cost of care, essential to organisations, individuals, the medical profession and the population.

Developing positive ways to encourage quality and innovation is important, as well as ensuring that there are sufficient positive drivers and incentives for education and training to be part of the core objectives within all NHS organisations. Such positive approaches must be backed up by robust monitoring, allowing intervention and remedy where standards are insufficiently high.

This report suggests a number of steps to change; no one single intervention will, alone, solve the problems facing post-graduate medical education and training. Many of the recommendations are inter-dependent. Further work has been recommended in a number of areas, and the Programme Board is invited to look at ways of taking this forwards

The next steps for these recommendations will depend on a number of organisations, as identified in the Summary of Key Recommendations. The Group recommends that the recommendations are revisited in a year's time and that oversight for progress resides with NHS: MEE