The Shape of Training Report
Response of the British Orthopaedic Association (Provisional)

The Independent review of the commissioning, delivery and regulation of medical education, led by Professor David Greenaway, published its final report in October 2013. The British Orthopaedic Association (BOA) has already contributed to a response to this report by the Federation of Surgical Specialty Associations (FSSA), published in March 2014, which describes the outcome of a meeting of representatives of the surgical specialty associations at which the potential impact of this report on surgical training in general was considered. This document develops that response further, by taking an overview of the current status of training in Trauma and Orthopaedic (T&O) Surgery and the implications on this of Professor Greenaway's recommendations.

The Shape of Training report made 19 recommendations in relation to five themed areas. The Education Board of the BOA reviewed these in turn and the Boards responses will be presented in relation to these 19 recommendations. The themed areas are:

Theme 1 - Patient needs must drive how we train doctors in the future
Theme 2 - Changing the balance between generalists and specialists
Theme 3 - A broader approach to postgraduate training
Theme 4 - Tension between service and training
Theme 5 - More flexibility in training

In the commentary that follows, numbers in brackets refer to the 19 recommendations set out in the Shape of Training report.

(1) *Appropriate organisations must make sure postgraduate medical education and training enhances its response to changing demographics and patient needs*

It is agreed that appropriate organisations should ensure that training enhances its responsiveness to changing demographics and patient needs. Trauma and Orthopaedics has historically suffered undersupply of fully trained individuals from training programmes and organisations have recruited from overseas to maintain the consultant workforce. Trainees have responded to the job market in their selection of specialty training to supplement the general training in both trauma and general orthopaedic surgery that the programmes provide. This has never resulted in an oversupply in any subspecialist area, suggesting that whilst supply meets, or falls short of, demand the job market ensures that specialist training occurs in a balanced manner to meet the needs of employers and the public.

(2) *Appropriate organisations should identify more ways of involving patients in educating and training doctors*

The BOA is keen to work with appropriate organisations to ensure that sufficient generally trained individuals are put through our programmes to meet the needs of an increasingly elderly population, and that their disabling musculoskeletal problems can be minimised.

The need to embrace patient opinion is fully supported, and the BOA already encourages patient representation at all levels, up to meetings of its Council. The BOA fully supports initiatives to ensure that patient representation is also better informed, to ensure the needs of the patient population are properly represented.

(3) *Appropriate organisations must provide clear advice to potential and current medical students about what they should expect from a medical career*

Provision of appropriate advice to undergraduates is a recommendation of Professor Greenaway and this is an initiative that the BOA is already developing. Whilst it is accepted that the advice given to undergraduates should be realistic, and that they should be fully aware of the likely state of the future job market, the BOA will remain committed to encouraging the highest quality candidates to apply for training in our specialty. Whilst the report focuses on the need to ensure that individuals are developed with a broad, general training, the BOA believes that training in T&O already fulfills this criterion and our present focus, driven by the urgent needs of the population, is to encourage specialist training in less popular specialty areas such as spinal surgery and major trauma. We are committed to helping shape the future workforce to match the healthcare needs of the population.

(4) *Medical schools along with other relevant organisations must make sure medical graduates at the point of registration are capable of working safely in a clinical role suitable to their competence level and have experience of and insight into patient needs*

It is agreed that medical schools should produce graduates capable of working safely in clinical roles suitable to their competence level with insight into patient needs. However, the BOA is also anxious that exposure to surgical specialties in the undergraduate curriculum has diminished in past decades. Sufficient profile has to be retained to ensure that undergraduates are fully aware of the burden of musculoskeletal disease in the population, the disease trends driven by population demographics and the appropriate care of this disease in primary care and specialist settings. Without this profile, there is a risk that recruitment into the specialty will suffer and population needs will remain unmet in the future – T&O already has the greatest burden of surgical patients on waiting lists for treatment.

(5) *Full Registration should move to the point of graduation from medical school, subject to the necessary legislation being approved by Parliament and educational, legal and regulatory measures are in place to assure patients and employers that they are fit to practise*

The issue of moving the point of registration to graduation is a complex one that will have its greatest impact well before trainees have the option to select T&O training.

(6) *Appropriate organisations must introduce a generic capabilities framework for curricula for postgraduate training based on Good Medical Practice that covers, for example, communication, leadership, quality improvement and safety*

With regard to the recommendations on generic framework for curricula, the BOA believes that its specialty curriculum, building on the core surgical curriculum, already meets the requirements indicated by this recommendation. The BOA remains committed to continuous review of its curriculum, based on Good Medical Practice and informed by patient needs.

(7) *Appropriate organisations must introduce processes including assessments that allow doctors to progress at an appropriate pace through training within the overall timeframe of the training programme*

The BOA developed a competency-based curriculum, originally conceived to allow individuals to progress at an appropriate pace which could, theoretically, result in the training journey differing between individuals. However, the implementation of this has been shaped by local requirements to result in a programme of fixed length with individuals streaming through this at different rates, with the use of targeted training where appropriate. The BOA feels that the recommendations of the Greenaway report need clarification, as the concept of allowing trainees to progress at different rates yet remain within a programme of fixed length seems conflicting.

(8) *Appropriate organisations including employers must introduce longer placements for doctors in training to work in teams and with supervisors including putting in place apprenticeship based arrangements*

The recommendation of a return to apprentice-type training is welcomed, though the specialty has never truly abandoned this principle. T&O, as a craft specialty, has long been concerned about the erosion of the relationship between training teams and their trainees. The recommendation of competency-based progression is a snug fit with the T&O curriculum as it stands, and secures the direction of its future development. It is agreed that experience in addition to the acquisition of competence should be a focus of training programmes and the BOA already supports the continuation of apprentice-style training beyond the award of a CCT, through its accredited fellowships and recommendations on mentorship.

(9) *Training should be limited to places that provide high quality training and supervision, approved and quality assured by the GMC*

It is agreed that training should be limited to places that provide high quality training and supervision, quality assured by the GMC. Equally important is the involvement of suitably motivated and qualified trainers, who meet accepted quality standards and who are provided with adequate resources to fulfil their role. Experience of training programmes across Europe suggests that consistency is best achieved by national oversight of the general and specialist elements of training within T&O. For this reason the BOA cautions against moving workforce planning, oversight and delivery to *too* local a level.

(10) *Postgraduate training must be structured within broad specialty areas based on patient care themes and defined by common clinical objectives*

It is agreed that training programmes should deliver broad general training – the objective of the T&O curriculum is to produce consultants capable of dealing not only with the broad range of elective problems that can be referred in from the community, triaging more complex and specialist cases as necessary, but also dealing with the full range of musculoskeletal trauma that can present to any Emergency Department. The BOA is committed to maintaining this generalist training whilst recognizing that the population needs specialist care to deliver the highest quality results and this too needs national coordination, as not all localities are capable of providing training across the spectrum of specialist areas of T&O. It is agreed that not all consultants and not all units will be capable of training – training should be focused where it is best provided by trainers who meet

quality standards and are provided with the resources needed to provide training. Other consultants and units may have a different focus – on service or research for example.

Foundation training should be broad yet should also allow graduates to make informed choices of career thereafter. Exposure to T&O in foundation years may be in the context of general medical supervision and care, as service roles have limited training benefit, but there is a danger that omission of specialty exposure through medical school and foundation training will distort the quality profile of those choosing to enter specialist training in the future.

Tiering of the consultant grade is not seen as beneficial. If a consultant has a general practice and large service workload he or she will chose to refer more complex or specialist cases to a consultant who has trained or credentialed in a narrower field of practice (as dictated buy population needs). This latter consultant will have divested areas of practice or ceased competency and experience development across a range of practice therefore the two consultants will be differently prepared, with different competencies, but one will not be superior to the other.

(11) *Appropriate organisations working with employers must review the content of postgraduate curricula, how doctors are assessed and how they progress through training to make sure the postgraduate training structure is fit to deliver broader specialty training that includes generic capabilities, transferable competencies and more patient and employer involvement*

It is agreed that patients and employers should contribute to the development, delivery and assessment of training programmes. Training of the workforce should be responsive to the needs of the job market at a local level. However, the BOA cautions that the lead time for producing trained individuals, and the fickle nature of local employment and commissioning, means that the only sensible way of overseeing the shape of training in T&O is through national oversight.

(12) *All doctors must be able to manage acutely ill patients with multiple co-morbidities within their broad specialty training and most doctors will continue to maintain these skills in their future careers*

The BOA fully supports the notion that training should be broadly based and that all doctors should retain the emergency care skills acquired during training. Indeed, the majority of T&O surgeons in the UK remain in charge of on-call teams managing the general intake of emergency orthopaedic patients and musculoskeletal trauma. However there is also compelling evidence that surgical outcomes and patient safety are optimized when care is more specialized. Therefore the recommendation to maintain a workforce in which every doctor retains a very wide skill base contradicts the conditions needed to provide the safest environment with the best outcomes. In T&O the BOA feels that 'general' skills should refer to the breadth of traumatic and orthopaedic subspecialty competencies developed through our curriculum that allow safe care of all patients with appropriate referral to networked specialty care. It is not envisaged that it is possible to retain competencies across all surgical specialties, let alone across all of medicine, therefore team care of patients in the hospital setting will be the norm for most T&O patients.

(13) *Appropriate organisations including employers must consider how training arrangements will be coordinated to meet local needs while maintaining UK-wide standards*

The recommendation that training arrangements should be coordinated to meet local needs whilst maintaining UK wide standards, is fully supported. However the breadth of T&O and its pace of

development mean that there is no true end-point to training. It is a lifelong process and whilst employers and patients should dictate the requirements, only national oversight can ensure that standards across the full range of general and subspecialty care is reviewed and maintained. The concept of retraining should be applied with great care in the craft specialties. Whilst many skills are transferrable across subspecialty areas the lead time to develop competence and experience is such that even changes in subspecialty areas of practice may have implications for patient safety. It has been shown, for example, that if T&O surgeons are simply made to use a different joint replacement implant to the one they normally use, the rate of complications increases suddenly and patient outcomes deteriorate. The concept of Continuing Professional Development (CPD) should be developed to support additional training for surgeons at the local level to develop their own skills to meet changing needs to the population within the specialty area.

(14) *Appropriate organisations, including postgraduate research and funding bodies must support a flexible approach to clinical academic training*

A flexible approach to clinical academic training is fully supported

(15) *Appropriate organisations including employers must structure CPD within a professional framework to meet patient and service needs, including mechanisms for all doctors to have access, opportunity and time to carry out the CPD agreed through job planning and appraisal*

Appropriate CPD is seen as the ideal mechanism for preparing the local workforce to deal with changing needs of the population. It is also a term that the patient population will understand, whilst reference to 'retraining' may have negative connotations.

(16) *Relevant organisations including employers should develop credentialed programmes for some specialty and all subspecialty training, which will be approved, regulated and quality assured by the GMC*

It is agreed that specialty training should meet national standards, overseen by the GMC. These standards are best set and reviewed at national level when the number of practitioners of a specialty in any employing organization is actually quite small, as it is in T&O surgery. The BOA is ideally positioned to set standards in subspecialty training, for approval by the GMC, and to work with the GMC to ensure that these standards are met.

(17) *Appropriate organisations should review barriers faced by doctors outside of training who want to enter a formal training programme or access credentialed programmes*

It is agreed that doctors who wish to train in a particular programme are supported in their efforts. The BOA, as an appropriate organization, will encourage doctors from all backgrounds to consider training in the specialty, and will support initiatives that develop their careers, in order to encourage the best quality candidates into T&O training programs, to best meet population needs.

(18) *Appropriate organisations should put in place broad based specialty training (described in the model)*

It is agreed that broad based training should be put in place – the BOA believes that in T&O this is already delivered.

(19) *There should be immediate consideration to set up a UK-wide Delivery Group to take forward the recommendations in this report and to identify which organisations should lead on specific actions*

The BOA is very keen to contribute to a delivery group for this report. The content and delivery of T&O training has changed continuously and will continue to change. It is agreed that service reconfiguration is inevitable and the BOA is extremely keen that training in the specialty does not suffer and that population needs are met. The BOA is an appropriate organization to shape training in T&O surgery to meet the needs of patients and employers in the future.

BOA Education Board, July 2014