Integrated Academic Training and Internal Medicine Training: Strategic and Logistic Issues - Guidance document

January 2020

Background

Stage 1 of the Joint Royal Colleges of Physicians Training Board (JRCPTB) designed Internal Medicine Training (IMT) programme was implemented in August 2019. This is an indicative three-year programme designed to better prepare doctors to become the medical registrar. Holistic decisions on progress will be made for the fourteen high level capabilities in practice (CiPs) using the professional judgement of appropriately trained, expert assessors.[1]

There are many recognised benefits and strengths of the new IMT programme, including a more generalist approach to training which better serves patient needs, particularly with respect to the ageing population with more comorbidities, complexity and a greater need for continuity of care and better care in the community. This is in line with the Shape of Training proposal.[2] In addition, the new IMT curriculum is based on the higher-level learning outcomes and incorporates the General Medical Council (GMC) defined Generic Professional Capabilities (GPCs).[3]

It is recognised that doctors in the integrated academic training (IAT) pathways need a training structure that is flexible enough to allow them to move in and out of clinical training while meeting the competencies and standards of that training.[2]

Since the implementation of IMT Stage 1 training in August 2019, there have been growing concerns that the new curriculum may not allow sufficient flexibility for academic trainees and conversely programmes may be developed that do not allow adequate clinical exposure for these trainees. In either case, this would be highly unsatisfactory for academic trainees. Therefore, a second meeting was held in Cambridge on the 19th December 2019 to provide resolution and guidance. Various stakeholders were represented including senior members from the GMC, JRCPTB, National Institute of Health Research (NIHR), Academy of Medical Sciences (AMS), Health Education England (HEE), NHS Education Scotland, Health Education and Improvement Wales, Conference of Postgraduate Medical Deans (COPMed) and academic trainees. The meeting discussed some of the strategic and logistic challenges now faced by academic trainees. It was agreed this is a four-nation issue. It was also agreed that the main output from this meeting should be a principles and guidance document summarising key themes from the discussions.

The trainees present at the meeting highlighted potential difficulties meeting the clinical training requirements, uncertainty about the rules, conflicting advice, difficulties getting leave to go to conferences, and timelines for applications to major funding bodies that were out of synch with the new clinical training model.

This report is divided into Stage 1 (years 1-3 IMT) and Stage 2 IMT for higher specialty training. It accepts the different models of IAT in each of the devolved nations of the United Kingdom.

Strategic and Logistic Issues of IMT and Integrated Academic Training

The key strategic and logistic issues of IMT and their impact on the IAT Programme discussed at the meeting are summarised in Figure 1.

Figure 1. Key Strategic and Logistic Issues of IMT and Integrated Academic Training

Strategic Issues	Logistic Issues
•Dual training in IM for all trainees. •Implications to duration of training. •Competency and outcome based training versus time based training. •Flexibility agenda. •Implications for less than full time trainees (LTFT). •SuppoRTT - supported return to training programme. •Potential funding issues. •Existing academic trainees and implications of changing to new curriculum in 2021-2022. •Managing transitions of training. •Timing of out of programme for research (OOPR).	•Programme management - placements; duration; timing. •Fit around new IMT curriculum requirements. •Organisational and funding issues eg. on call. •Slot sharing options. •Supernumerary posts with over-recruitment of academic posts to manage gaps. •Optimising clinical and academic supervision. •Providing structured mentoring and support for academic trainees. •Planning and support for combined (academic and clinical) ARCP panels

Guidance for Academic Training

IMT Stage 1: Years 1-3

The 3 main themes were around:

1) Structure of the programme and management
2) Deliverability and flexibility of programme
3) Supervision and support

IMT Stage 1 strongly recommends indicative targets including: a 4-month placement in geriatrics, 3 months experience in critical care medicine (over 3 years), attendance at 80 clinics over 3 years and evidence of being actively involved in at least 100 patients presenting with acute medical problems per year with a minimum of 500 patients in total by end of IMT year 3. It is acknowledged forward planning, organisation of placements and timing are key to ensure that all the necessary capabilities can be obtained during the indicative timeframe, acknowledging that academic clinical fellows have only 75% of the clinical training time compared with their non-academic counterparts. Getting year 1 "right" was acknowledged as being essential to continued success, as was having detailed discussions between the academic trainee and their appropriately trained educational supervisor early in IMT year 2, particularly acknowledging the crucial clinical ARCP decision point at the end of year 2.

It is recognised that there should be flexibility around the programme such that academic trainees are able to achieve both their academic and clinical capabilities. Generally, it is felt that the critical care component of IMT should not be modified and that reduction of other clinical elements of the programme should be proportionate so that the trainees will still have adequate experience in order to display the necessary capabilities. It is acknowledged that the GPC framework will allow some of the generic capabilities to be also acquired during the academic component.[3] Clinical academic training must be personalised, planned and integrated across both clinical and academic areas. The need for individualised bespoke academic training pathways should be the norm with sufficient

protected time for research and flexible deliverability of this within programmes should be facilitated through early discussions between the supervisors, academic leads and training programme directors (TPDs). The clinical component of training must remain competency based rather than time-based and must be managed appropriately subject to the usual governance, quality management processes.

It remains an expectation that both IMT and IAT elements can be delivered within an indicative three-year envelope, and programmes should be planned on this basis. Elongated programmes should not routinely be offered at the outset, but with extensions to clinical training available if necessary, in line with Gold Guide recommendations.

High quality appropriately trained supervision and support of trainees is recognised as essential for success of the programme. This will require faculty development of trainers, with specific training to supervise academic trainees, enabling a clear understanding of the clinical and academic training requirements. There should be effective communication between the trainee, clinical supervisors, academic leads and TPDs. Well organised clinical and academic inductions at the beginning of the year are essential. Where appropriate trainees must have access to appropriate programmes of research and management skills training.

Trainees must be provided with clear expectations on performance at the outset. Early meetings between the trainee and their academic supervisors and clinical supervisors to set a personal development plan (PDP) with clear goals and SMART objectives for the year both for their academic and clinical needs is strongly recommended. Mechanisms should be in place for early identification of trainees requiring additional support and this should be facilitated with appropriate targeted interventions. There should be a timely pre-ARCP meeting to go through any specific training needs to promote standard ARCP outcomes.[4] Educator development should include training in improving quality of educational supervisor reports for both clinical and academic components. Mentoring, both from clinical academics and peers is recognised as being hugely valuable in supporting trainees to achieve their potential and this should be provided in a structured way.[5] Trainees should also be offered careers advice and support particularly at transition points.

Figure 2. Academic Training and IMT Stage 1 – Guidance

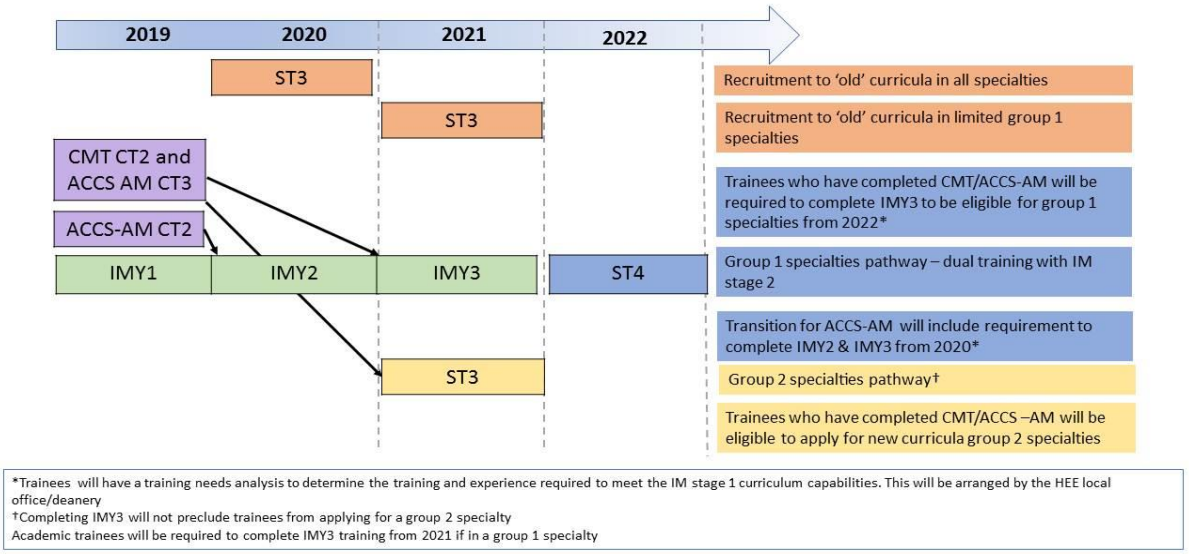
Structure of programme and management	•Trainees to spend 25% of training time in academic placements (9 months over 3 years). •Academic induction to occur during first month of the academic placement. •Faculty development of supervisors to specifically support academic trainees. •Mechanisms in place to identify trainees requiring additional support with regular monitoring of trainee's academic and clinical progress. •Well planned integrated academic training that is protected and coordinated with clinical training to achieve clinical and academic capabilities.
Deliverability and Flexibility of programme	•Provision of flexiblity of placements based on clinical and academic training needs. •Early meetings and discussion with educational supervisors (ES) and training programme director (TPD) to plan individualised bespoke training programme. •Emphasis on competency based indicative training time versus actual time based. •Flexibilty and adaptability of programme around LTFT requirements.
Supervision and support	•Each trainee to have one named ES for clinical training and one ES for academic training for a minimum of 12 months, who has been selected, trained and assessed as per national guidance with specific training to supervise academic trainees. •Best practice: meeting in first month with clinical and academic ES to set clear targets, goals, SMART objectives for the year. •Formal interim pre-ARCP review meeting involving TPD and clinical and academic training leads to ensure satisfactory progress being made and provide support for any specific training needs. •Provision of mentoring support from both trainers and peers. •Provision of careers advice/support particularly at transition points.

Stage 2 IMT and Higher Specialty Training

Trainees must complete IMT Stage 1 and acquire the full MRCP(UK) Diploma in order to enter specialty training at ST4 in group 1 specialties from 2022. Group 2 specialties will recruit trainees who have satisfactorily completed two years of IMT and passed MRCP(UK) into ST3 level.[1]

The pathway into specialty training could potentially be from many different routes with different entry and transition points. This is summarised in Figure 3. From 2021, academic trainees in Group 1 specialties will be required to complete IM year 3 training.

Figure 3: Recruitment into IMT and Transitions



Academic trainees in group 1 specialties will dual train in IM stage 2 and obtain a dual certificate of completion (CCT) in IM and in their chosen specialty at the end of their training. Academic trainees in group 2 specialties will not be required to do IM year 3 and will obtain a single CCT in their chosen specialty.

The principles and themes from Stage 1 IMT apply equally into Stage 2 IMT and specialty training for the programme management, provision of flexibility and high-quality supervision and support. The clinical component of training should again remain competency-based rather than time-based

In addition, it is important to recognise the different requirements of each specialty and the timing of the academic components. Some trainees may still be in their academic clinical fellow (ACF) post during IMT stage 2 and specialty training and these trainees will be planning for their MD/PhD projects and securing funding as well as considering the timing of the out of programme for research (OOPR) application. Some trainees may be planning to apply for an academic clinical lecturer (ACL) post or be in an ACL post with 50% protected academic time. Each will have differing academic and clinical requirements for each stage of training.

Trainees may also potentially have different timescales for completion of their PhD and out of programme experience and this maybe during IMT stage 1, stage 2 or in between. Therefore, a degree of flexibility for all these trainees will need to be maintained and accommodated within the training programme.

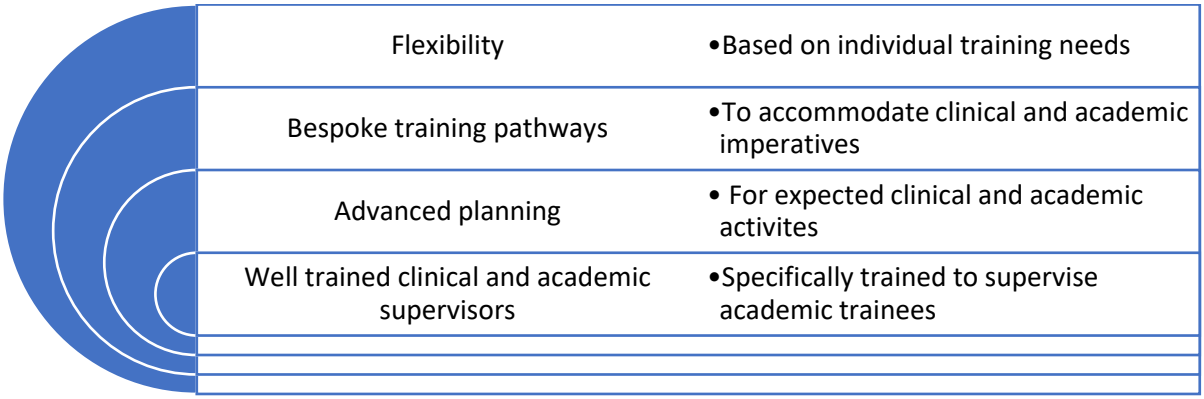
Support should be provided to trainees returning to clinical training after a period of time out of programme for research (OOPR). The HEE SuppoRTT guidance should be utilised for these trainees.[6]

The GMC GPC structure allows for some transferability of capabilities between academic and clinical components such that some capabilities gained during academic training can be recognised for clinical training as well. There needs to be a focus on the indicative training time rather than actual time particularly for the academic trainees.

Academic training pathways should be promoted and valued as there is clearly a need for training of clinical academics.[5] It is the responsibility of all to ensure the success of academic training.

In summary, the success of integrated academic training will be enhanced by close working of the clinical and academic leads and educational supervisors with the trainee to ensure a bespoke academic training pathway is created and supported with flexibility based on the individual training needs. Faculty development of supervisors providing high quality supervision for academic trainees with mentoring and career support particularly at transition points will ensure continuing success.

Figure 4. Key recommendations for success of clinical academic training in IMT



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