The Impact and Value of the Introduction of Stand Alone Core Medical Training Days at County Durham and Darlington Foundation Trust.

S. Y. Lim, N. Kumar
University Hospital of North Durham
namita.kumar@cddft.nhs.uk

Introduction

Modernising Medical Careers (MMC) was introduced in 2005 with the aim of ensuring a transparent and efficient career path for doctors[1]. It also effectively replaced the Calman Training programme for higher specialist training. The Foundation Programme was introduced in 2005 and recruitment to Specialty Training (ST) began in 2007. Initially, the ST programmes devised by MMC were run-through training, a structure within which the curricula approved by PMETB could be delivered in a seamless and educationally coherent manner.

Core Medical Training (CMT) was introduced in 2008 as the first stage of training if one wishes to follow a career in a medical specialty. CMT programmes are designed to deliver core training in general internal medicine by acquisition of knowledge and skills as assessed by the workplace-based assessments (WPBA) and the MRCP(UK). Programmes are usually for two years and are broad-based consisting of four to six placements in medical specialties[2]. Trainees at the end of CT2 have to apply competitively to entry into higher specialist training at ST3 level upon satisfactory progress through assessments in the two year core training.

In response to the then PMETB (now GMC) standards of training[3] and the feedback from CMT trainees that every other 'type' of trainee had stand alone teaching and they did not, the divisional medical tutor (NK) set up stand alone monthly training days which were made mandatory. The days provided topic-based teaching mapped to the curriculum in general internal medicine. It would be fair to state that the move within general medicine from traditional teaching methods to days such as this caused some anxiety from physician colleagues. The teaching days take time to organise, colleagues' time to teach and considerable administrative resource. We therefore evaluated the CMT training days and how they have benefited the pioneer group of CMT trainees at CDDFT.

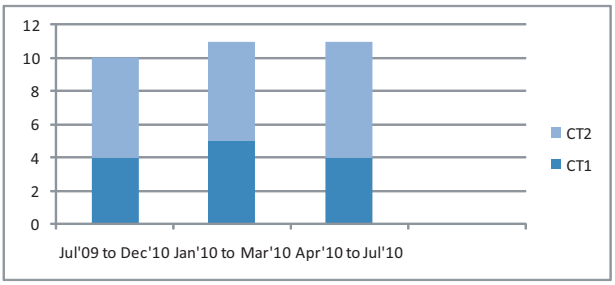
Method

From August 2009 to July 2010 (one academic year), CMT training days were held at a monthly basis in the three hospitals across the trust - the University Hospital of North Durham (UHND), Darlington Memorial Hospital (DMH) and Bishop Auckland General Hospital (BAGH). The attendance for the training days was mandatory and it was counted as absence if the trainee did not attend without sending apologies beforehand. Each session incorporated four consultant-led clinical topics, trainee-led case presentation and journal clubs. Each trainee who attended the training day was asked to complete a standardized evaluation form. The areas evaluated included the venue, organization and quality of the taught topics. The quality of taught topics was scored by presentation, teaching method used and relevance to training needs. The scoring scales given were: 1. Poor, 2. Adequate, 3. Good, 4. Excellent.

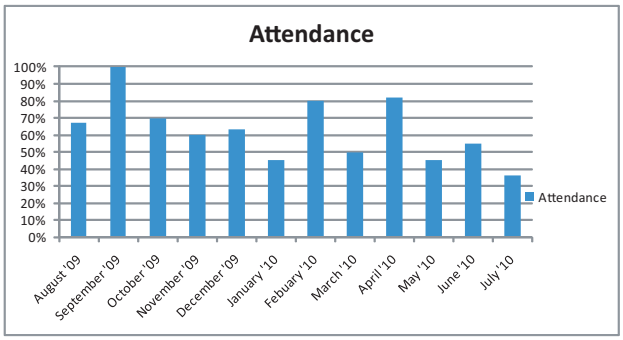
On the last training day in July 2009 the trainees who attended the session were asked to fill in a questionnaire to assess the stage of their MRCP examination. The CT2 trainees were also asked if they successfully progressed to ST3 in the specialty and region that they wanted. A further email questionnaire was sent to obtain a high response rate.

Results

Throughout the 12 months from August 2009 to July 2010 the numbers of CMT trainees in County Durham and Darlington varied slightly due to the movements of some trainees in and out of the Trust during their four monthly rotations. The average number of trainees was 11. One CT2 trainee left the post in January 2010.



There were 12 training days during the set period. The attendance was very variable. It ranged from 36% to 100%.



Generally the trainees rated the clinical sessions highly. The mean score was 3.70 out of 4. Interestingly there was little difference in the scores between the trainee-led sessions and those delivered by senior colleagues.

Table 1: *Mean score of sessions on evaluations*

	Score/4
Venue	3.15
Organisation	3.25
Clinical Topics	3.70
Case Presentations	3.72
Journal Clubs	3.32

Table 2: Topic Covered

Topic	Number of Sessions
Neurology & Stroke	11
Gastroenterology & Hepatology	9
Miscellaneous	7
Rheumatology	4
Respiratory	4
Cardiology	4
Infectious Disease	3
Communication/ Management	3
Genitourinary Medicine	1
Diabetes & Endocrine	1
Haematology	1
Dermatology	1

We used MRCP examination results as a hard measure as an outcome of CMT training at CDDFT. A total of nine CT2 trainees had been at CDDFT for at least 4 months during the study period. One trainee dropped out of the CMT programme and was excluded. Out of six trainees (75% response rate) who responded to the questionnaire, five trainees obtained full MRCP at the end of the training programme. One trainee changed the specialty at the end of the training. Five trainees advanced to ST3 level and all but one got the first choice of the specialties they wished to train in. Of the CT1 trainees, one doctor obtained MRCP during the study period.

Discussion and Conclusions

GMC standards dictate that we must ensure that we cover the curriculum as set by the Royal Colleges. Therefore traditional apprenticeship models of ward rounds and interest and availability-led lunchtime sessions will not deliver this alone. The trainees valued the sessions highly and enjoyed the sessions they

led also. This is important not only in terms of professional responsibility to life-long learning but resource, the skills learnt by the trainees whilst doing this and the commitment to learner centred life-long learning.

In terms of a hard outcome measure 83% of our CMT trainees obtained their MRCP and a similar proportion continued to the higher specialist training of their choice. This further supports the continuation of the scheme. But the time for colleagues and administrative staff is considerable and the impact of work intensity and the European working time regulation on the trainees should not be underestimated. In particular the closure of acute medical work at BAGH has impacted negatively on CDDFT and this has been borne out by the GMC survey in 2010.

With regards to the considerable clinician time required this *must* be acknowledged by trust management in the job planning process if we are to remain a trust that has junior doctors. Very few, if any trusts have collated and published data such as this within the region and this is an achievement that CDDFT should be proud of. It may even encourage more trainees to work here, despite the work intensity.

The CMT training days have raised our profile as we were one of the first in the deanery to do this. We can ensure we meet curriculum needs and the sessions are valued by the trainees. We also need to acknowledge that work intensity makes traditional learning methods less accessible. Therefore CMT training days should be continued and we wish the new divisional tutor in medicine every success for the future of the programme.

Acknowledgements

Elaine Newman for her persistence, patience and time in organizing these days.

References

1. Modernising Medical Careers (www.mmc.nhs.uk)
2. Joint Royal Colleges of Physicians Training Board **www.Jrcptb.org.uk**
3. **http://www.gmc-uk.org/Genericstandards_for_training.pdf_31300567.pdf/accessed** 26th January 2011