GUM postgraduate specialty training from 2016 onwards

BASHH Spring Conference Oxford 2016
Doctors in Training session

9 July 2016

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GUM SAC chair
Objectives

• To articulate issues affecting GUM as a specialty and to consider implications for training now and in the future

• To provide accountability and address concerns

• To update on planned changes to GUM curriculum in 2016

• To deliver latest information on the GUM plus Internal Medicine dual accreditation programme 2021-2025

• To continue dialogue: @DrRakN or rak.nandwani@nhs.net
The GUM SAC (part of JRCPTB)

- Specialist Advisory Committee to meet GMC standards

- One of the 29 medical specialties

- Workstreams include; Curriculum; Assessment; Recruitment; Certification & CESR; Quality Management. Also Diplomas; Academic Training; UEMS & Workforce

- TPDs, co-opted members, lay rep and trainee reps

- Feeds into JSC attended by RCP President

www.jrcptb.org.uk/specialties/genitourinary-medicine
Dealing with uncertainty

• Being a medical trainee is a time of uncertainty

• Getting all the experience and exams (and the costs)

• Balancing clinical time and academic training

• Will I get a job (& be able to compete with peers)?

• Where will I end up working (& have to relocate to)?

• Work-life balance (relationships, carers, pressures)
More uncertainty now than ever before

- Junior doctors contract negotiations
- Shape of Training implementation
- Global banking crisis and austerity
- Brexit
- Health & Social Care Act 2012
- Impact of commissioning and tendering
Plus wider external influences

- Changing general population demographics
- Ageing staff profile and recruitment
- Increasing integration with social care
- Technological changes (public rather than service IT)
- Consumer/patient expectations
- Political and global decentralisation
Short to medium term job prospects

• The ability to deliver what the service requires is key

• Number of advertised GUM consultant posts now exceeds number getting CCTs. Tender delays working through

• Anxieties about London transformation project: will focus services on essential and reduce duplication to save cash

• “Class of 1989” cohort effect yet to kick in: GUM expansion bulge in late 1980s, senior consultants now in wider leadership roles, pension changes and retirements
2016 updated GUM curriculum

- Pending GMC approval; plan to launch near end of 2016
- Major change is to HIV curriculum reflecting impact of ART
- Short new sexual dysfunction section (BASHH SIG)
- Specific reference to transgender/non-binary individuals
- Updated legislation acts, devolved administrations and current terminology (eg gender based violence, CSE)
2016 HIV curriculum

- Now 8 key sections corresponding to national guidelines (instead of previous 18):
  - 22. HIV testing and diagnosis
  - 23. Epidemiology, natural history and general management of HIV 1 and HIV 2 infection
  - 24. Prevention of HIV transmission
  - 25. Complications of HIV infection
  - 26. Antiretroviral treatment
  - 27. Viral hepatitis including co-infection with HIV
  - 28. Psychosocial aspects of HIV
  - 29. Sexual and reproductive health
24. Prevention of HIV transmission

(Please note: for mother to child transmission see section on Sexual and Reproductive Health for people living with HIV)

To know the risk factors for HIV transmission in order to identify those both at increased risk of HIV acquisition (HIV negative) or onward transmission (HIV positive). To use this knowledge to undertake interventions to reduce the risk of HIV transmission.

To assess indications, prescribe and monitor post-exposure prophylaxis (PEP) for non-sexual exposure to HIV, post-exposure prophylaxis for sexual exposure (PEPSE), and when available pre-exposure prophylaxis (PrEP).

To assess the need for and prescribe treatment as prevention (TasP).

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<thead>
<tr>
<th>Knowledge</th>
<th>Assessment Methods</th>
<th>GMP</th>
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<tbody>
<tr>
<td>HIV transmission</td>
<td>Dip GUM, Dip HIV,</td>
<td>1</td>
</tr>
<tr>
<td>Describe with reference to HIV:</td>
<td>Mini CEX, CBD, MCR</td>
<td></td>
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<tr>
<td>• Methods of transmission</td>
<td></td>
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<tr>
<td>• Risk groups and behaviours (including chemsex, intravenous drug use, blood or tissue recipient)</td>
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<tr>
<td>• Influence of HIV viral load on transmission including transmission during PHI</td>
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<tr>
<td>Risk reduction</td>
<td>Dip GUM, Dip HIV,</td>
<td>1, 3</td>
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<tr>
<td>To advise individuals at increased risk of HIV acquisition on interventions to reduce transmission risk</td>
<td>Mini CEX, CBD, MCR</td>
<td></td>
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<tr>
<td>Post-exposure prophylaxis (PEP)</td>
<td>Dip GUM, Dip HIV,</td>
<td>1, 2, 3</td>
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<tr>
<td>Describe and explain indications for PEP and related issues:</td>
<td>Mini CEX, CBD, MCR</td>
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<tr>
<td>• Occupational exposure risks and universal precautions</td>
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<td>• Assessing risk of exposure to prevent transmission/acquisition</td>
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<td>• PEP regimens, monitoring, post PEP follow up</td>
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<tr>
<td>Explain the requirement for disclosure of HIV status to occupational health and other relevant organisations according to national guidelines to prevent HIV transmission</td>
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<td>Describe and explain indications for PEPSE and related issues:</td>
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<td>• Assessing risk of exposure to prevent transmission/acquisition</td>
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<tr>
<td>• PEPSE regimens (avoiding drug resistance), monitoring, post PEPSE follow up</td>
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<tr>
<td>Pre-exposure prophylaxis (PrEP)</td>
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<td>1, 2</td>
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Transition to 2016 curriculum

- All ST3 and ST4 trainees will transfer to the new curriculum and WPBA requirements.

- ST5 trainees can remain on the existing curriculum if their CCT date is within 2 years OR transfer to the new curriculum after discussion with their ES if any additional training required.

- ST6 trainees can remain on the existing curriculum (the DipHIV allows for the 2 parallel curricula) if they obtain CCT within 2 years OR transfer to the new curriculum after agreeing any additional training targets with their ES.
Shape of Training for physicians

- Two years foundation training after qualification

- Then 3 (rather than 2) years core medical training including acute unselected take leading to MRCP(UK)

- Selection to 4 year specialty training programme (incorporating Generic Professional Capabilities)

- Acute take participation must be relevant to specialty practice. Different specialties will contribute in different ways supporting care of patients who present on take

www.jrcptb.org.uk/new-internal-medicine-curriculum
Proposed outline model for physician training

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

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

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

• First entrants to Internal Medicine stage 1 training will not be before 2018 and possibly 2019

• Therefore first completion of these 3 years to enter specialty training programmes will not be before 2021

• Will require a detailed implementation plan for trainees in all specialties during the transition period

• Opportunity with 2016 curriculum to increase exposure to relevant acute based medical specialties (eg renal, HCV)
Competencies in Practice (CiP)

• Concept of Entrustable Professional Activities (EPAs)

• Can the doctor do an activity leading to a “trusted decision”

• What are the key observable activities, tasks and behaviours that can be used as descriptors? What evidence is available (eg exams, certificates, WPBAs)?

• Moves away from all those e-portfolio tick boxes by looking at the big picture rather than all the little parts

• Pinnacle competencies; could use them for CESRs

Internal Medicine syllabus

- The GMC Good Medical Practice and the Generic Professional Capabilities are things **all doctors** are required to demonstrate.

- The Internal Medicine syllabus is being developed which includes these plus presentations and conditions from all medical specialties which **all physicians** are expected to be able to deal with.

- There are 14 Internal Medicine CiPs, which include topics such as managing an out-patient clinic, patient safety/quality improvement, teaching, research & managing take.
GUM Competencies in Practice

• No need to duplicate CiPs required by all physicians
• Post-CST credentialing for minority expertise topics
• Currently 8 specialist GUM CiPs (in draft):

  • Delivering a level 2 sexual health out-patient clinic
  • Managing complex sexual health presentations
  • HIV out-patient care
  • Specialist HIV in-patient care
  • Prevention of HIV, BBV and STIs
  • Early detection of HIV & STIs in all settings
  • Safeguarding public health & targeting populations
  • Service management and commissioning
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Dual accreditation in GUM + GIM

• From 2025, all GUM trainees will be dually accredited in both GUM plus General Internal Medicine

• There will be no opt-out to drop either GUM or GIM and obtain single accreditation (although it should be easier to switch from one dually accredited specialty to another)

• The only current pathway to obtain dual accreditation with GUM is to complete a CCT in GUM and then start another specialty programme (claiming credit for competencies already attained) or vice versa
What will the service need in future?

- People will continue to have sex

- Being a consultant is not primarily about clinical competencies

- Employers require specialists who can provide leadership, service modernisation, quality improvement, support governance, develop teams and deal with uncertainty

- GUM is about population health and social determinants as much as the patient being seen in the service
Mixed ecosystem of posts

- Traditional “GUM clinic” with STI focus (but fewer of these)
- Integrated sexual health services with targeted populations
- Mixed sexual health and HIV service (mainly out-patient)
- HIV medicine posts including ward-based in-patient care
- Acute physician with special interest in HIV/sexual health
- Hybrids including academic and public health functions
The less evidence-based final slide

• Nurture your own unique selling points

• Keep an open mind to opportunities

• Think beyond the purely clinical

• Take good care of yourself and those close to you

• Getting a CCT and a job is only the start of another process