SHAPE OF TRAINING

Item 3 Annex A

Shape of Training call for ideas and evidence

Introduction

1. The review is considering what changes are needed to postgraduate medical training to make sure it continues to meet the needs of patients and health services in the future.

2. This includes looking at the balance of the workforce between specialists and generalists, options to support greater training and workforce flexibility, and how to address the tensions between obtaining training and providing a service.

Methodology

3. The Call for Ideas and Evidence was launched on 8 November 2012 and ran until 8 February 2013. We engaged with a range of individuals and stakeholders through meetings, seminars, site visits and a monthly e-update. Our engagement activities were UK wide with events taking place in England, Northern Ireland, Scotland and Wales.

4. We asked 18 open-ended questions and allowed for free form responses. To evaluate this data, we undertook a qualitative, thematic analysis based on the recommended practice set out by the government and industry leaders like the Consultation Institute. We were interested in the quality of the responses and the merit of the feedback rather than the quantity of respondents. We broke down the analysis, where possible, by stakeholder groups. This helped us understand if there were any distinctions between the different categories of people and organisations.

5. An initial analysis is being undertaken by the Shape of Training executive. We reviewed the responses and removed any duplicates. We then developed guidance for each of the executive members looking at questions about the way to evaluate the responses. We are doing a comprehensive analysis of each question to show the breadth and variety of responses.

6. We are evaluating the feedback to identify main themes or trends, whether there was an overall consensus, any counterpoints that stood out from the majority of responses as well as particular approaches for the future shape of training. We

examined each question to see if the balance of responses was affected by other variables or whether there were particular views held by different organisations. For instance, the balance of responses between the public and the profession and between different professional groups was examined routinely.

7. A member of the executive (not involved in the analysis) and two Expert Advisory Group members will audit the analysis and report as part of our quality assurance and to make sure we have accurately captured the breadth and depth of comments. Their feedback and comments will inform the final draft of the summary report on the evidence.

Overview of respondents

General data

8. We received 382 responses in total. 142 from organisations and 240 from individuals, including doctors at different points in their career from the Foundation Programme to retirement. We also heard from patients and public groups, the medical Royal Colleges and Faculties, deaneries and a number of organisations that employ doctors in training.

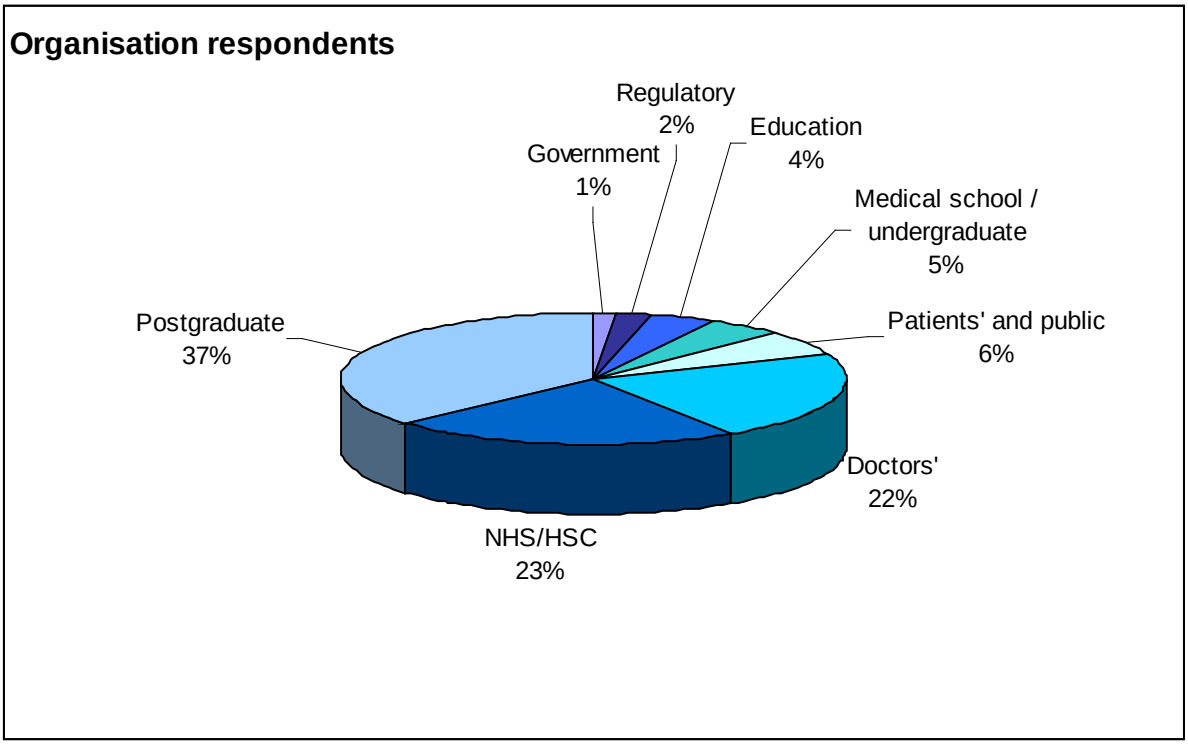
9. We received 29 responses from organisations with a UK wide reach such as the General Medical Council (GMC) and the Academy of Medical Royal Colleges (AoMRC). 140 responses came from England including Health Education England (HEE) and NHS Employers. From Scotland, we received 23 submissions including NHS Education for Scotland (NES) and one from Wales (Abertawe Bro Morgannwg University Health Board). We only received 2 responses from individual doctors in Wales and no specific responses from Northern Ireland.

Organisations

10. The majority of organisation responses were from postgraduate institutions. We categorised the AoMRC, individual College and Faculty, deaneries and training committees together because of their roles and responsibilities in developing and managing specialty curricula. Of the 52 responses from postgraduate institutions, 7 were specifically from groups representing doctors in training.

11. But we had quite a strong response from employers, especially in England, from NHS Employers and a small number of emerging Local Education and Training Boards (LETBs). We also heard from a number of organisations representing doctors including the British Medical Association (BMA) and several specialty associations such as the Association of Surgeons in Training and the British Junior Cardiologists Association. Nine patient and public organisations responded to us, including the National Association of Patient Participation (NAPP). Although we heard only from 5 medical schools, we received overall feedback from their overarching organisation, Medical Schools Council (MSC) and from the Russell International Excellence Group.

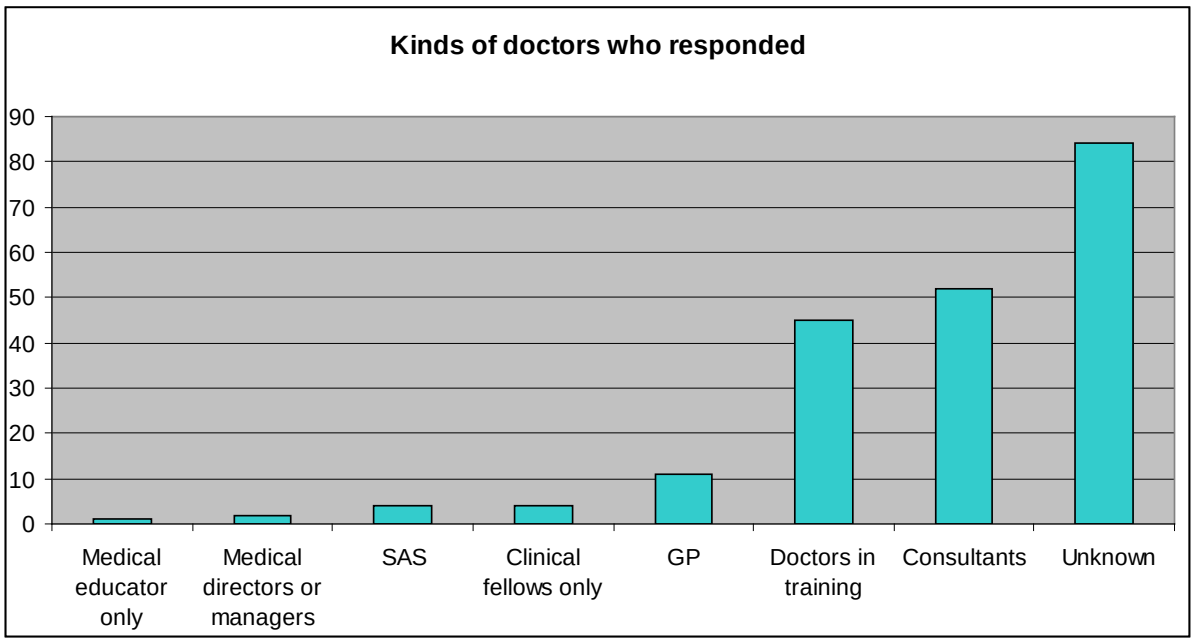
A handful of organisations involved with education, research and funding for doctors and other healthcare professionals also responded including the Wellcome Trust and the Medical Research Council (MRC). The graph below shows the percentage of organisation respondents:



12. Of the 240 individuals who responded, 203 were from doctors. We also heard from a small number of other healthcare professionals, medical students and a member of the public. We received 29 responses from people who did not tell us about themselves and have categorised them as ‘unknown’. The graph below shows the types of individuals who responded:

Doctors

13. 41% of doctors did not categorise themselves. But of the doctors who told us about their jobs, the majority were consultants. About 26% of doctors also indicated they were medical educators while 1% were involved in research as a researcher or clinical fellow. The table below breaks down the kinds of doctors who responded:



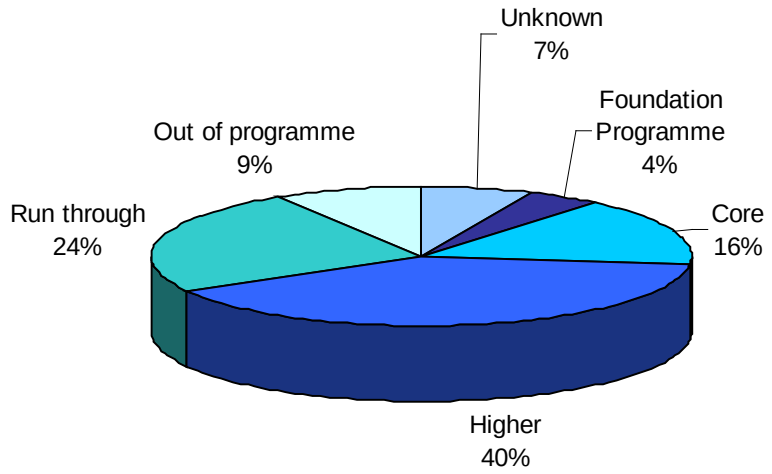
14. Excluding doctors in training, 53 doctors indicated they were male and 23 were female. 32 doctors told us they worked full time, while seven indicated they worked part time. Of the part time workers, four were women and three were men. Of the individuals who responded to the question about their age, the majority were within the 55-64 age range with most of the part time workers falling into this category. The second largest respondent group were doctors between 35 and 44, who were predominately men and worked full time.

15. 114 individuals answered the ethnicity questions. 94 were white British or Irish, 11 respondents were Asian or Asian British, five were white other, two were African and two were mixed ethnicity.

Doctors in training

16. Overall, 22% of the responses were from doctors in training. The majority were from doctors who were fairly advanced in their training (higher training). Eight doctors identified themselves as clinical fellows or academics but only one indicated they were out of programme while completing their academic or research work. Most of the doctors were in the 25-34 age category. Four of these doctors worked part time and were split evenly between men and women. All the doctors between 35-44 worked full time. The graph below shows some detail about the doctors in training who responded to us.

Doctors in training respondents



Balance of the workforce

17. People told us about how patients will be cared for over the next 30 years and what impact this may have on the kinds of doctors that will be needed. With significant overlap between the answers, we have analysed them together to build up a comprehensive picture of possible changes to healthcare and the medical profession.

18. We asked:

a. Over the next 30 years, how do you think the way patients are cared for will change? We received 323 responses to this question. A small number of respondents suggested the 30 year time period was too long to predict possible developments. Most answers focused on the likely drivers of change over the next 30 years and how care should change to meet them.

b. What will this mean for the kinds of doctors that will be needed in primary care? In secondary care? In other kinds of care? We receive 212 responses. Respondents tended to reflect that a change to the way people will be cared for in the future will change the way doctors' practice.

c. What do you think will be the specific role of general practitioners (GPs) in all of this? We received 299 responses that considered how GPs will work across different care settings and with different kinds of doctors.

d. How can the need for clinical academics and researchers best be accommodated within such changes? 373 responses were received. Most responses considered how academics and researchers should work within the health service in the future.

What is driving change?

19. In general, organisations and individuals described very similar pressures that will impact on healthcare over the next 30 years. However, some medical Royal Colleges, Faculties and Specialty Associations set out these drivers within the context of their specialties. Similarly, some groups representing particular patient concerns reflected on how changes will impact on their representative groups.

Changing patient demand

20. Almost all respondents suggested the interplay between patient expectations and demands, medical and technical advances, information technologies and economic constraints will inevitably challenge how healthcare is delivered. While most respondents suggested changing patterns in patient demand will necessitate a different approach to health and social care, only a few reflected specifically on demographic change. They expect the UK will have far more people with multiple and complex health conditions. This trend will be exacerbated by an increase in the number of elderly people, people who survive and live longer with conditions that were once terminal and the impact of lifestyle diseases such as obesity. The East of England LETB argued '*We believe that the national demographic will continue to change. Within [our area] we are already experiencing high birth rate, in part due to European migration and in some areas due to ageing and retirement location trends, a disproportionately ageing population with high levels of age related morbidity including dementia.'* Some respondents such as the BMA, also suggested global travel and environmental change will impact on the diseases and conditions normally seen here while the Faculty of Public Health predicted '*there are likely to be unpredictable changes including the emergence of new diseases.*'

21. The majority of respondents indicated people will become increasingly better informed about their health and treatment options as access and availability of information becomes more main stream. Doctors and other health and social care professionals will have to manage these expectations and help patients understand their options while delivering a more individual and tailored (and possibly more expensive) approach to care. The National Dignity Council believed *'Patients will expect to be listened to, informed about their diagnosis and involved in their treatment plan...Patients themselves will be better informed and will understand that their relationship with their doctor is reciprocal and will treat them with respect and understanding.'*

22. Patients will also want to and be expected to take on more self-care and monitoring with support from healthcare staff, aided by technology such as mobile

phones that can monitor blood pressure. A doctor in training described '*A move towards more focus on patient autonomy and quality of life - ensuring that patients are equipped with information and given opportunity to make decisions about where, when and how they are cared for.*' NHS Employers also suggested '*The patient will have greater information and influence over how their care is delivered. We will see a larger number of expert patients, information on quality will drive patient choice and providers will compete for business based on quality and outcomes.'* But some respondents thought the core relationship between doctors and patients will remain unchanged, even as the healthcare structures change around it.

23. A small number of respondents such as the Association for the Study of Medical Education (ASME), the British Association of Dermatologists and some individual doctors thought this shift to more empowered and informed patients will result in a demand for direct access and self-referral to some specialists, especially for already diagnosed conditions. ASME stated '*The current role of GPs as gatekeepers may need to be reconsidered once the market is more open so that patients can refer themselves to specialists.*' A few respondents commented that patients will also want more access to consultants, particularly in hospitals.

Medical and technological changes

24. The realisation of medical and technical research was seen by almost all respondents as game changers and was particularly lauded by organisations like the Medical Schools Council (MSC) and the Wellness Trust. Advances such as genomic medicine will allow personalised and tailored care and people will expect individualised therapies. Better (and more accessible) diagnostic and screening technologies alongside more preventative interventions will improve health at community and population levels (and possibly counter some lifestyle conditions). The Association of Surgeons in Training suggested '*The focus will move towards screening and early detection of disease, allowing prevention, cure or even lifelong delayed progression. The mapping of the human genome and advances in areas such as cancer genetics will lead the way to much more bespoke targeted treatments. Individuals will have their genomes mapped which will allow them to know at an early stage in their lives what diseases are likely to affect them and make the necessary lifestyle alterations.*'

25. Healthcare professionals, teams and patients/carers will start to use information and communication technologies (ICT) for large parts of their interactions. Improvements in e-records will allow more joined up patient care and increase accountability and monitoring of the quality of care. A doctor in training warned *'Patients will increasingly use mobile technologies and information/communities on the internet and will be better informed…There will be greater access to some services and investigations in the community, but this will be limited with a continued need for significant acute and speciality care.*' But the London Deanery suggested '*Further advances in technology will assist the drive out of hospital and impact on the skills required within the medical workforce.'*

26. But these advances will mean all doctors and other healthcare professionals will need to have adequate knowledge and skills in areas like genomic medicine in order to manage them effectively. A number of respondents also suggest academic and clinical research will require further investment to make sure we continue to reap the benefit from medical and technical outputs. As the Medical School Council suggests '*Scientific advances, made possible by medical research, have brought about a greater understanding of the molecular basis of disease, which together with rapid technological developments offer significant opportunities to evolve clinical practice. In an age of increasing informatics comes ever increasing patient awareness and expectations…Advances in precision medicine will require medical students and doctors to have a more profound understanding of the scientific basis of medicine to drive improvements in patient care. Technological developments will make frequent re-training essential in order to take advantage of developments.*'

Where care will take place

27. Almost all stakeholders agreed the majority of care will take place outside of hospitals. Over 300 responses suggested care will be delivered increasingly in the community including homes and residential care centres by multi professional teams and care networks. This shift will blur the boundaries between primary, secondary and social care so that people are treated in an integrated way across different care settings. CAIPE explained '*The focus will be on care in the community involving professionals from both primary and secondary care backgrounds. Boundaries between the two will need to become blurred and roles flexible. Effective collaborative working will be required both within the medical profession (inter-disciplinary) and without the medical profession, working with other professions (inter-professional)*.' Likewise the response from BMJ Learning points out '*More care will be delivered in primary care; more care will be delivered by members of interdisciplinary teams; and care will need to be better integrated so as to avoid cost inefficiencies such as those associated with duplication of clinical management. Integration of services will involve patients moving along care pathways and receiving care bundles (when appropriate)*.'

28. But the BMA, while recognising the benefits of integrated care, didn't support further changes to the healthcare system: '*While the integration of services is achievable, it can and should be delivered without any further re-structuring or re-organisation of the NHS, legislative change or structural upheaval…An integrated service could be achieved by adopting models of community care, co-location or introducing specialised care centres.*'

29. The majority of respondents, including the GMC and AoMRC reflected that as care shifts into the community, more specialists will work in local clinics or centres, possibly associated with GP practices. The Radiology Patient Liaison Group favoured a structure based on the level of diagnostic and expert care needed: '*A 3 tier approach where tier 1 will be the small local unit (community hosp or small DGH) able to assess and deal with some issues, but pass on more complex work to tier 2*

(Bigger DGH, teaching hospital) and super specialist stuff to tier 3 (specialist centre such as GOSH or Oswestry).' GPs and other doctors trained more broadly will link into specialist care centres, healthcare networks and hospitals. A few responses considered whether GPs should provide care within hospital settings. The Derbyshire LETB believed '*Federation between primary and secondary care professionals and more blurring of boundaries and GPs also going into hospitals to deliver care particularly at the front door to ensure patients get onto the right pathway at the earliest opportunity*.' This view is reiterated by the Royal College of Physicians of London: '*Having medical practitioners working across these interfaces will help, and this may include general practitioners (GPs) with special interests, community specialists and GPs working in hospitals. Social care and public health need to be much more engaged with hospital care*'

30. A number of respondents thought there will have to be fewer hospitals and significant amount of specialist care will be centralised into regional care units. The British Cardiovascular Society believed '*Centres where facilities are concentrated for the needs of patients across a wide geographical area will still be called hospitals. These will be fewer than at present since the public will expect that admission to hospital means admission to an environment where adequate acute care is deliverable 24/7.*' A number of respondents suggested this would mean that patients will likely have to travel further for some specialist care.

31. But a few respondents, particularly individual doctors, challenged the idea that more care will shift to the community. One doctor speculated '*I strongly doubt that more "care in the community" is really the answer - though more self-care may be*.' This perspective was support by others, who believed patients will demand to be treated by specialists in hospitals. As a Medical Educator argued '*Clearly there will be a move from secondary and tertiary care in to primary care and the community. However, I do not believe this change will be as great as many believe, since patients with greater information will increasingly insist on expert opinion.*' Other respondents suggested most medical advances and technology will still be centralised in hospital because of the cost of equipment.

32. Quite a few responses demanded a change in the way we think about patient care so that it no longer focuses on the location like primary and secondary care. As a clinical fellow suggested '*Patients will receive specialist input earlier in the care pathway and have better access to care and use of more technology within care - rather this is what I would hope if things change for the better.*' The Academy of Medical Royal Colleges (AoMRC) also emphasized this point '*There is a need for more pathway defined patient management integrating primary, secondary and tertiary care with seamless input from social services…Individually tailored care seeing the patient as a whole rather than a part of the body or condition.'*

How care will be delivered

33. Nearly all respondents suggested that a shift towards more community based care and fewer hospitals would affect both the kinds of doctors needed and where they will practice. Care is likely to become more polarised into acute and emergency and non-acute in interventions while at the same time, doctors and others will be expected to care for patients in a wider range of settings (home and residential care, local clinics/surgeries, regional centres, highly specialist care centres/hospitals).

34. Several respondents also remarked that the review should consider how other health and social care professions may impact on the medical model of training and practice. Multidisciplinary teams and care networks will become standard with health and social care professionals becoming more mobile. The National Association of Clinical Tutors (NACT) suggested a team based approach at regional levels: '*A hub and spoke system of care within a region including GPs and LEPs will enable best care for our patients. One team rather than multiple teams will ensure a more streamlined care pattern rather than patients moving from one team to another. Doctors in the spoke organisations will need to participate and rotate into the acute care centre. This sharing of acute work will enable the one team approach within a region.*' An individual doctor reflected '*fundamentally; teams need recognition, doctors often lead and contribute in teams, the 'kind' of doctor will follow team organisation*.'

Kinds of doctors

35. In order to manage this shift, many respondents categorise doctors into four areas: specialists in hospitals, specialists in the community, general specialist working in and across hospitals and the community and general practitioners. However, respondents thought these groups of doctors would work more flexibly across care settings and within multidisciplinary teams. Quite a few respondents, particularly individual doctors, emphasised the need for less protocol driven care with doctors providing more leadership and professional judgements, while others though doctors will increasingly need to develop more varied careers. The KSS Deanery speculated *'Portfolio careers will be more appropriate with doctors carrying out a number of roles or working to improve or learn new skills for a part of their time.'*

36. Over 230 respondents advocated strongly that we will need more generalists because most patients will be cared for outside of hospitals. But how care is delivered will have to change. Employers and postgraduate medical organisations, such as NHS Employers and the AoMRC, thought care will have to be delivered 24/7 in both primary and secondary settings. GPs and generalists would provide acute and emergency treatment as well as manage non acute care. Patients would only go to hospital if their conditions couldn't be managed within the community. An individual doctor suggested '*These generalists should be able to provide basic emergency care and treatment with appropriate facilities for monitoring patients.*

Identify those who require immediate further intervention in secondary care from those who could continue to be managed in a local setting with appropriate specialist advice.' A number of respondents also suggested future care will have to be delivered more frequently by consultants, with less reliance on doctors in training to deliver service. This is picked up in more detail within the tension between service and training theme.

37. But specialty organisations, like the Association of British Neurologists and the British Cardiovascular Society, warn we will also need more specialists, especially in the community and specialty clinics, to deal with growing health needs linked to an ageing population, long term conditions or lifestyle diseases. As the East of England Trainee forum explains '*There will be a greater need for general practitioners, paediatricians, obstetricians, elderly care and emergency service physicians (accident and emergency, acute medicine, acute surgery, anaesthetics).* The Royal College of Paediatric and Child Health confirmed this approach: '*There is a need for seamless care between GP and secondary Paediatric and Child Health. General specialist in secondary care should come out to work in local health care with GPs and give support to family practitioners and local health care teams.*'

38. Several respondents still supported the need for subspecialty experts, particular in hospitals, but in fewer numbers. As medicine becomes more complex, we will need people who have expertise in quite technical areas. Others countered this position by arguing that other healthcare professions within the healthcare team will be able to do much of the technical work, leading to fewer specialists with technical skills. These points are picked up further in the section on workforce issues and the multi professional team.

39. Although there was overall consensus for care being provided by GPs and generalists across care settings, a small number of respondents did not support this view. A medical educator believed the trend will be towards more specialist care: '*As a specialist it is hard to keep up with the changes and literature in my own field let alone keeping up with a more general literature. Whilst I understand the importance of general medical training and do my best to stay as general as possible I would be surprised if the future meant more general rather than more specialist training.*' This point was mirrored by the Ophthalmic Trainees Group which believes '*This will largely depend on government policy in particular if it is intended to keep the primary care physician as the intermediary gatekeeper for access to healthcare. We suspect that this will not continue to be the case and that there will be less need for primary care physicians and a greater requirement for sub specialists.*'

Defining generalism

40. A number of respondents fed back that the definitions of generalism and generalists within the review were unclear. Some offered possible interpretations. For example, The Academy of Medical Royal Colleges and Faculties in Scotland pointed out '*Generalism will be very important, although the definition being*

considered needs further work.' The BMA agreed '*The term 'generalist' has not been defined within the review documentation; it is therefore unclear what is meant.*' Indeed the Royal College of Physicians of London argue strongly: '*The Shape of Training review refers to such doctors as 'generalists.' Such a term does not accurately reflect the substantial training and expertise required. Furthermore, it implies that 'generalism' is inferior to other specialties, whereas internal medicine should be recognised as the most important and most challenging specialty in acute care. We therefore urge the review to drop the terms 'generalist' and 'generalism.*'

41. Despite some concern about the terms, most respondents interpreted generalists broadly to mean doctors who have been trained to deal with a wide and varied range of care within different care settings including both acute and non acute situations. The Royal College of General Practitioners views generalism as: '*Medical generalism is an approach to the delivery of health care that routinely applies a broad and holistic perspective to the patient's problems…The ability to practise as a generalist depends on the doctor's training, and on the routine use of skills that helps people to understand and live with their illnesses and disabilities, as well as helping them to get the best out of the healthcare options that are available and appropriate for their needs.*' This approach is reiterated by the NHS West Midlands Workforce Deanery: '*The competencies and capabilities of the generalist will be essential for these doctors who support individual patient centred care and the ability to develop a relationship based continuity of care whilst having the capability of needs assessment and service development for the population of registered patients that they care for*.'

42. Most respondents tended to regard generalists as doctors with a broad base of knowledge and skills within defined specialties, including general practice. But what defines the 'general specialist' will differ between specialties. The British Infection Association explains: '*There will be increasing expectations among patients that they will be cared for by generalists who have had specialty, though not necessarily sub-specialty training (using the term here to mean GIM physicians, paediatricians, gynaecologists, etc.) rather than general practitioners.*'

43. A number of respondents also raised the possibility of a doctor who is trained to manage patient care across specialties. Most recognised this as the role of the GP in primary care and community based care, but quite a few also lobbied for a similar role within hospitals and secondary care such as a 'hospitalist'. The NHS Education for Scotland suggested '*There will be a greater need for the GP-Community/Generalist (the family physician model in other countries) and this group will require longer training times. There will be a greater need for the Hospital/Generalist, with a broad experience, possibly across several 'specialties', and possibly separating 'assessment' from 'treatment' skills.*' An individual doctor also thought this role could manage the transition from hospitals back into community care: '*If we had a set of doctors who managed the last day of a patient's hospital care and the first day/2 days of their 1ry care, this might lead to earlier discharge from hospital and better quality recovery.*' However, the BMA was against

this approach: '*The BMA believes that with the continuation of specialties such as general medicine, general surgery, paediatrics and geriatrics means there is no need to introduce a new 'generalist' service delivery post or specialty to meet the needs of patients in the future*.'

44. The bodies representing doctors and the medical royal colleges strongly rejected the idea that generalists can be trained to a basic level that allows them to deliver and manage acute intakes. The AoMRC was particularly adamant that '*Many trainees are anxious that training all as general specialists might represent a step toward creating a second tier of consultants.*' Many respondents across all stakeholder groups were clear that perceptions of generalism and generalists need to be changed to make it a more prestigious career option. As the NHS Education for Scotland argued '*Work will be needed to engender the cultural shift required to enable the service and the profession to value generalism. Generalist posts are currently seen as unattractive.*' The Royal College of Physicians of London warned '*Acute medical registrars have a workload that is increasing annually, and they feel undervalued and poorly respected by management...The expansion of this workforce needs to go hand-in-hand with greater attractiveness of (General) Internal Medicine to all doctors, and it should not be part of a process doctors pass through to reach the next stage of their career*.' An individual doctor summed it up: '*At present it is too often perceived that basic level skills are inferior to specialist skills...this is not so they are just different*'.

45. Most individuals and organisations argued that generalists would require a longer training period or reconstruction of training to capture the breadth of experiences needed to provide competent general care. This is looked at in more detail within the Breadth and Scope of Training theme. But this view was summed up nicely by a doctor in training/researcher: '*It is absolutely imperative that training for general specialists at least, is extended, as the amount of experience and level of judgement required in making accurate diagnoses in relatively undifferentiated patients can only come from a certain period of time, for which is no substitute and no short cuts.*'

Service changes and reconfiguration

46. Many respondents raised concerns over service configurations, particularly the tension between commissioning and rationing care against clinical decisions and patient expectation. The impact of financial constraints was acknowledged by several respondents with many raising concerns that this will marginalise training.

47. A significant number of respondents also worried that the healthcare system and patient care would become increasingly fragmented, with noticeable differences across UK. Some respondents forecast a move towards a more fee for care service, reliance on private care or a system built through competition rather than clinical excellence. The Opthalmic Trainees Group suggest '*The boundaries between public versus private healthcare providers will blur as the financing of the service moves*

more towards an insurance based model instead of a central government led model. We are concerned that commissioning health care will prioritise cost over quality.'

General Practitioners' role

48. Most respondents suggested GPs will continue to act as gatekeepers for access to specialist and other healthcare services. They will have a more enhanced role in coordinating and managing care, especially across the primary and secondary settings. The AoMRC thought '*More generalist practitioners who work across the traditional primary/secondary care boundaries, some with special interests, with greater training in medical care and diagnostic skills*'. A few responses didn't see this as a change in GPs roles, other than taking on commissioning responsibilities in England. But a small number of individual doctors suggested GPs will only have a role in helping patients identify the right specialists. As a doctor explains '*There will be no general physicians practicing medicine in primary care that resemble what we know as GP's today. They will be well trained, technically sound, and have a good understanding of health service jargon…Patients will understand their rights to demand access to healthcare and the limitations that are placed upon this by controls that are put in place centrally. The GP will not act as gatekeeper but as executor of these controls.*'

49. Respondents saw the role of GPs and, to a lesser extent, general specialists as key to promoting a holistic approach to care that deals with both emotional and physical issues. The NHS West Midlands Workforce Deanery pointed out that '*[GPs] will need to have a broad understanding of diagnostics and therapeutics, they will need to understand the choices available in secondary care and when and where to access them. The need to deal with patients with complex co-morbidity and increasingly personalised therapeutic solutions will be important. This will require excellent communication skills and a good knowledge of information systems.*'

50. In order to support the shift to more community based care, GPs should become leaders within collaborative teams and care networks, with other healthcare professional taking on more initial patient care. GPs will become responsible for referring patients into specialty care pathways. The Hampshire PCT described the changing role of GPs as '*predominantly frontline managers of paramedical staff. The triage of all patients will become a nursing or HCA task. This will serve to distance the decision from the patient and allow more economic (rationed) use of facilities or referral.*'

51. GPs will also have to increasingly link to other GPs and specialty clinics to provide patients with local and community based options. Indeed some respondents indicated that GPs will take on roles traditionally set within secondary care such as diagnostics while other health and social care professionals shift to activities currently done by doctors. A few respondents, such as the NHS Education for Scotland thought that the GP role would differ depending on geographic and local circumstances. For example, in rural areas GPs will have to take on far more

responsibility for transferring patients to hospitals while in urban areas, GPs will have to manage patients within complex specialist networks. Some respondents also speculated that as the GPs deal with more complex care, specialists will need to provide support and mentoring to them. The British Cardiovascular Society saw a closer relationship between hospital doctors and GPs: '*There will need to be better relationships between local family doctors and hospital based specialists….Hospital based cardiologists will however be needed to provide leadership to locally delivered aspects of cardiovascular care (e.g. community clinics). This will include: coaching or mentoring family doctors; training specialist nurses; quality control initiatives e.g. reviewing audit data etc*.' Others thought some conditions should no longer be cared for by GPs but go directly to specialist units in the community such as supporting HIV patients.

52. But in order to do this, GPs as part of larger multi professional teams and networks will have to provide continuity of care even on weekends and evenings. Nearly all respondents thought this broader role would require GPs to take on more acute and emergency care as well as preventative advice and interventions. Patients should be able to access primary care 24/7. A medical educator suggests '*GPs are required to provide a level of care in the community that is responsive to the needs of that community on a 24/7 basis.*' But one doctor thought that a shift towards more personalised care may mean GPs will need to spend longer with patients and may have to manage small patient lists.

53. The majority of respondents suggested GPs will still provide a broad range of care, but should also develop speciality or special interest areas such as dermatology and mental health. Many indicated that these specialty areas could be obtained through credentialing and accredited training. An extended role for GPs may also attract doctors interested in more varied careers or who are considering changing specialties. But several individuals and organisations such as the Royal College of General Practitioners and Committee of General Practice Education Directors (CoGPED) believe that to meet these needs, GPs will have to train longer and to some extend, mirror training currently given to general specialists.

Clinical academics and researchers roles

54. Respondents unanimously agreed that doctors in academic medicine and research roles must continue to be supported and valued. It was recognised that they make valuable contributions to science, medicine, education and patient outcomes. This was reflected well by National Association of Patient Participation: '*Research skills need to be developed in medical schools and should be continued as part of practice. Academics should have up to date knowledge, possibly by undertaking a short period of practice each year. It is valuable to continue to use a mentorship system where academics can work with trainees*.'

55. The National Institute of Health Research (NIHR) believe that '*specialist services will be increasingly organised on a regional basis through functional clinical*

teams working with evidence-based, shared, care protocols, open to accepting innovation rapidly, and active in applied clinical research to close knowledge gaps.' With more rapid medical and technical advances, most respondents recommended all doctors should have broad training in research methodologies and opportunities for research experience. The Wellcome Trust and Medical Research Council point out *'it is also important that the wider clinical workforce is sufficiently research aware to build the capacity of the NHS to apply research findings and contribute to research and the spread of innovation.*' This led the MSC to suggest '*It is vital that there is an academic underpinning to all training, both generalist and specialist. New training paradigms are required that can equip all trainees with the professional judgement to interpret, apply and embed research findings and the output of innovation and thus contribute fully to the development of service*.'

56. Overall, respondents thought academic training and career development should be flexible. Some organisations such as the MDRS Career Planning Group and Joint Royal College of Physicians Training Board would like to see opportunities for doctors to work in academic medicine and research at different points in their training, not just in the early years. The East of England Trainee Forum would like to see '*Increasing the numbers of academic foundation posts for those interested in pursuing these career avenues at an early stage would be beneficial. There should also be more collaboration between the clinical and academic settings. Allowing trainees to take time out for research, without penalising re-entry into training would be a positive step.*'

57. Some respondents suggested ways we could help doctors build up both an academic and clinical career such as a competency based approach or credentialing to remove time pressures on completing training. The MSC would like to develop '*A flexible approach which allows all trainees to gain research experience, as well as providing support to those who wish to pursue more focused research training, should be encouraged. Barriers to flexibility must be addressed; for example, trainees who are awarded academic grants and fellowships should have a right to take these up, through inter-deanery transfers if need be. They should be supported to balance their clinical and academic duties*.' For a small number of organisations this flexible process would allow doctors to move quickly into their academic or research area without developing generalist skills. But most respondents such as the AoMRC and MSC would to like develop academic medicine in a way that allows doctors to move into it later in their careers after more general training. The MSC also suggests '*To attract greater numbers of trainees into broader based research experiences, appropriate exit routes should be well defined for those who decide not to progress further along the academic pathway. It is important that this is not perceived as 'failure*'.'

58. A number of respondents also called for more integrated roles for academic doctors within the emerging care structures. A number of respondents see an increasing role for clinical academics within community based medicine. The NACT suggested '*Academics should work within their specialty setting in regions that have*

links with academic organisations. The region should look at the academic needs of its community so that research can directly influence and change the area it is conducted in.' The BMA extended this position: '*the proportion of medical academics required in each specialty should be urgently considered. Research opportunities should be widely promoted and not confined to just those on an NIHR academic clinical fellowship or clinical lecturer programme. Commissioning must also take account of the need for academic opportunities and ensure that all providers are engaged with the research agenda of the NHS and provide facilities and support to do so. This is particularly important as the emphasis moves from secondary care to the community, where it can prove challenging to build internationally competitive research teams*.'

What will training look like?

59. We asked 'If the balance between general practitioners, generalists and specialists will be different in the future, how should doctors' training (including GP training) change to meet these needs? We received 289 responses to this question with a number of responses drawing up possible approaches or models for training in the future.

60. The principles and approaches suggested by respondents is discussed in Item 3. We will complete the full analysis of this question by the end of March.

Flexibility

61. We asked 'How would a more flexible approach to postgraduate training look in relation to:

- Doctors in training as employees;
- The service and workforce planning;
- The outcome of training and the kinds and functions of doctors;
- The current postgraduate medical education and training structure itself (including clinical academic structures)?

62. We received 268 responses covering the range of stakeholders.

63. There was consensus from all respondents that medical education and training needs to be more flexible to reflect the needs of the service and patients. Stakeholders, particularly employers and postgraduate medical institutions, focused on the importance of broad based generalist training and the need for transferable competencies within the training structure. Nearly all stakeholders raised the importance of ensuring that flexibility meets the changing demographics of the medical workforce including more flexible work arrangements.

64. There was quite a lot of agreement from respondents about how a training structure could be made more flexible for doctors in training as employees. But, many respondents emphasised strongly that a more flexible system must be appropriately quality assured. There was some concern around the risks that increased flexibility might have, with one doctor commenting '*Increased flexibility in a career path risks 'half trained' doctors at the end'.* In contrast, other stakeholders suggested further flexibility within the system is not needed. One medical educator said '*We already have flexibility - give any more and the workforce will be unmanageable and costs of administering it astronomical*.'

Transferable competencies

65. Most respondents thought a more flexible approach to training for doctors should be based on transferable competencies and the ability of doctors to move between specialties and care settings. Current training is very rigid with doctors facing many difficulties when changing specialty. Respondents were concerned that doctors are being discouraged from changing speciality because they have to returning to the start of a programme, on lower pay and at a lower grade. An individual doctor in training commented that '*It is ridiculous to have an experienced doctor having to go back to the beginning just because they are forced into the straight jacket of a training scheme*'. Similarly, doctors are forced to make life long career decisions far too early and face restrictions on their career choices when they want to change specialties later in life.

66. Many respondents thought transferable competencies would help doctors plan and manage their careers better. The BMA expressed: 'A r*obust system of properly accredited transferable competencies would alleviate the difficulties associated with changing specialty, both for doctors and workforce fluidity*'. Stakeholders agreed that approach would avoid unnecessary lengthening of training for all specialties. Most respondents also supported better career advice and more opportunities to experience a variety of specialties before making key life decisions.

67. There was also consensus that there needs to be more flexibility for doctors to move between different care settings. One medical educator explained that '*For a flexible approach to training that would meet the future needs of both patients and doctors, movement between training provider organisations must be possible*'. It will also be necessary for clinical academics to be able to move between NHS and University posts, the BMA commented that '*Clinical academics should be able to move seamlessly from the NHS to university employment without detriment*'. Overall stakeholders were in agreement that a flexible approach to training cannot exist without transferable competencies.

Training vs service needs

68. A number of responses highlighted the importance of striking the balance between training needs and service demands. The majority of respondents agreed

that service provision is an essential element to training. It gives doctors a number of important skills such as managing different pressures, working in teams and taking leadership roles. The Joint Committee on Surgical Training said '*Service is an integral part of training and must be acknowledged as the best way for trainees to learn clinical and technical skills and competencies as well as professional skills and behaviours such as judgement, communication, compassion and empathy*'. Similarly, the Defence Postgraduate Medical Deanery stated '*Doctors are training to deliver a service to patients and to divorce service delivery from training is illogical*'.

69. A few stakeholders thought doctors should only focus on training rather than provide service coverage, but only in the early stages of their training. The British Association of Audiovestibular Physicians (BAAP) suggested '*Doctors in training should not be part of the service, they should be supernumerary to allow proper supervision*'.

70. Though service provision is an integral part to training, stakeholders highlighted that doctors in training should not only provide service. They are also there to train. The JCST pointed out '*The service should not be dependent on trainees for the delivery of care, their status should be that of trainee first and service provider second*'. Respondents agreed that service delivery is essential for training, but doctors also need to have dedicated and protected training time.

71. Stakeholders were in favour of an employment system which recognises both the service and training needs but gives priority to training. East Lancashire Hospitals NHS commented '*Doctors in training need to have a single employer so that they can move around between hospitals trying different specialties*'. Stakeholders agreed that this system would improve flexibility and allow doctors to gain a deeper wealth of experience. A number of responses to this question detailed a desire for training contracts to be held by a single provider to allow more flexible movement within the medical workforce. The NACT stated '*If the contract for junior doctors was held regionally then they could move from one institution to another (including the community) so that their training needs would be met rather than a service commitment to the employing organisation*'. In contrast, many respondents argued doctors should remain in posts for longer to build up better team experiences and learning and to facilitate better supervision and mentoring. See balance of the workforce theme for further detail.

Broad based training

72. Most respondents agreed that doctors in training should undertake a period of broad based generalist training which would allow the workforce to be far more flexible. St George's University of London stated '*A greater emphasis on generalism during the early stages of training will undoubtedly permit greater flexibility*'. Several stakeholders, particularly medical royal colleges and deaneries, argued that broad based generalist training is necessary for the early stages of training but it will be

difficult to implement. The Royal College of Anaesthetists commented '*Ensuring that broad-based training results in transferable competencies that meet current service as well as future training needs will be a challenge*'. A number of responses also highlighted the need to remove run-through specialty programmes as they do not offer any flexibility.

Workforce planning

73. A number of stakeholders highlighted different workforce planning issues and solutions. Overall, responses emphasised that workforce planning currently is increasingly difficult to get right. The British Geriatric society commented that '*Workforce planning is persistently poor, predictive modelling is not accurate and there is a disparity between the number of doctors needed in junior grades and the number who will be able to obtain consultant posts on obtaining CCT*'. There was also some agreement that increased flexibility will make workforce planning more difficult. The Royal College of Anaesthetists thought '*Wide-scale movement between specialties may be destabilising and make workforce planning more difficult than it already is now*'. There was also some agreement that workforce planning needs to be delivered at a local level.

74. Some responses highlighted the importance of ensuring that workforce planning considers the needs of the population including local needs. The Newcastle upon Tyne Hospital said '*To create greater flexibility will require robust, accurate, centrally managed workforce planning, informed and supported by local healthcare need*'. The British Association of Paediatricians in Audiology (BAPA) agree stating '*Service development and workforce planning will need to take into account the changing demographics of the population and this must be paramount*'. Some responses highlighted concerns with current workforce planning and trainee numbers. For example, the Academic Trainee Doctors Group said '*Workforce planners should not see trainees as an expendable resource, the number of trainees recruited should only match the future workforce requirements*'. What is evident from the responses is that currently workforce planning does not recognise the correct balance between training and service needs. The Scottish Recovery Network said '*Workforce planning should involve ensuring that the workforce had the correct balance of professionals with recognition of both shared and individual training needs within the service*'. Some stakeholders also suggested that workforce planning needs to support doctors shifting practice areas in the future.

Flexibility in the workforce

75. A number of responses identified the need to consider the impact of increasing numbers of women on the workforce and the importance of ensuring flexibility within the system to meet the needs of women doctors. The Royal College of Surgeons had identified that in 2010 women made up just 24% of surgical trainees and 8.5% of surgical consultants, their patient liaison group commented

that '*A more flexible approach to postgraduate training of surgeons is needed to prevent the drop-out of women from surgical careers, due to the difficulties of taking a career break to have children and still be able to progress with their careers*'. Most doctors, not just women value the benefits of Less Than Full Time (LTFT) training. But some respondents, particularly doctors, felt part time and LTFT training are still perceived negatively. One doctor said '*There is a poor culture within the NHS which does not respect part time doctors*'. There was agreement that LTFT and part time training allows greater flexibility within the system and greater employee satisfaction. As a doctor in training commented '*More part time training positions would allow doctors to train in more than one speciality, a speciality/GP plus research/education/leadership*'. There was consensus that opportunities for part time training and LTFT across the specialties should be encouraged. It is important that with the increase inflexible training, we ensure that the needs of patients are met at all times.

76. Some respondents also highlighted the difficulties faced when taking time out of training. There was consensus for out of programme activities to be more accessible and encouraged. The Medical Schools Council were in agreement by stating '*Whilst current regulations do allow out of programme activity, this should be positively facilitated and encouraged, including re labelling such experience as, for example, 'Programme Enhancing Activities*'. At present many doctors feel they have little or poor support when taking time out of training. An NHS organisation stated '*At present the notion of taking time away from a competitive speciality (like the surgical specialities) to pursue outside interests is tantamount to resignation*'. Out of programme activities need to be encouraged and valued.

77. Stakeholders commented on the effect Working Time Regulations (WTR) has on the ability for training and the workforce to be flexible. Stakeholders agreed the WTR has impacted hugely on the quality of training. For example, the Special Advisory Committee in Audiovestibular Medicine comment that '*Training has produced junior doctors who miss out on continuity of care because of the WTR*'. Some stakeholders, particularly doctors in training, are concerned that doctors in training are missing out on acquiring skills and experience because of the WTR and needed longer training times to compensate.

General specialty training

78. Overall there was wide consensus that the outcome of training should be more generalists providing the majority of service, with referral to specialist care when needed. The outcome of a more flexible approach to training will be more generalists within the system, doctors with wider depth of knowledge which will benefit the service. The BMA said (13) '*An increase in the number of doctors undertaking broad specialty themed programmes, before embarking on their specialty specific programme, will result in doctors acquiring a well-rounded wealth of knowledge*'. This is discussed in more detail in the section of the balance of the workforce theme. But in terms of flexibility, we must make sure that a move towards

more generalists allows for career progression. Cambridge University Health Partners said '*More generalist doctors will be needed and this could have a benefit for health services, though it is important to have a system based on progression, so if a generalist wishes to become more specialist they have the flexibility to do so*'.

Training structures

79. Although the response to this question was varied in terms of stakeholder suggestions for training structures, there was strong consensus that any training structure needs to encompass a large element of flexibility. The Advanced Life Support Group stated '*All elements will need to be more flexible and more adaptable*'. Respondents again pointed out that increased flexibility is not without consequences. The British Junior Cardiologists' Association commented that '*A more flexible approach may however increase the workload of any institution overseeing it*'. Overall flexibility within training structures was seen as important for the development of future doctors and necessary to ensure the workforce meets patient needs.

Competency based training

80. A number of respondents indicated that a move towards competency based training and assessment would be preferred and would allow for increased flexibility within training structures. Competency based training as opposed to current time based training, coupled with core general training was favoured by stakeholders as the best way to ensure flexibility in training. The Royal College of Physicians stated '*A structured, competency-based, curriculum focussed approach will be key to ensuring specialist services can be delivered to their current standard*'. Competency based training not only ensures flexibility within structures but also ensures high quality of standards are still met. But there was concern as to how a competency based approach would apply to all as one doctor commented '*A competency based curriculum would work although most of the curricula are far too complicated with too many micro-competencies*'.

81. Some stakeholders were conscious of the negatives of competency based training. ASME commented that 'Competency based outcomes throughout postgraduate training would lead to more flexibility but also less predictability of an individual doctor's progress through training'.

Modular approach and credentialing

82. Responses emphasised the need to incorporate the concept of modular learning in training structures. Stakeholders were in agreement that a modular approach to training will ensure flexibility within training and will benefit doctors and the service. BMJ Learning commented '*Modularisation throughout training will enable trainees to change direction during their training or at the end of their training. This will be in the interests of both trainees and patients*'. Support was also given to the

concept of credentialing, with most stakeholders in agreement that credentialing will increase flexibility for training. NHS Employers were also supportive of a modular approach to training, they commented that ‘A system of 'modular credentialing' would facilitate a 'career ladder' approach, encouraging doctors to step in and out of training’. Modular learning will ensure increased flexibility within training structures and many modules would be common to several broad specialties allowing movement between specialties to be less rigid and transferable competencies would also be encouraged. Modular learning and credentialing will create a more flexible training program and result in a more adaptable workforce. This is picked up in more detail in the Scope and Breadth theme.

Academic pathways

83. The ability to undertake research and take time out from training to develop academic skills was seen by stakeholders as a necessary and highly important aspect of training which needs to be encouraged and better supported. It is essential that flexibility is embedded in academic pathways. There was consensus for academic elements to be incorporated into all training programmes, the BMA said ‘*More research and academic opportunities should be embedded within other training programmes*’. Currently, fulfilling academic elements is a struggle due to the lack of encouragement to take time out of training to pursue academic activities. Stakeholders were also in agreement that academic pathways should not be labelled as out-of-programme activity, one doctor suggested that ‘*Clinical academic structures should be more widespread and allow academic expertise to be developed at the same time, rather than time in and out of training programmes*’. This view was shared by a number of respondents, it was clear that there needs to be better integration between academic and clinical work.

Patient needs

84. We will complete this theme by the end of March.

Scope and Breadth of training

85. We asked ‘Are the doctors coming out of training now able to step into consultant level jobs as we currently understand them?’

A note of caution

86. We received in excess of 350 responses to this question. Despite the closed nature of the question, very few respondents offered short, unequivocal ‘yes/no’ answers. Even where a clear view was discernible it was often subject to qualification of one sort or another.

Is there an issue?

87. Just as there were many who felt that new CCT holders were able to step into consultant posts, there were almost as many who felt they were not, as well as those who felt it was a mixed picture and impossible to generalise.

88. Thus the GMC was typical of many organisations associated with training in insisting that current training is in '*very many respects…superior' to that of the past. BMJ Learning said that doctors 'coming out of training are able to step into consultant level jobs as we currently understand them' and the BMA concurred, insisting that there is 'no evidence to suggest otherwise'*.

89. The alternative view was that 'training is less thorough than in the past'. The Radiology Patient Liaison Group, for example, wrote that new CCT graduates were probably not ready to step into consultant posts.

90. Some saw the picture as mixed. The British Infection Association, for example, said there is '*currently a large variation both within and between' specialties*' and Mencap said that it would be '*inappropriate' to generalise*.'

91. NACT noted the feelings of unpreparedness by doctors in training did not necessarily mean that they were unprepared.

92. Others simply deferred judgement. They felt that whether or not there are deficiencies in the current system will only come to light in a few years' time, when the foundation year doctors reach their CCTs (London School of Hygiene and Tropical Medicine).

Experience

93. One of the most prominent themes was that doctors emerging from training '*are not as experienced clinically as starting consultants in the past*' (Advanced Life Support Group). This was evident regardless of whether the respondent thought doctors at the end of training were ready for consultant roles. For many the lack of experience was attributed to '*the reduction in training time*' (ASME) and the WTR meaning that doctors in training see fewer patients. One doctor referred to them as '*often woefully short on experience and learning*'. Another regretted that '*we will complete our training having a fraction of the experience of those who have gone before us*'.

94. The experience deficit was particularly felt in the craft specialties where trainees needed the time and caseload to practise and achieve mastery of their disciplines.

95. But while some lamented that '*new consultants do not always [have] enough experience to deal with every eventuality likely to crop up*' (doctor), others regarded

this as part of the normal learning curve for anybody taking on a new role and by no means indicating the inadequacy of the individual or of their training. The important thing was that those new to the role should receive appropriate support and mentoring in their early years to enable them to build up experience and hone their expertise.

96. Deficiencies in experience related to a number of different areas. For some, there was too much specialisation and a 'lack of general medical training' (Association of British Neurologists). The British Association of Perinatal Medicine commented that 'specialist neonatologists who have recently completed training are not really able to manage the breadth of complex perinatal care and that longer or post-CCT programmes were needed. A doctor commented that '*GPs appear to lack the knowledge and experience to work in such a generalised field*'. Another referred to '*too early subspecialisation and not enough generalist training*'. East Midlands LETB referred to the '*Reduction in clinical experience, including continuity of care*'. Another individual respondent felt that their colleagues are *'remarkably well- trained but probably lack the breadth of experience, because once specialist trainees, the only non-specialty work they've done is the general medical take, with little other specialty work in other branches of general medicine since MRCP*.' There was recognition that they are 'good, even excellent, specialists but few have the general medical competencies required and very little of the leadership or management skills' required to deliver a high quality service.

97. Many respondents drew attention to the fact that post CCT and overseas fellowships are increasingly being used as a way of building on and consolidating experience needs which are not met during training.

98. The comments from the British Infection Association, for example, noted that those who have obtained their CCT through the minimum training period tend to require '*considerable support in their early consultant years*' compared with those who have taken longer, often as a result of undertaking clinical research. These comments were echoed by the British Society of Gastroenterology which referred to concerns that trainees on run-through training '*are reaching consultant posts too early and without sufficient experience*' and that many were undertaking research or fellowships to remedy this deficiency. But the Ophthalmic Trainees Group complained that such fellowships, although popular, '*should not be used to make up for inadequacies of a training programme*'.

99. Several commentators saw a possible solution to the experience deficit in the re-creation of the 'senior registrar grade where the 'trainee...'rehearses' the consultant role' (doctor).

100. But others, while acknowledging that current CCT trainees emerge with less experience than their predecessors, felt that they are '*competent in most cases to work effectively as consultants*' (Association of Paediatric Anaesthetists of GB and Ireland).

Skills deficiencies

101. Some saw the key deficiency in new consultants as a lack of decision making skills. The Abertawe Bro Morgannwg University Health Board (ABMU LHB) referred to new consultants being '*often unable or unwilling to make decisions or take responsibility*'. This is linked to the theme of infantilisation of trainees which was picked up by a doctor who attributed the difficulties experienced by new consultants to the fact that '*they may not be trusted to take complex decisions during training*'. A medical educator referred to their '*reluctance to accept responsibility even as senior trainees*'. The Association of British Neurologists suggested the problem was that doctors in training '*tend to experience less autonomy*' particularly towards the end of their training.

102. A frequent refrain was that individuals emerge from training clinically competent to undertake consultant posts but lacking the essential management and leadership skills. A doctor wrote: '*Many also have no real experience of the considerable non-clinical, managerial duties which constitute the workload of both GPs and consultants*.' Another responded: '*more training in hospital management is needed as this now seems to take up as much if not more time than clinical duties.*' RCP London Trainees Committee said that new consultants are '*unprepared for the administrative and other aspects*' of the job and the RCPCH Trainee Committee said that 'managerial and leadership competencies' necessary for the role were not always developed. Quality improvement, service re-design and educational leadership roles were also seen as undeveloped areas.

103. This view was echoed time and again by organisations. Derbyshire LETC wrote that they need 'a period of supported consolidation to get wider skills and get confident leading the team, management skills, business planning and finance and understanding the wider health and social care agenda' [sic]. Oxford University Hospitals wrote that there needs to be 'more emphasis on training in management/leadership skills and running clinical governance programmes'. The London Deanery referred to the need for skills in system improvement. RCPCH summed up the views of many: '*In paediatrics, most are able to step into consultant roles clinically but are often short on learning and experience to be able to take on leadership, quality improvement, service redesign and educational leadership roles.'*

Changing nature of the consultant role

104. Many felt that the issue was not that current training regimes are inferior to those of previous years, but that 'the demands of the jobs have changed substantially'. 'Consultant jobs are not the same as they used to be' wrote one doctor. Similarly, East of England LETB wrote that 'the future Consultant is not the same as the Consultant' of previous years. In fact, there was 'enormous variation in what constitutes a consultant job in different specialties in different locations' (Medical Manager) and there needs to be 'a realistic view of what the consultant role

is and how this progresses over a period of time for an individual' (Medical Manager). The Faculty of Public Health summed up the views of many when it wrote that 'there is a need to shift the view of and nature of consultant level jobs rather than training as it is important that consultant posts are not seen as destinations.'

105. In fact, not only were consultant roles changing but so was the NHS. East Midlands LETB referred to doctors being trained 'for the previous NHS, there is a bit of a lag'. The RCGP said that new consultants and GPs 'are probably not fit for purpose for an adaptable career in the changing NHS'. It went on to argue that a 'more holistic approach [to care] is required, with a focus on goal centred rather than specialty-centred care planning.'

Solutions

New NHS grading systems

106. If new consultants were seen by many to struggle with the transition to their new role, one of the solutions was to re-calibrate or re-structure the consultant job. It was argued that the '*consultant tier is too flat…There should be career progression as a consultant, with adequate remuneration for additional responsibility*.'

107. St George's University London echoed this theme by suggesting '*consultant grading*'. East Midlands LETB introduced the idea of *'different levels of career grades…with doctors becoming emergency safe and skilled, then generalists in a specialty with only a few moving onto subspecialist training'*.

108. NHS Employers saw value in '*a period of employment in a post-CCT career post focused on service delivery*' as a way of addressing the deficit in confidence and experience felt by some CCT holders. NHS Grampian expressed similar views, suggesting that 'doctors should not come out of training with an expectation of a 'consultant level job'.'

109. RCP did not support the creation of a 'pre-consultant grade' but did propose '*phased grades of consultant*'. The British Geriatrics Society shared this view, and perceived the sub-consultant grade as a device for introducing shorter training and seven day working: '*We do not feel there is a role for 'judgement safe' doctors providing general medical service at consultant level but with less years of training in order to fulfil the requirement for consultant led 7 day working*.'

Generalist v specialist training

110. JCST suggested a number of changes to training. They included:'*Broadening surgical curricula to include allied medical competencies; Concentrating pre-CCT training on the achievement of generalist skills and competencies within the surgical specialty; Moving the majority of special interest training to post-CCT via 2-3 year*

*funded fellowship posts, linked to service needs and commissioned by the responsible bodies in the 4 nations of the UK;… A broader-based curriculum, which includes transferable skills, would also promote flexibility across surgical and medical specialities and could help even out peaks and troughs. An example would be the current problems recruiting in emergency me*dicine and the absence of opportunities for core surgical trainees to transfer (into EM).'

Mentoring and support

111. Regardless of whether current training was deemed sufficient preparation for consultant roles, many respondents recognised the importance of mentoring and support to ease the transition (NHS West Midlands Workforce Deanery). For example, the AoMRC argued that CCT graduates are well trained and highly competent but recommended '*all consultants have a mandatory mentor for at least the first year in consultant practice (ideally first 3-5 years)*.' The RCOG referred to a '*clearly expressed desire for more suppor*t' for newly appointed consultants. And the East of England Trainee Forum declared: '*All doctors should be appropriately mentored when newly appointed*.'

112. We asked: Is the current length and end point of training right?

113. As with the responses to question 10, the statistics only tell part of the story. From over 350 responses, only 85 respondents gave answers which clearly indicated that the current length and end point of training was right. 75 respondents thought it was not. The rest either did not answer at all or offered a different analysis of, or approach to, the problem.

Life long learning – there is no end point.

114. Many respondents pointed out that it was misleading to talk in terms of an end point to training. There '*should be no end point to training and on-going CPD is essential*' (Advance Life Support Group). The GMC said that training should equip doctors '*to continue developing and greater emphasis needs to be placed on the role of CPD in maintaining and developing doctors' competence*.'

Competency based training v time based training

115. The most common theme was that training should be competency rather than time based (for example, RCP&S Glasgow and BMJ Leaning). However, respondents were often reluctant wholly to separate the two concepts. Thus the BMA asserted that '*completion of training should be based on competences rather than length*' but opposed increasing the length of training as this would increase costs '*without any discernible benefit*'. The Academy Doctors Trainee Group wrote that *'the focus should be on gaining competencies rather than a strict time limit on training*' but did not want any shortening of training since they saw this as a pretext for a more

generalist approach and the introduction of a sub-consultant grade. One doctor saw a fundamental tension in the way training was organised: *'We have a competency-based but time-limited training system. The two are in opposition. Some people need more time than others.'*

116. There was also an isolated voice who urged moving from competency based training to training based on patient outcomes in order to make '*performance reliably good*'.

Length of training

117. For many, duration was important though there was no clear consensus about whether training was too long, too short or just right.

118. Those who appeared broadly satisfied with the current length of training included the British Thoracic Society, NHSE ('about right in most specialties'), Faculty of Public Health, British Society of Gastroenterology and the Ophthalmic Trainees Group.

119. For the British Society of Dermatologists training was 'probably too short'. Similar views were expressed by, among others, the British Cardiovascular Society, the British Infection Association, Newcastle upon Tyne Hospital and ABMU LHB,

120. GP and surgical training, in particular, were identified by many as being too short (NHS London, Newcastle upon Tyne Hospital, RCGP, among others).

121. Where training was perceived as being too short, the reduction in the number of hours' and the EWTR were frequently identified as the cause of the problem. Even those who were generally satisfied about the length of training referred to difficulties in some of the craft specialties where the reduction in hours and the need to practise skills and build experience were seen as crucial. Thus Cambridge University Health Partners referred to '*craft specialties where competence improves with caseload*' and argued that training 'necessarily...needs to take longer in some specialties'. The RCS Patient Liaison Group wrote of the '*significant effect that the European Working Time Directive has had on the training of junior surgeons with many struggling to obtain sufficient theatre time to observe, assist etc*'

122. For others training was too long. One doctor complained that too much time is '*wasted in early years of training performing essentially administrative tasks*', and another wrote of activities that could be delegated to other professions. This was echoed by a medical educator who maintained that a '*move to multi professional working would reduce the time required for training by about 1 year*.' The Association of Anaesthetists of GB and NI complained that it is '*pointless that trainees who know what they want to do have to continue to gain experience in specialties they will never use again*'. And some employers '*felt that in many*

specialties current training is too long with curricula being all encompassing' (East of England LETB) and '*needs a more generalist earlier end-point*' (Wessex Deanery).

123. Many respondents said that the appropriate length of training needed to be linked less to the specialty and more to the individual trainee. A doctor wrote: '*It depends on the trainee (ie should be truly competence based) for some it is too long and inflexible and the learning curve has flattened too much for others it may need to be longer or more graduated into a consultant role.'*

124. The MDRS Planning Group took a similar view and noted that while '*some are held back*' by the inflexibility of the current system, others '*feel rushed through elements of training*'. The solution was a 'true competency based training' in which individuals would progress at their own rate. '*Surely training should be as long as is needed to achieve competence assuming the trainee is progressing at the appropriate rate and standard*.' NHS Grampian felt that the needs of the individual could best be met by a '*modular, competency based approach*'.

125. Linked to this idea was concern about the '*current rigid structure*' of training (STC Northern Deanery). RCOG saw this changing in the future when '*programmes will be individualised to…reflect different training and service needs*.'

126. There were also nuances to the too long/ too short debate. Again, Cambridge University Health Partners noted that the length of training also depended upon the sort of doctor you were trying to produce, arguing that 'for a generalist in a DGH it may be sufficient, but for a specialist in a tertiary centre it may not'.

127. But the idea that training to become a generalist was necessarily shorter was challenged by many. A doctor pointed out: 'there is a perception that training as a generalist is much 'easier' than as a specialist, and that it should take much less time... this...assumption...would be poor for patients. The challenges of developing as a generalist are complex and varied and need careful thought and sufficient time and experience.'

128. The NACT also made the point that training generalists '*will not take less time*' while the MSC said that the end point of training may need review '*to take account of the need for a longer period of generalist training*'. Newcastle upon Tyne Hospital responded that '*a move to length[en] time for all trainees to gain broad based skills early in training' is likely to mean that 'overall length of training will need to increase*'. But one advantage of this would be that it would '*allow trainees to provide service with sufficient skill and experience to be lightly supervised for core generic service*' (Newcastle upon Tyne Hospital). In addition, longer generalist training may bring the compensating benefit that post-CCT sub-specialty training is shorter (NHS Grampian).

What is does the end-point of training signify?

129. The key was to be clear about the aims of the training programme. One medical educator wrote that we have to 'Train to the task', and posed the question: '*What are the tasks required of a new fully trained doctor in 2012 in my specific organisation in my specific specialty in my specific team?* A medical educator asked: '...*is it to produce a practitioner skilled in virtually all aspects of a speciality irrespective of the type of consultant post; or to produce a practitioner with less subspeciality exposure who is able to further develop knowledge and skills most appropriate for their roles*'.

130. There was a broad view that the end point of formal postgraduate training was the ability to undertake '*independent practice within the security of the team*' (Medical Educator) and that this should be denoted by the award of the CCT. The BMA also wanted to stress the link between the CCT and eligibility for consultant posts, saying that doctors should not be required to undertake any post CCT training to take on consultant or GP posts). The British Association of Urologists referred to CCT holders being equipped '*to deliver 'core' and emergency care...as a member of the surgical team*'. Others referred to the aim being to produce individuals who are 'judgement safe' in their discipline (NHS Grampian).

131. Some, such as the RCP Edinburgh were clear that although the CCT signified '*readiness for independent practice*' it did not signify completion of training. Indeed, for most the aim or end point was to produce a doctor able to practise at consultant (and definitely not sub-consultant) level. But there was recognition among many specialties that this did '*not achieve subspecialist expertise in many cases*' (Ophthalmic Trainees Group). NHSE clearly saw this sub-specialty expertise as something to be acquired post-CCT in order '*to maintain optimum flexibility in the workforce planning for these, often small, areas of the medical workforce'. That need for a 'Broader,' more generalist capability is also reflected in the comments of the RCP which said that it should form 'a greater part of training curricula and replace some current narrower subspecialist capabilities*.'

132. But the idea that the acquisition of learning beyond the CCT was mainly concerned with increasing specialisation was balanced by the observation of the GMC that it was 'a*bout the capacity to adapt to the changing environment*'.

133. But even though the end point of training was perceived by most as being the ability to enter independent practice, some saw this in terms of a gradual progression from generalist to specialist: '*I envisage a system where consultant (or specialist) is reached 3-4 years after FY. This could be the first CST. Some doctors will choose to stay at that level, providing broad care, but without higher skills or management responsibility. Others will choose to continue their training BUT FOR PART OF THEIR TIME WILL FUNCTION AS A SPECIALIST AT INDEPENDENT LEVEL PROVIDING BROAD CARE.*'

134. In contrast to the BMA, the NHSE even saw this gradual progression needing to '*develop to include [a] period of post-CCT experience between entering the specialist register and attaining a consultant post*'.

135. A more radical view came from another medical educator who questioned the fact that there is 'currently only one successful endpoint – CCT. This makes every doctor who steps out without getting to CCT a failure.' He asked, 'Can't we have different end points?' This was strongly endorsed by NHS Education for Scotland which urged the need to move away from the idea that training is a single process with one end point. There should be training to different levels with different end points: '*The aim of the training structure should be that all doctors should reach the point where they are 'judgement-safe' in their broad specialty area. Many will go on to develop in-depth competence in another area in due course - some will take longer than others. The period of training leading to judgment safety should be closer to current training to middle grade level and could be equated to the minimum training periods in the European training directive.'*

136. This idea is also reflected in the comments of RCP&S Glasgow ('A range of end-points would give greater flexibility...') and East of England LETB which advocated a '*stepped approach to training*' which '*would mean that some doctors only cover the shorter broader curriculum with only a small number progressing to longer more specialised programmes*.'

137. The GMC suggested that a shift in the end-point of training geared toward creating more generalists might require re-examination of the terminology around attainment. For example, 'Certificate of generalist physician training', Certificate of specialist surgical training' and 'registered credential in cosmetic surgery' may be more accurate reflections of a doctor's practice than the current CCT.

Credentialing

138. Some tried to describe what life-long learning might mean for training. The MSC, for example, referred to the need for 'competency based systems of credentialing for specialty training'. The West Midlands Workforce Deanery urged that thought be given to 'more modularised and on-going learning'. They went on: *'May be we should stop thinking about the end point of training and ask whether or not a doctor is ready for unsupervised/independent practice (and entry to the specialist register) and in what contexts. For example a paediatrician may be ready for independent practice in general paediatrics but would need to ask colleagues if faced with a very sick child.'*

139. A medical educator wrote of the need for 'increased post-CCT training opportunities/credentialing'. RCP Edinburgh envisaged consultants acquiring new competences following the CCT: '*Training will continue as CPD throughout a consultant's career, with the option of further sub-specialty training as required by*

the service….some specialist and super-specialist competencies that are only required by a small proportion of consultants, would be achieved after appointment as a specialist, and would be targeted by the local service that requires this expertise.'

140. We asked 'If training is made more general, how should the meaning of the CCT change and what are the implications for doctors and their subsequent CPD?'

No change

141. There was a very clear trend among respondents that however training may change, the meaning of the CCT should not. That is to say, the CCT should continue to be '*the formal point at which a doctor is able to work independently as a consultant or general practitioner*' (Academy Trainee Doctors Group). This view was reiterated by, among others, ASiT, BJCA, British Association of Dermatologists, the Group of Anaesthetists in Training (GAT) Committee (*'it is difficult to identify either training or patient benefits to trainees achieving anything other than a CCT as it currently stands'*), Hospital Consultants and Specialists, individual doctors ('*The current CCT model is a good one and should not change*'), AoMRC (*'CCT should remain as a benchmark of readiness for independent practice at consultant level'*) RCGP ('*an end point in training when sufficient competence has been gained and demonstrated by the trainee performing safe independent practice in the appropriate clinical context*') and the BMA. AoMRC also dismissed the superficial attractions of the 'judgement safe' level of practice.

142. The British Cardiovascular Society was equally clear that any increase in generalism '*should not be at the expense of specialist training'* because *'patients demand and require consultants with advanced specialist skills'*. This view was shared by the British Society of Gastroenterology which maintained that making training more general would not be 'in the interests of patients' and would 'deskill' those training in craft specialties. The Ophthalmic Trainees Group was even more adamant in their opposition, arguing that generalism was at odds with the requirements of technological progress and that a generalist CCT would be a '*useless qualification in a world that is becoming ever more specialised*.' One doctor saw generalism simply as '*a dilution of standards'* and another responded '*Don't make training more general'*. The RCOphth said that '*Neither training nor CCT should be dumbed down*.'

143. Other individual doctors were more sanguine, accepting that properly trained generalists '*can provide excellent health care and it would avoid a lot of unnecessary inter-hospital referrals as more specialised consultants feel unable to deal with the most basic problems.*' The same individual summed up: *'quite honestly we need a common sense, generalist approach far more*.' The RCoA seemed to concur, writing that the '*CCT should be regarded as more of a driving licence designed to produce doctors who are broadly competent generalists*.'

144. Insofar as there would be change it would mean that the '*CCT holder is a generalist and has not undertaken any subspecialty training*' (Hospital Consultants and Specialists). '*Specialising would be done after CCT is gained*', wrote another doctor. And '*CCT should mean – competent in the generalist aspects of that specialty, not a superspecialist in every aspect of that broad specialty.*'

Implications of generalism

145. However, others saw generalism as heralding some fundamental changes. BMJ Learning noted that '*many generalists will want to go on to specialise' and this may lead to 'further specialist training with a different CCT endpoint*'. The logical conclusion seemed to be 'two end points of training', one generalist and one specialist. This was echoed by the British Association of Perinatal Medicine RCPCH which wrote that the '*CCT for specialist needs to be different than the generalist' and an individual doctor who described 'the "general' certificate then the 'specialty' certificate*'.

146. Conversely, the British Geriatrics Society was keen to avoid strict lines of demarcation between generalists and specialists, describing the challenge 'to incorporate the generality, and particularly how to manage frail and complex older patients, into the body of specialty training, rather than reinforce subsequent distinctions that once can either be a specialist or a generalist.

147. But one doctor has mapped out in some detail what the change should mean for current medical roles and doctors aspirations to become consultants: '*The meaning of the CCT should change to allow one to practice independently in a broad speciality area, e.g. general medicine, general surgery, obstetrics and gynaecology, paediatrics, psychiatry, etc. Then one could sub-specialise in an area of interest, qualifying them to manage patients in their speciality area, and to accept referrals for the same. By shortening the length of compulsory training, this would improve workforce planning and reduce rates of dropout from training programmes. This may mean that not everyone can be a consultant in the current sense of the word. However, not every doctor may enjoy the management responsibilities of the consultant role, and it is certainly true that the consultant will have less clinical contact than training grades. Therefore it would be likely that a number of non-consultant senior roles would have to be defined, and that the majority of doctors will enjoy working in these roles. It is probably likely that the majority of doctors will find an area of interest and sub-specialise. Hence, these doctors will have mandatory continuous professional development (CPD). For those who choose not to sub-specialise, it will be necessary to ensure that doctors undertake CPD, for example in the form of attending courses, writing published articles, and/or revalidation activities.*'

148. As responses to earlier questions had also identified, generalism may mean that training leading to a CCT takes longer and is 'not an end-point (doctor). AoMRC, for example, insisted that *'High quality generalism takes longer to achieve*.' Though

one medical manager contended that the fact that the CCT was not an end point meant the opposite could equally be true. The Academy of Medical Sciences highlighted that an earlier CCT might make research pathways unattractive and that there needed to be '*clear pathways to success in clinical academia*'.

149. Though most saw generalism and specialism as part of a single continuum, one medical educator was clear that generalism was not simply a waypoint on the road to specialisation, but an entirely different evolutionary development: '*Generalist and specialty training needs to remain separate and should not be seen as part of the same continuum.*' The Faculty of Intensive Care Medicine made a similar point, noting that 'generalists are essential but these are not half-trained specialists: '*In effect these are specialists in acute care with particular expertise in decision making where both time pressures and considerable diagnostic and prognostic uncertainty exist.*'

150. NHSE drew several important themes together. It highlighted the importance of mapping 'transferrable skills and competences' across generalist and specialist disciplines so that trainees do not have to repeat training in skills they have already acquired. It also acknowledged the arguments of those who said that technology points to ever increasing sub-specialisation, but insisted that the speed of such developments supports the case for '*an increase in post-CCT sub-specialty training as opposed to incorporating these highly specialised skills into training leading to CCT*'. Employers, noted NHSE, were better able to determine the demand for those specialist skills within a 2-3 year time frame rather than a 5-7 year period as is currently required.

151. The London Deanery saw the possibility that generalism might bring a reduction in the current 'unhelpful' proliferation of specialties and sub-specialties. Like many, it saw sub-specialisation linked to credentialing driven by service need. The Wessex Deanery similarly referred to 'Many fewer CCTs.'

152. Perhaps the most radical view came from NHS Education for Scotland, which sought to break the link between '*acquisition of specialist registration and consultant appointment*'. It wanted to align the CCT more closely with a European model so that the CCT was '*seen as a more basic level general/specialist qualification*'. Subsequent specialist expertise would be achieved by means of credentials. For its part, the GMC noted that changes to the nature of the CCT may make it necessary to re-examine '*the relationship between certification and inclusion in the specialist (or any future generalist) register*.'

Changing terminology

153. The British Infection Association picked up the themes of earlier questions in suggesting that the CCT was a 'misnomer' and that the implication of generalism was that certification becomes a waypoint. It suggested the alternative term of 'specialty certification' which would be followed by '*formal certification or*

credentialing [sic] in one or more further specialties or sub-specialties'. This mirrored the comments of others. Doctors referred variously to '*layers of CCT*' and '*a tiered sense of the level of training*' while Cambridge University Health Partners observed: '*If the service requires that the majority of secondary care doctors should be generalists, then the CCT should be given at the end of generalist training and another type of qualification given to those who have done further training as specialists.'*

154. Another doctor suggested changing the CCT to a CCGT (General training) half-way through higher training and CCST (Specialty training) could become the final passport to consultant level. Newcastle upon Tyne Hospital envisaged a three tier structure: recognition of basic skills, recognition of specialty specific skills at a broad level, and recognition of specialty skills and generic skills sufficient for practice as a consultant. West Midlands Workforce Deanery envisaged doctors acquiring a number of CCTs as '*recognition of competencies at different stages*' of their careers and going in and out of training during their careers. However, it concluded that it was '*difficult to see what advantages would accrue from such an upheaval*'.

155. A cautionary note was also struck by one doctor who saw the scope for '*generalist careers [to be] devalued'* in comparison with specialist careers.

CPD

156. Most respondents acknowledged the continuing importance of CPD, though without necessarily describing how it might need to change.

157. As with the impact of generalism on the CCT, some saw no cause for changes to CPD. A doctor said that it would remain a matter for consultants to 'identify their learning needs and direct their own CPD'. A medical educator saw 'no implications for CPD'.

158. But the BMA was one of several commentators to note potential change. It referred importance of CPD not becoming too narrow in its focus. It observed that to meet the future needs of patients part of doctors' CPD should '*focus on developing general skills*'. This echoed the comments of the Association of British Neurologists which said that for the majority in its specialty '*ongoing CPD in all areas of neurology will remain of utmost importance*'. The Scottish Recovery Network referred to the need to keep up to date *'in the wider field'*.

159. But maintaining '*a broader base of skills is clearly going to present greater challenges*' (Association of Paediatric Anaesthetists of GB and NI) and this pointed to a need for 'more clearly defined specific requirements for each doctor group'. Others, including the NACT, picked up this theme, which saw CPD becoming more planned and linked to the creation of a formal system of credentialing: '*CPD needs to be planned against national credentials. As new skills and treatments come on board*

CPD should be planned against these so that qualifications in new areas can be gained rather than picked up.'

160. Individual doctors referred to CPD needing to include formal '*assessment of knowledge and skills*' and requiring '*more structure [including] more organisational and practical…support after CCT*', for CPD to be 'more uniform' and 'a more formal role for accrediting CPD for a specific purpose'. A medical manager saw effective appraisal as the means of bring '*better planning*' and '*a more structured approach to the delivery*' of CPD. The Defence Postgraduate Deanery saw subspecialisation as something which would take place post CCT with an 'impact on CPD' but likely to be 'a more formal training scheme'. Cambridge University Health Partners also saw CPD as the vehicle to convey doctors from qualification as a generalist '*to become either specialists or clinical academics*'.

161. The RCOG followed a similar theme in calling for '*a structured approach to the post-CCT career*'. It saw CPD as the vehicle for doctors to enhance their clinical skills and demonstrate competence in new areas. RCPCH similarly wrote of the need for 'targeted and programmed CPD' for trainees in subspecialties.

162. KSS Deanery noted how the increasing sophistication of post-CCT CPD needs will have implications for funding and '*become a political issue for the paymasters*.'

Credentialing

163. Several respondents linked more formal CPD requirements with the development of credentialing. St George's University went further, suggesting that credentialing may make the need for a CCT redundant as it will identify when a doctor has achieved sufficient experience/competence to take on defined responsibilities/roles. It also saw credentialing as reinforcing the idea of CPD as 'continuing training' rather than just 'a series of 'updates''. NHSE saw post CCT specialty training as dependent on '*a properly regulated credentialing system to accredit training*'.

164. We asked 'How do we make sure doctors in training get the right breadth and quality of learning experiences and time to reflect on these experiences?'

Training v service

165. The dominant theme in the responses to this question was the need for a better balance between the demands of the service and time for training. This was evident across all groups of respondents. Thus the Advanced Life Support Group said the *'balance between service delivery and training needs to be reset*'. The Association of Anaesthetists noted that '*Good departments protect their trainees from too much service delivery*'. The British Association of Dermatologists wrote of the need for a '*balance to be struck between service commitments, time for independent study and research*'. A doctor reported that '*the nature of busy 13 hour*

shifts has meant people don't stop for lunch, don't sit down as a team and don't have any time to reflect'. Other doctors wrote that '*the service should not be 100% dependent*' on trainees and that '*Less time [should be] spent in service provision roles and greater time allowed for reflection*'. The RCP said that doctors needed to be '*able to focus more on their education and training, rather than coping with an unmanageable workload*.'

166. One doctor said that time for training needed to be reflected in their job plans, a remark which was echoed in the comments of both Oxford University Hospitals Trust and the RCPS of Glasgow: '*Greater use of formal job-plans for doctors in training with protected time for training and teaching could be considered*.'

167. A medical educator proposed that 'Training could be organised to combine periods of service delivery followed by periods of experiential learning and project work supported by time for individual reflection'. He noted, however, that this would mean '*the service output would be reduced compared to current arrangements*'.

168. The MSC complained that the funds allocated for education and training were being spent on service delivery. Addressing this would bring 'a*n immediate and dramatic increase in quality*'. While COGPED saw a 'trained doctor delivered service' as key '*so that service delivery for learning has adequate time for reflection*'.

169. However, there were also those who argued that training should not be divorced from service delivery. NHSE said that the two must go 'hand in hand'. East of England LETB shared this view, arguing that '*doctors learn best when they believe they are delivering a service that benefits patients and is valued*'. However, that service delivery needed to take place, wherever possible, with the aim of '*fulfilling defined learning objectives*'. There were echoes of this is the proposal from the Wessex Deanery for '*graded exposure to increasing clinical complexity of service responsibility*'.

170. KSS Deanery saw value in better alignment between educational curricula and service needs: *'Curriculum delivery should be mapped as a mandatory requirement for the programme deliverers. Sharing this information with the employer and the HEIs should ensure that doctors in training get the right depth and quality of learning experience required. However, as mentioned above, the nature of mandates and targets within the curriculum have to be constantly updated to emerging patient need'.* An identical view came from the NHS West Midlands Workforce Deanery: '*Colleges should be asked to again review their curriculums and their assessment strategies with the objective of ensuring that they are congruent for the purposes and needs of the health service and to ensure the fitness for purpose and capability of the future workforce. There must be a greater emphasis in understanding and describing the generalist role and the competencies that are needed, for each specialty area. All curricula should be mapped to link together where appropriate in recognising the needs of trained doctors to work together in the NHS for patients,*

and with patients, and to deliver patient care effectively in the new models of delivery (i.e. closer to patients homes and across various health service systems), and to ensure that they have demonstrated their preparedness for this in order to be signed off.'

171. RCPCH CCH SAC saw a different solution: '*Ideally we would make the trainees supernumerary*' in order to address the '*constant tension between service needs and training needs*'. The Faculty of Intensive Care Medicine advocated a similar approach: '*Uncoupling of training to service needs would also allow the development of a real competitive market in training and is likely to further increase the quality of training.'*

Reflection

172. Alongside time to learn was the need for time to reflect. The GMC noted that progress has been made in restricting the overall number of hours worked but the '*benefits are lost if the pattern of work and service requirements are of such intensity that doctors in training no longer have time to reflect on what they have learned'*. The BMJ Learning similarly noted that '*Time to reflect…will need to be built into all training programmes*.' But this does not currently appear to be the case. A doctor wrote that '*we must ensure doctors have time in their job plans to reflect on their learning experience*'. The British Society of Urological Surgeons warned of the lack '*opportunity to reflect and discuss experiences*'.

Meaningful learning experience

173. Linked to concerns about the dominance of service requirements over learning needs were a number of objections that too much of trainees' time is spent performing tasks of little educational or experiential value and which might be better performed by others. A doctor wrote: '*Remove the scut work*.' The British Association of Perinatal Medicine referred to the need for '*multi-professional staff delivering some of the care presently delivered by specialists in training' so as to 'allow more time for focussed 'specialist training"*.

174. On the other hand, some complained of valuable learning opportunities being taken by other staff: 'Stop insisting that patients can be managed effectively by non-medically trained 'practitioners' and enable junior doctors to use these training opportunities.' (doctor). But a medical educator wrote that trainees should be enabled '*to deliver the sort of service often provided by nurse practitioners in the routine care of… patients as a way of helping them understand CDM better and improving their ability to work in teams*.'

175. There was also frustration that too much learning time was occupied with paperwork and assessments rather than practical activity. '*Stop the paper exercise, let the doctors work and train in real life*', wrote one respondent. Another doctor

complained of a training structure which '*encourages a tick-box approach to workplace-based assessment*' (WPBA) and called for WPBAs to be abolished. The Association of British Neurologists called for *'Less emphasis perhaps on completing log books and 'reflection time', and more on actually doing clinical time.*' And COGPED wanted to enhance '*access to experiences beyond routine clerking, phlebotomy and discharge paperwork completion*'. Another doctor wanted '*Ward time and protected study time*.' And, repeating the refrain about the effects of the service, the British Geriatrics Society complained that doctors in training posts '*should not be used to fill service gaps in lower quality hospitals*'.

176. The Defence Postgraduate Medical Deanery wanted to see 'modularised training' used to ensure breadth of experience. Each module would have specified time, competencies and proficiencies which once completed would then be consolidated in a defined time period of service delivery in that area.

Specialising too early

177. One doctor argued that in order to get the necessary breadth of learning experience the idea of choosing a subspecialty early in the career should be removed: '*This makes most of the current trainees see themselves as "just passing through" and will not have to do this ever attitude develops. Secondly the common and general procedures; for example in surgery; appendectomy, hernia repair, drainage of abscesses and good suturing technique should be taught and assessed before you can be signed off as having completed that posting*.'

178. There were also those who saw breadth of experience linked to continuity of care. A doctor respondent wanted trainees to 'start caring for the patient while [the patient was] still acutely unwell, and follow their progress so they may increase their confidence in management'. A medical educator endorsed this view: 'they do not see enough of the patient journey'.

Learning environments

179. Where doctors learn was also seen as important in gaining the right sort of learning experience. The GMC wrote of the importance of ensuring the '*quality of the educational environment in which training takes place*'. ASME noted that many current posts 'are located to meet service needs and not where the learning opportunities are mapped against the curriculum'. The RCoA took a similar view, and concluded that not all institutions should be training environments: *'...not all hospitals will engage in formal post graduate training of doctors in traditional CCT programmes. The current model of shoe-horning training around service delivery is unsatisfactory and there will be a need to separate service from training at least for some sections of the training pathway.'* The British Geriatrics Society agreed, saying that training posts '*should be allocated' to hospitals that are recognised as providing 'good quality, inspirational training*'.

180. But the opportunity to experience different environments was important for breadth and quality of learning. A doctor wrote of '*Rotations around different centres of learning for exposure to different types of [patient] and illnesses. Another called for 'more opportunities for out of programme experience*'. The College of Emergency Medicine referred to training programmes '*in differing clinical environments, both small and large departments, rural and urban and with a variety of trainers with differing specialist interests*'. The British Thoracic Society was keen to maintain a balance of rotations in secondary and tertiary care as well as more '*training in integrated work with primary care*'.

181. But, equally, trainees needed to spend long enough in one place to reap the benefits. Kings College Hospitals described the need to balance the opportunities to experience different institutions and specialties with *'the value of spending longer periods in different places and jobs in order to consolidate…experiences and training*'. Of particular concern were the three and four month rotations in the Foundation Years '*which prevent the trainee from settling and learning in a stable environment*'. This view was echoed by NHSE. A medical educator linked this with the idea of continuity of care, noting that in '*attachments that last only 6 months, they will not have seen an individual patient for long enough and over 3 years it cannot be guaranteed that they have worked with every chronic (let alone acute) condition in any depth*'.

Recognition of trainers

182. The role of the trainer was also seen as key to high quality training. The BMA welcomed the GMC's plans to introduce new arrangements for the recognition of trainers. Similarly, BMJ Learning wrote that quality learning experiences '*will require fully trained trainers and supervisors'*. NHS Education for Scotland said the key lies in ensuring effective supervision. The British Association of Urological Surgeons called for '*More time in trainers job plans*', a view reiterated in the comments of Oxford University Hospitals Trust.

Strong regulation

183. A number of commentators looked to effective regulation to ensure quality of the training. RCOphth wrote that organisations that '*quality manage training need real teeth to be able to remove posts from LEPs who are not providing suitable training environments.'* The BJCA picked up this theme, stating that quality can '*only be assured by effective quality control'*.

Tensions between service and training

184. We will complete this theme by the end of March.

Other comments

185. We will complete these 3 questions by the end of March.

Summary

186. We will complete this by the end of March.