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SHAPE OF TRAINING

Caring Professionals – Educating doctors for the patients of the future

Final Report of the Independent Review into the Shape of Training

Led by Professor David Greenaway

Foreward

Executive summary

Being prepared – will include summary of main/key messages, outline of model and narrative.

Recommendations

List recommendations here when agreed

The review's purpose

1. The purpose of the Shape of Training review is to make sure we continue over the next 30 years to train doctors who are fit to practise in the UK, able to meet patient and service needs and provide safe and high quality care.

2. We were asked to focus on postgraduate medical education and training across the whole of the UK from the Foundation Programme into specialty training and continuing professional development (CPD). We also considered doctors' expectations and opportunities coming into postgraduate training from undergraduate

My hope is that any doctors who treat me do so with competence and kindness and always professionally. I want to be treated as a thinking person and not to be talked down to or over. I would like to be treated holistically and humanely and not just as a representative of a particular complaint.
(Patient)

education and the Foundation Programme.

3. Our recommendations apply to all four UK countries. It is crucial that reforms to medical education and training produce doctors who have reached national standards and are able to address the rapidly changing health needs of the UK population. We recognise that the four UK governments are taking forward the delivery of health services differently and we need to educate doctors flexibly to respond to these challenges.

4. The image below shows the career structure of most doctors and you can read more about how medical education and training is organised in the UK in Annex XX.

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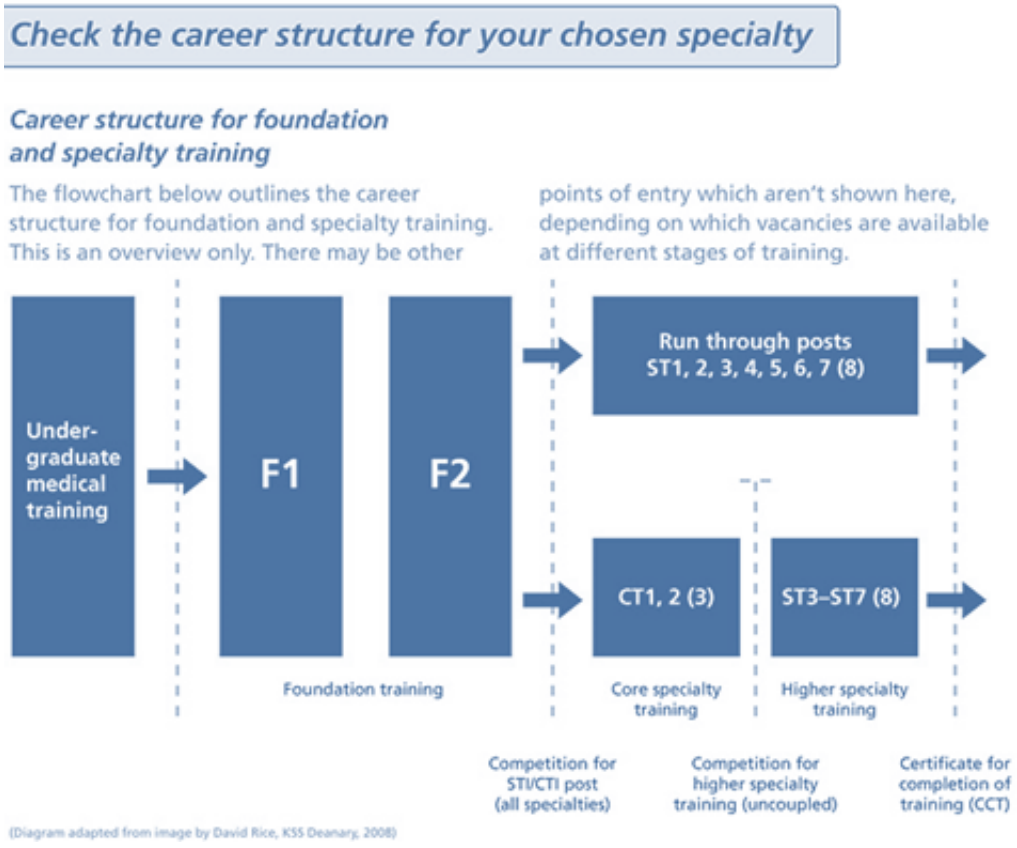


What was learned from previous education and training reviews?

5. Over the last decade, there have been six major inquiries considering aspects of the structure, function and effectiveness of medical education and training in the UK. These reviews, as a whole, concluded the current system is slow to adapt to patient and service needs. The training structure limits opportunities for doctors to

change specialities, develop knowledge and skills outside their specialty curricula or move in and out of training. A recurrent theme in all the reviews was a call for more flexibility in the way we train doctors.[1] Annex X sets out a summary of the implications of their recommendations on this review.

6. The Sponsoring Board asked us to consider these previous reports' recommendations, and give particular attention to *Aspiring to Excellence*, in which Sir John Tooke called for a more flexible and broad based approach to training, integrating both training and service into workforce planning.[2] Tooke also said there must be more clarity about doctors' in training contribution to service delivery and how doctors work within the multi professional teams. These elements featured strongly within this review's themes.

[Include reference to Wales, NI and Scot reports on training/service delivery]

7. The NHS Future Forum (England), in its report to government on education and training in January 2012, reemphasised the need to develop a more flexible career pathway for doctors and a means of fostering generalism in the community and the hospital. These issues were core to the Shape of Training review.

Comment [2]: Future forum is England so we need to say that. We need in this sentence to use at least one report from DA

How the review was structured?

8. The Review was launched through an agreement between all the organisations responsible for the regulation, commissioning and delivery of medical education and training:

- Medical Education England (MEE) – now Health Education England (HEE)
- the Academy of Medical Royal Colleges (AoMRC)
- the General Medical Council (GMC)
- the Medical Schools Council (MSC)
- the Conference of Postgraduate Medical Deans of the UK (COPMeD)
- NHS Education Scotland (NES)
- the Northern Ireland Medical and Dental Training Agency (NIMDTA)
- NHS Wales.

[1] *Aspiring To Excellence: Final Report of the Independent Inquiry into Modernising Medical Careers,* led by Sir John Tooke, January 2008; *High quality care for all: NHS next stage review final report*, Professor Lord Darzi, June 2008; *Foundation for Excellence: An evaluation of the Foundation Programme*, Professor Jon Collins, October 2010; *Scottish Foundation Programme Review Report*, Dr Alistair Cook, November 2010; *Time for Change: A review of the impact of the European Working Time Directive on the quality of training*, Professor Sir John Temple, May 2010.
[2] *Aspiring To Excellence: Final Report of the Independent Inquiry into Modernising Medical Careers*, led by Sir John Tooke, January 2008.

9. Collectively they formed the Shape of Training Sponsoring Board. It was responsible for setting the review's strategic direction including its scope, timelines and outputs. These were agreed in the review's Terms of Reference on 22 March 2012.

10. Professor David Greenaway, Vice-Chancellor of the University of Nottingham, was appointed by the Sponsoring Board to lead this independent review. He assembled an Expert Advisory Group (EAG) to help him identify issues and potential options for changes to postgraduate training. Members of the group were selected for their independent expertise and advice rather than as representatives of their organisation.

11. More information about the review's governance can be found in Annex XX.

What did the Terms of Reference set out?

12. Building on earlier work led by Medical Education England (now Health Education England), and involving key stakeholders including the devolved administrations the Terms of Reference identified key areas within five themes for the review to consider. You can read them in Annex XX.

Themes and issues in the Terms of Reference

Patient needs

- Clarity about the competencies attained by doctors at different stages of their careers
- Roles and responsibilities of all doctors

Workforce needs: Specialists or generalists

- Balance between generalists and specialists needed to deliver care and implications for medical training
- Timing of the CCT, the content and length of training, exit points, the timing of sub-specialty training, recognition of competencies
- Role for CPD and credentialing

Breadth and scope of training

- Support needed for right mix of knowledge, skills and behaviours to prepare doctors for the different contexts
- Balance between sufficient exposure to acutely ill patients and emergency interventions and care in the community
- Time to reflect on practice and learn from experiences

Training and service needs

- Role of doctors in training within the service and competing needs of the service and training

Flexibility of training

- More flexible training to allow doctors to move more easily between specialities and into and out of training
- Support for doctors pursuing academic or management careers

13. We considered this review against the backdrop of rapidly changing medical and scientific advances, evolving healthcare and population needs, changes to healthcare systems, the information and communications technology (ICT) revolution. Doctors' roles and responsibilities will have to accommodate new technologies, systems and professions.

14. We recognise that the medical profession does not exist in isolation and other health and social care professionals are fundamental in delivering a safe and high quality service. But we were commissioned to review medical education and training. There is no doubt that doctors must be trained to work in multi-professional teams and respect the roles and responsibilities of their colleagues. The review's principles might help inform thinking about how other professionals could be trained.

Methodology

What was our review process?

15. The Terms of Reference defined the key questions and we undertook a comprehensive process of consultation and evidence gathering to address these.

16. We engaged with patients, doctors in training, trainers, employers and organisations involved in delivering training. We consulted in England, Northern Ireland, Scotland and Wales including rural and urban settings.

Our engagement activities

- Monthly web and e-updates
- 9 sites visits
- 5 large seminars
- 16 targeted workshops
- Over 65 meetings / discussions
- 54 oral evidence sessions
- Call for ideas and evidence (written responses)

17. In the first phase, we conducted a literature review, undertook desk based research, site visits and held five large seminars. These activities helped us scope out the key issues.

18. In the second phase, we explored key issues through a written call for ideas and evidence, which resulted in almost 400 submissions. We used this information to develop principles and possible approaches to medical education and training.

19. Finally we tested these principles and frameworks through the workshops, discussions and more than 50 oral evidence sessions.

20. This extensive consultation process provided opportunities for individuals and organisations to express ideas, judgements and experiences. Responses were not

formally weighted or quantified but we did recognise that some organisational responses represented the views of a large number of individuals.

21. In total we received feedback from over 1 500 individuals and organisations in England, Northern Ireland, Scotland and Wales. You can read more about our engagement activities and who we engaged with in Annex XX.

Patient needs drive how we must train doctors in the future

22. Our assumptions are based on what experts currently believe will happen to the UK population and future healthcare structures. Some of these trends are unpredictable.[3] Therefore we need to create a training structure that makes sure the medical workforce can respond to this uncertainty.

Comment [3]: We need to include the various DA documents in here that talk about the direction of travel of services.

Changing population needs

23. There are several demographic trends that will change the balance of the UK population over the next 30 years. We examined the impact of changing demographics as a means of understanding how patient needs may change and how doctors' training will be shaped by this.

24. There will be an increasing number of older people (it is difficult to define this age group. The pension age is 65 but the Older People Commissioner in Northern Ireland defines it as people over 50). Census data also show that rural areas will continue to have a higher percentage of older people compared to urban areas in the UK. Even though they make up a relatively small group compared to the population as a whole, they require more medical interventions.

25. Unless there are radical changes in lifestyle choices, more people in all age groups will be living with multiple illnesses. We know, for example, the number of conditions can increase a patient's use of health service resources more than the specific diseases on its own. A recent report found 42% of the population in Scotland had at least one long term condition and 23% had two or more.[4] Doctors will need to understand how these conditions impact on each other and on the patient. XX.

We live in an increasingly diverse and educated society with a range of beliefs. Whether a particular intervention achieves a certain effect is a technical issue, but whether the effect is desirable is an ethical one. Trust is also of paramount importance. (Doctor)

26. Ethnicity and socio economic factors will continue to impact on doctors' practice.

[3] A scenario based report that forecasts possible demographic trends based on changes in socio economic conditions in the UK is available at Annex XX .
[4] Barnett K, Mercer SW, Norbury M, Watt G, Wyke S, Guthrie B (2012). *Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study.* The Lancet online

Most people over 65 experience multiple co-morbidities, but onset of these occurs 10-15 years earlier amongst those living in deprived areas. [5] They are more likely to experience mental health problems alongside their physical conditions than more affluent groups. [6]

27. Given this changing demographic, most doctors will care for patients who will have increasing healthcare needs. Many of them will be frail with complex conditions. Doctors who treat adults must have more of their training dedicated to understanding and addressing the needs of older people. There will be increased pressure to recruit more doctors who can provide a broad spectrum of care for vulnerable patients, including emergency and acute care, mental health and links to social care.

28. To meet patient needs, we must train doctors who are flexible enough to care for a range of patients in diverse circumstances and be able to adapt as local and national populations change. The GMC's core guidance, *Good Medical Practice*, which sets out the professional duties and values expected by all doctors, must be put at the heart of doctors' training and CPD. Doctors must have a broader understanding of diseases and a key element of postgraduate training will be to produce doctors capable of caring for patients more holistically, even if they end up working in focused practice areas -covered in Section X.

Recommendation 1: Professionalism must be embedded into doctors' training (including cultural and socio economic awareness) and recognise patients' individual circumstances such as the impact of aging on their health and social care needs.

Changing the way people are cared for

> *Managing all of this whilst improving the quality, affordability and equity of healthcare for patients, will need a new breed of doctors: doctors capable of leading and managing complex change across constantly shifting institutional boundaries.* (Doctor in training, General Practice)

29. We looked at what patients expect to know about doctors' roles and responsibilities throughout their careers and how they should be involved in postgraduate training. We found little understanding of doctors' career pathways by patients and members of the public. Patients are often not aware of the expertise and seniority of those treating them. But patients should, and want to, know who is taking care of them and how they fit within the team. More clarity about the role of doctors within a team at different points in their

[5] Barnett K, Mercer SW, Norbury M, Watt G, Wyke S, Guthrie B (2012). *Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study.* The Lancet online
[6] ONS, REF

career will reassure patients they are being treated by the right doctor with the right level of supervision for their needs. The outcomes of training are considered in section XX.

30. The review also explored wider issues of how care might be delivered in the future and its implications for training. Patient outcomes, higher levels of patient and staff satisfaction, as well as reduced hospital stays and emergency re-admissions of acutely ill patients are improved where specialists are involved in community care and GPs and doctors trained in general areas of a specialty are involved in co-ordinating hospital and communitycare.[7]

Doctors will have to work in teams and be prepared to listen. Doctors will have to communicate well with one another, other members of the team and with patients and be prepared to treat all members of the team with respect and dignity. (Patient Representative Group)

Impact of patient needs on service delivery

31. We know, through the work with National Voices, patients expect 'person focused coordinated care' based on good communication and team work, including helping them to understand their care and navigate different services across health and social care boundaries.[8] With a more integrated approach, doctors will have to work differently. Patients expect increasingly to be supported in understanding their treatment options and to be involved in care decisions.

As patients our interest lies in seeing healthcare practitioners who understand that we are a whole person not a collection of parts to be looked at in turn by different professionals. This means that while healthcare practitioners might specialise in one area they retain / develop the ability to see that area within the whole and take responsibility for coordinating their actions with those of others in the healthcare team' (Patient Representative Group)

32. To deliver this, doctors must have a broad enough understanding of the different aspects of patients' needs and be able to manage and communicate these within a multi professional team and across different care settings. Postgraduate medical education and training will have to focus more on these generic professional capabilities to meet these needs – discussed section XX.

[7] Kings report page 30 – insert references to research studies
[8] National Voices. 2013. *A narrative for person-centred coordinated care*. Commissioned by NHS England.

Blurring the boundary between primary and secondary care

33. A care model where people are increasingly treated near to home with better continuity in their care improves patient outcomes and reduces hospital admissions. [9] If this approach is developed, more doctors (including specialists) will work within community based teams away from hospitals. [10] Specialised centres will need doctors trained in particular specialties, but in fewer numbers. General practitioners (GP) will have to develop GP and healthcare networks (with other GPs and specialists) where patients can access more targeted and specialised care within primary care when needed. To deliver safe care in any setting, all doctors will need to be grounded in generic knowledge and skills coupled with the ability to manage not just clinical diagnosis but the interface between different services and specialists. (The summary of the Call for ideas and evidence has more details about changes to service delivery in Annex XX).

34. To meet the challenges of a more community based care model, postgraduate training will have to train all doctors to provide care in community and acute admissions settings. Barnett et al. called for medical education to produce '*generalist clinicians to provide personalised, comprehensive continuity of care*.' [11] Doctors may want to further specialise in a narrower area of practice through credentialed programmes. This is discussed further in section XX.

Patients want to be more involved in training doctors

> *We recognise as patients that providing a service can itself be a learning opportunity but this only happens when individuals are given the time and support to learn from what they are doing and provided with feedback on their activities.* (Patient Representative Group)

35. The Health Foundation suggests patients must be involved in quality, safety and care evaluation, clinical decision making and service development and through being enabled to increase their health literacy and self-care. [12] Similarly there is growing evidence that subjective experience can impact on outcomes and the expectation that patients take responsibility for their own health. The literature review in Annex X has more information about this.

[9] King's Fund, National Voice

[10] Royal College of Physicians, Hospitals on edge: Time for action, 2012; N Timmins, *Tomorrow's Specialist: The future of obstetrics, gynaecology and women's health care,* Royal College of Obstetrics and Gynaecology, 2012.

[11] Barnett K, Mercer SW, Norbury M, Watt G, Wyke S, Guthrie B (2012). Research paper. Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study The Lancet online

[12] Christmas and Milward, October 2011. *New medical professionalism: A scoping study for the Health Foundation*..

36. We learned doctors sometimes struggle to put into practice the patient centred learning from medical school. [13] This was linked to a lack of support and learning opportunities with supervisors, coupled with too much administrative work. If we want doctors to work in partnership with patients, we need to strengthen how they are supervised and supported in training - discussed further in section XX.

37. Patients' needs must define care and service delivery. This means patients must be involved in educating and training doctors. This can only happen if they are supported in taking on more proactive roles including teaching and giving feedback. Learning from patients and carers must be an explicit part of postgraduate curricula and assessment systems and should be part of a review of curricula – details in section XX.

Recommendation 2: Patients must be involved in educating and training doctors including feedback and teaching roles.

Workforce needs will change the balance between specialists and generalists

38. The Review's Terms of Reference asked us to look at the balance of generalists and specialists. We were not asked to review the current medical workforce or suggest the numbers of doctors needed in the future. Instead we have looked at the tensions and pressures that will change the balance between different categories of doctors over the next 30 years.

Pipeline into medicine

39. We must explicitly inform potential and current medical students about the kinds of doctors needed in the future and how this will impact on their careers. For example, employers are likely to recruit more broadly trained doctors to work across hospital and community. Future workforce demands might mean highly specialised doctors will struggle to find jobs or these jobs will only be available in particular locations. Medical schools and postgraduate institutions must provide realistic advice about a career in medicine which should emphasise how medical careers will be driven by patient and workforce needs.

'If future pathways will not meet expectation[s] for all who wish to take up senior appointment, this will need clear explanation starting with school career services to ensure expectations are managed from the earliest opportunity. New roles and structures must be developed that will meet the needs of employers and patients with the flexibility to adapt the structure to suit local circumstances' (MDRS Career Planning subgroup of HEE)

[13] Lit review

40. To help medical students and doctors make informed decisions about their careers, the Sponsoring Board organisations and the Departments of Health must publish recruitment and retention rates, information about progression and the kinds and numbers of doctors needed now and in the future.

Recommendation 3: Medical schools and postgraduate institutions must provide clearer advice to students to help them make realistic career decisions.

The current medical workforce

41. Organisations that employ doctors in training face several challenges when managing their responsibilities for medical training, service delivery and patient care. Their aim is to have the right kinds and numbers of medical staff to provide safe and effective care.

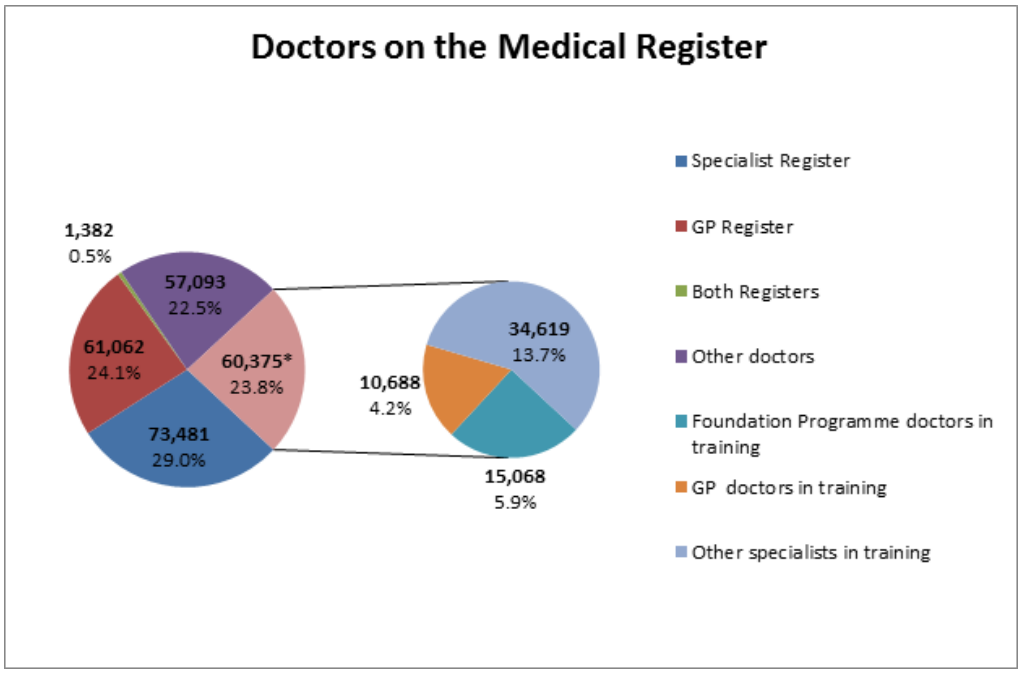
42. But some of the more generalist specialties are struggling to fill posts. Other specialties attract fierce competition, often in areas where there is a need for smaller numbers. For example, specialties such as paediatrics, psychiatry and emergency medicine have reported lower competition rates for training places than specialties such as surgery.[14] We heard that this was shaped by perceptions of high workloads and intensity as well as limited career development and burnout. Difficulty in recruiting into specialty training has, in some cases, resulted in doctors in training already in post or locum doctors filling in rota gaps, raising patient safety issues.[15] Employers told us they need a flexible workforce that would give them more options to plan day to day work cover.

43. There is an ongoing trend in the current workforce towards a more specialised medical profession, as shown in the chart below. Doctors in training make up nearly a quarter of this workforce and if nothing changes, we can expect about fewer doctors become GPs than specialists.[16]

[14] Medical Specialty Training (England) Competition Information 2012. Available at: http://www.mmc.nhs.uk/specialty_training/specialty_training_2012/recruitment_process/stage_2_-_choosing_your_specia/competition_information.aspx [Accessed on 9 August 2012]

[15] GMC, State of medical education and practice, 2012.

[16] The Doctors in training slice represents all doctors in training, as reported in the 2013 NTS Census taken on 26 March 2013. This total differs from the figure of 59,535 reported in SoMEP 2013 due to differing exclusion criteria. For example, the figure in SoMEP was derived after additionally excluding some trainees from the 60,375 due to their being in training after already having entered the Specialist or GP Register.



44. Closing this gap between specialists and more generally trained doctors including GPs will only happen when employers place more value on doctors with a broader scope of practice, who are be able to provide more acute care and be much more integrated into multi professional teams. They must make these broader roles more attractive through career support and development. If more jobs require doctors trained in the general areas of their specialty, then more doctors will train to fill these roles. The structure of postgraduate training must be adapted to provide broader specialty training to support the service better.

45. A move towards a medical workforce with a boarder approach to patient care will mean more doctors will be capable of working in rural and isolated areas. With a bigger recruitment pool, these areas might be able to attract more doctors to these areas.

46. [Case study of recruitment issue in rural area eg inverness]

The medical workforce in the future

47. We heard that employers want a system that future proofs their medical workforce. They need a mix of doctors who provide care in different settings and in a range of ways depending on local service needs. Patients would value a system that supports them across primary and secondary care boundaries. Postgraduate training must focus on preparing doctors with generic clinical and professional competencies that can be adapted and enhanced to support local workforce and service requirements.

Clear networks of clinical and educational supervision are needed to ensure that support is available and actively sought from the multi-disciplinary team when a doctor encounters challenges beyond their current level of competence. The key to achieving this is about developing a supportive learning culture within the training environment and for doctors themselves to develop a clear insight into their own abilities and boundaries of practice. (Organisation employing doctors)

48. Pushing against these workforce and employment demands is the pressure to provide value for money in a difficult financial climate. Employers have to balance patient expectations and doctors' aspirations against delivering a safe service. We heard serious criticism about the inflexibility and rigidity of curricula- discussed in section XX.

49. Like patient needs, workforce and service needs will be better addressed by doctors trained in the broad areas within their specialty. They will be better prepared to take on different roles and responsibilities to meet local requirements.

A broader approach to the breadth and scope of postgraduate training

50. The Terms of Reference asked us to look at the context in which training is delivered including length of training, exit points and recognition of competencies. We also consider the impact of training transitions on doctors, the service and patients.

Supporting transitions in the medical career

51. Doctors are expected to take on more responsibilities and work with less supervision and support as they move through their training and into the early years after training. These transition points include the move from medical school to the Foundation Programme and initial employment, from the Foundation Programme into specialty training, from specialty training into practice. Doctors may also experience transitions throughout their career when they change jobs, roles or take on more responsibilities. Professional judgement, working as an employee in a pressurised environment and taking on more management and leadership responsibilities are often cited as concerns during transitions.[17]

52. Risks to patient safety and care increase when medical students move into their first clinical placements (often call the August changeover). Patients admitted on the first Wednesday in August were reported to have a higher early death rate than patients admitted on the previous Wednesday.[18] These concerns by 90% of

[17] BEN G impact of TD research on professionalism; Jan illing; Trudie Roberts, Hamel - FP etc
[18] Jen et al, 2008 in Vaughan et al, 2011.

respondents to a Royal College of Physicians survey which rating the impact of this changeover as negative.[19]

53. The GMC now requires medical students to complete a period of clinical experience prior to graduation (about 6 weeks) alongside shadowing at the site of their first placement. These experiences should be extended to give students more opportunities to work in multi professional teams in different care settings. Activities should focus on what to expect in the first few years of training including practical experiences working through professional and ethical issues.

54. Medical students and doctors in training learn to care for patients in fragmented ways. They will see patients at particular points in their care but rarely see the contribution of other health and social care professionals or the outcome of that care. For example, Foundation Year 1 doctors told us they sometimes spend hours completing discharge summaries and other administrative paper work for patients theyhave never met or treated. They did not value this as a way of communicating with the wider multi professional team or providing continuity of care. This compartmentalised view undermines patient centred care and encourages doctors to think of patients as conditions rather the whole patient.

55. If we want to train well rounded doctors who understand patient care more broadly, they must understand the impact of their care and what other support patients might need along the way – from the patient's perspective. An approach that allows students and doctors in training to follow patients through their care pathway would benefit doctors – an example is described in the box below. Recognising there will be practical challenges in implementing this, a longitudinal approach would sit best within medical school or as part of the Foundation Programme when doctors could have supernumerary roles without impacting on service delivery. Foundation doctors should be able to follow a small number of patients through their care pathway within each placement.

Several medical schools in the USA – including Harvard Medical School - have introduced 'longitudinal integrated clerkships'. For one year, students work with doctors in core specialties (internal medicine, neurology, obstetrics/gynaecology, paediatrics, surgery, radiology and psychiatry) continuously throughout the year while simultaneously following a panel of patients representing a wide spectrum of medical conditions. Evaluation of these clerkships has found the students perform at least as well as traditional students on national knowledge and skills tests and better on clinical skills assessments.[1] Students on this programme fed back that they felt better prepared for practice including professional aspects of involving patients in decision making, understanding the impact of social context on patients.

[19] Vaughan et al, 2011

Recommendation 4: The GMC, Medical Schools Council and postgraduate institutions must extend clinical opportunities that focus on patient journeys and what will be expected of doctors as employees for medical students and Foundation doctors.

Variation between medical schools

56. Respondents also raised issues with the variability on preparedness of graduates between medical schools, shown in the chart below.[20]

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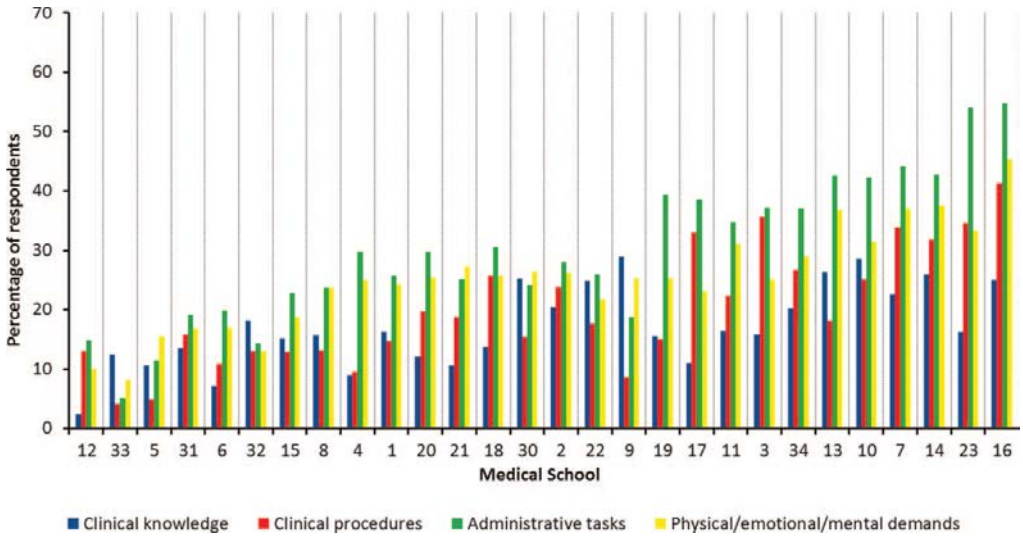

Percentages of doctors indicating 1 year after graduation that they felt unprepared for four aspects of their work, by medical school.

Source: Goldacre MJ, et al. Postgrad Med J 2012;00:1–6

57. Patients and employers need to be sure all medical students are meeting the outcomes in the GMC's *Tomorrow's Doctors* – the standards medical students are expected to achieve before they graduate. The GMC and MSC have started work to understand the reasons for these variations and their implication for training and on patient safety. We expect the GMC and medical schools to put in more rigorous checks to make sure all medical graduates demonstrate at the point of registration they are capable of working safely in a clinical role suitable to their competence level. In section xx we discuss moving Full Registration to the point of graduation. It will be absolute necessary with this regulatory change to demonstrate that graduates are ready for full registration because of risks to patients.

[20] Goldacre, MJ. et al. Foundation doctors' views on whether their medical school prepared them well for work: UK graduates of 2008 and 2009. *Postgrad Med J* 2012.

Recommendation 5: The GMC, MSC and medical schools must ensure medical graduates at the point of registration are capable of working safely in a clinical role suitable to their competence level.

Implications of the Foundation Programme on postgraduate training

58. We were not asked initially to consider changes to the Foundation Programme. But respondents, including Sponsoring Board organisations, pointed out a pressing need to consider it in light of future reforms to.

59. The Foundation Programme enables medical graduates to consolidate and develop their capabilities to care for the whole patient and make a more informed decision about their future career direction. It provides generic training to bridge the transition from medical school into specialist/general practice training.

> *All trainees should have the opportunity to spend time in community/primary care and hospital/secondary care settings, both during foundation, and subsequently.'*
> *(NHS Scotland)*

60. Overall the Foundation Programme is seen very positively. Doctors in training welcome the chance to try out different specialties before making a career choice and they move into the work environment in a more supported way. Placements give doctors opportunities to train in broad specialties areas and recent changes mean doctors work in both primary and secondary care. Evidence suggests they are using these experiences to inform their decision about their specialty.

61. The Foundation Programme should continue over the next few years as a two year introduction to medical practice in both community and hospital settings, but as changes to education and training evolve the second year could be incorporated into higher training.

62. In section xx, we discuss introducing broad based training in specialties as a new postgraduate training structure. When this is in place, the Sponsoring Board organisations should move Foundation Year 2 into specialty training.

A case for moving Full Registration

63. We were asked to consider the case for moving Full Registration to the point of graduation. This regulatory change could help meet the challenge of oversubscription to the Foundation Programme. Concerns of oversubscription for Foundation Year 1 (F1) posts are the result of an unplanned growth in medical student numbers and static Foundation Programme numbers. Right now, UK graduates who do not get F1 posts are limited in their career options because they would not be recognised as a fully qualified doctor in other countries. By changing the point of Full Registration, graduates would possess a portable qualification which

would be accepted abroad. However, changes would not address the competition bottleneck at F2 or going into GP and specialty training.

64. This approach, if introduced without stringent safeguards, could pose risks to patients. We know from successive UKFPO reports that some 200 doctors a year experience significant difficulties in F1 and a similar number in F2 (around 2.6% of each cohort) to the extent that their training needs to be lengthened, remediation put in place, or both. And a number of new doctors are dismissed by their trusts for serious disciplinary matters, or simply leave training altogether.

65. Unless changes to the Foundation Programme are UK wide, there is a risk that training will be developed and delivered differently across the four UK countries. There would be less flexibility for doctors to train across borders, in part because of how Foundation Programme posts are funded within England, Northern Ireland, Scotland and Wales.

66. Moving Full Registration will have to be fully examined including the legal and regulatory implications for this change. Patients and the service are likely to expect graduates who have Full Registration to meet the same competence level as the current threshold. This change will inevitably have a knock on effect on undergraduate medical education, which will have to prepare graduates to meet more advanced outcomes.

67. Before taking this proposal forward, we would expect a package of measures to be in place to make sure graduates are fit to practise at the end of medical school:

- The GMC and MSC to review undergraduate medical education to make sure graduates are able to practise safely at the point of Full Registration.
- The GMC and MSC to consider a national licensing examination. This would give the public and employers assurances that graduates are safe to work without limits to their registration.
- Doctors during postgraduate training will work only in approved and quality assured training environments.
- The GMC and postgraduate institutions review professional examinations to make sure they demonstrate doctors have met specialty requirements at the end of training and are safe to work outside of approved training environments.

Recommendation 6: The Sponsoring Board organisations should move Full Registration to the point of graduation from medical school, provided the educational, legal and regulatory frameworks with might include changes to undergraduate medical education, a national licensing examination, quality assured training environments and professional specialty examinations at the end of training.

Generic capabilities

68. Medical education goes beyond learning the technical aspects of medicine. It is fundamentally about becoming a dedicated doctor. Therefore, the professional identity formation of physicians - meaning the development of their professional values, actions, and aspirations - should be a major focus of medical education.

69. More doctors in the future will need to care for patients with complex health needs and across different settings. Postgraduate curricula should be shaped by professional values and generic capabilities expected for all doctors with specialty specific requirements embedded within this framework. We also heard that curricula are rigid and no longer fit for purpose, particularly if we want to develop broadly trained specialists. We discuss the need to review curricula in section XX.

70. Many of the qualities of good educators, leaders and clinicians could be characterised as core capabilities. The ability to communicate effectively, empathise, lead, be diligent and conscientious, could be included in the list of capabilities that trainees must possess or be expected to develop. These illustrate the kinds of knowledge, skills and behaviours which are complementary to doctors' clinical skills but which, crucially, are integral to professional practice. The GMC is leading on developing these generic capabilities based on *Good Medical Practice* to make sure they are embedded in curricula.

71. Advances in science, technology and medicine will change dramatically over the next 30 years. To meet these challenges and provide the best possible care to patients, all doctors should be research literate and be capable of contributing to research. It is essential that there are flexible training pathways for doctors with the desire and aptitude for a career in academic medicine.

72. We also heard that well rounded doctors need to have an understanding of and experience in physical of care and mental health. This has implications for curricula – psychiatrists need more training on medicine and other specialties need more training on caring for patients with mental health concerns. But it also suggests all doctors have to have a general understanding of different aspects of healthcare.

Recommendation 7: The Sponsoring Board organisations must introduce a generic capabilities framework based on professional values.

Competence and capability based training

73. In the UK, postgraduate curricula already need doctors to demonstrate knowledge, skills and abilities through measurable and observable assessments. But time is still strongly featured in our current structure, underpinned by minimum time requirements in the relevant European Directive. It is used as a proxy measure for many competencies and overall progression is based on an annual review of how they have met their training requirements. And for many craft specialties time is

important in terms of moving beyond competence into 'mastery'. The time component means the length of training is relatively predictable, albeit many doctors take longer than the predicted length of training

74. We agree training must continue to be bound to some extent by time. But the current approach to progression is too rigid. Doctors should be able to progress through their training at their own rate based on appropriate assessments of competencies and capabilities. We recognise that a greater shift towards outcomes and competencies might increase tension between service continuity, delivery and training. Ultimately, it will give patients, doctors, trainers and employers more assurance that they have met the necessary requirements to work safely and competently with appropriate supervision.

75. We also heard that assessment and evaluation throughout postgraduate training is becoming increasingly bureaucratic – ticking boxes- not necessarily demonstrating capabilities or showing that a doctor is consistently working safely. Trainers told us their relationships with doctors in training have eroded over the last decade. Changing the way doctors are supervised will help address this concern. But assessment and assessment systems as well as the evaluation of progression must be considered in light of reforms to postgraduate education and training.

Recommendation 8: The Sponsoring Board organisations must introduce processes that allow doctors to progress at their own rate through training within the overall training length.

Making supervision and support central to training and service delivery

76. A shift to an approach that puts supervision and support at the centre of training and service delivery would address many of the challenges in the current structure.

Longer placements

77. Confidence and preparedness (discussed in section XX) might be mitigated by doctors training longer in one place. Employers have reported doctors in training sometimes struggle to build effective teams.[21] Most specialty doctors in training rotate through different posts every 6 to 12 months once they have completed the Foundation Programme. These doctors benefit from this work pattern because they get more experiences and learning opportunities. But short timeframes make it difficult to plan workloads, rotas and development opportunities for the rest of the team or unit. Employers also raised concerns that constantly changing key team members, affects the way the team works. Research on how teams work found that

[21] Medical Education England, Employer workshop for Phase 1 Shape of training project, 2011.

where teams are functioning poorly, there is less cohesion, leadership, innovation and quality of care.[22]

78. Longer time within a placement would help doctors integrate better within teams, have closer relationships with trainers, consultants and team members as well as gain support during career and training transitions. This longer time within a stable work environment would give doctors more bespoke training opportunities, resulting in some being able to demonstrate competencies and capabilities rapidly while building their confidence.

> '*We all, and all our programme directors strongly support reducing the frequency of rotations…people need to bond with a big multi-professional team that works and so reducing the frequency of rotations, provided you can have appropriate quality of service and quality of training.*' (Postgraduate Institution)

79. We recognise clinical knowledge and skills might be learned within shorter placements – like the current structure, but to build up professional capabilities and learn to manage critical relationships takes longer. Doctors could, for example, in the early stages of training benefit from placements lasting 6 months while doctors towards the end of their training could stay in one place for at least a year (exact placement timings would be determined by the relevant specialty). We heard, for example, that some employers already keep their doctors within the same team or department for at least six months when they move into their next training stage. This gives them time and space to consolidate their new responsibilities and requirements while still relying on team support and relationships built up from the previous year.

Apprenticeship based approach

80. With longer placements, we will be able to re-introduce some elements of apprenticeship back into medicine, more common during the previous SHOs era. We need to create a much closer link between service and training so that all service delivery provides meaningful learning and training experiences rather than just fill rota gaps. A more apprenticeship based approach to training would give patients more confidence that their doctors are working competently at their level of training and that they are supervised appropriately.

[DEFINE APPRENTICESHIP HERE]

81. Doctors would train and work with a small number of trainers and team. Trainers would be better able to assess training progress and areas of development. This will inevitably put pressure on employers to manage rotas. But doctors must have more personal supervision to get the best training opportunities and build up

[22] C Borrill, The Effectiveness of Health Care Teams in the National Health Service, 2011.

confidence with trainers about their competence. As doctors progress through training, supervision will become less direct. They will also provide more service coverage as their responsibilities increase, including providing acute and emergency care.

82. When developing an apprenticeship based approach, some key elements should be considered:

- Supervisors and trainers need to be recognised and supported in their roles including the time and resources to provide quality training.
- Local education providers would need to make sure negative role modelling; undermining and personality conflicts don't derail the training relationship.
- Some training placements may not give doctors access to the full range of experiences and opportunities to meet the curricular outcomes and requirements. Those providing training would have to work together to make sure there are regional and national mechanisms to address these shortfalls.
- Given the resource implications for employers, this will mean not all doctors and local education providers should be involved in training.

Recommendation 9: The Sponsoring Board organisations and employers must introduce longer placements for doctors in training to work in teams and with supervisors including putting in place arrangements for supervisors and doctors in training to work regularly together in an apprenticeship based approach.

The outcome of postgraduate training

83. We have defined broadly the level of competence expected in doctors at different points in their careers. Doctors must continue to be able to make difficult judgements in complex and complicated situations and often outside of recognised protocols. Other healthcare professionals might increasingly provide large amounts of care including diagnosis and prescribing. But ultimately doctors will still make and be responsible for critical medical decisions. There is no appetite for postgraduate training to produce a less trained doctor – a 'sub-consultant'.

84. The outcome of postgraduate training must recognise and value doctors who are trained in the broad areas of their specialty. Further specialisation or subspecialisation should be determined by workforce and patient needs. The current CCT should be changed to a Certificate of Specialty Training for all doctors who complete postgraduate training. It should recognise the general specialty area in which they have been trained. For example, a GP would get a Certificate of Specialty Training (General Practice) or a surgeon would get a Certificate of Specialty Training (General Surgery).

85. The GMC in consultation with other organisations will have to put in place the necessary arrangements for the regulatory recognition of this exit point, including a review of the implications for the current specialist and GP registers.

Levels of competence

86. We believe there are three broad levels of competence:

a. Doctors who are emergency safe and capable of dealing with the patient in front of them. These doctors need some support but are able to safely assess patients in acute and undifferentiated situations without direct or hands on supervision. Doctors generally would still lack experience and the breadth of knowledge and skills needed to deal with complex and riskier cases. This describes doctors within a year or two of specialty training.

b. Doctors who are able to make safe and competent judgements in broad specialist areas. They would be accountable for their professional decisions. This is what we currently call 'independent practice', but doctors work in multidisciplinary teams and relying on peer and collegial groups for support and advice. We expect them to provide leadership and management, not only for the patient in front of them, but for the team, unit and system in which they work. They would oversee and make calls on risky and complex cases and would have enough experience, confidence and insight to manage patients more holistically across several 'specialties' and within different teams. This is the outcome of postgraduate training and would result in a Certificate in Specialty Training.

c. Doctors who are judgement safe but have in addition acquired more in-depth specialist and subspecialty training in a particular field of practice. But they would still have to be able to assess and treat patients with multi morbidities. This is not necessarily a progression away from working in the general areas of a specialty but might involve a narrower field of practice in greater depth. This would be recognised through credentialing and would be driven by workforce and patient needs.

87. Doctors would benefit from training in areas relevant to patients rather than in specialties –as they are currently defined and would train, for example, in caring for women, or children, or elderly people, or people with long term illness or disabilities. We support the idea that specialties should be bundled into 'stems' – an approach first recommended by Tooke in *Aspiring to Excellence*.

88. We would expect specialty stems to be characterised by patient care themes and be defined by the dynamic and interconnected relationships between the specialties. Stems will have common clinical objectives which will form a core part of specialty curricula. But to make sure doctors have a broad understanding of other areas of medicine, they must have opportunities to train outside their specialty stem for up to a year. This time would still count towards their training.

89. Some specialties have started to move towards this approach. General medicine, psychiatry, general practice and paediatrics are piloting a broad based programme. Doctors train in areas across all specialties in the first two years of the programme and then narrow down into one area. It is too early to draw conclusions - the first cohort on this programme started in August 2013. But it is worth noting that there were a large number of applications for the programme and continuing interest by doctors to be involved in this type of training. A description of a future model for training is described in section XX.

Recommendation 10: The Sponsoring Board organisations must structure training within stem specialties based on patient care themes and defined by common clinical objectives in order to produce doctors who are judgement safe and capable of practising with limited clinical support within a multi professional team.

90. We anticipate that some specialties such as general practice will have to be longer to take account of the broader approach to training – up to four years after a one year Foundation Programme. Other specialties will have shorter training times as curricula are adapted to deliver a broader specialty approach. More narrow specialty and subspecialty training will take place after the certificate of specialty training.

91. Details about levels of competence and capability and length of training will need to be considered through a review of curricula by the Sponsoring Board organisations. It should define the specialty stems and determine how specialties within the stems interact. It must consider questions around broader and more general training within specialties themselves, including what aspects can move into credentialing. It should look at embedding generic capabilities and aligning competencies across specialties in order to aid their transferability. We would expect a review of curricula to consider how to make patient involvement more explicit in training. Changes to curricula must also fit with employer arrangements, requirements and opportunities.

Recommendation 11: The Sponsoring Board organisations working with employers must review postgraduate curricula, assessment and progression to deliver broader specialty training within stems, generic capabilities, transferable competencies and more patient and employer involvement.

Tension between service and training

92. The role of doctors in training within the service and the competing needs of the service and training were key issues set out in the Terms of Reference.

93. The Francis Inquiry into Mid Staffordshire NHS Trust and the Keogh Review into 14 hospital trusts raised concerns about staffing levels as well as support and

supervision within healthcare teams.[23] The GMC, while positive about the overall quality of training, has identified significant concerns about the training environment, especially were it overlaps with demands in the workplace. [24]

94. To help with these challenges, the Academy of Medical Royal College Trainee Doctors' Group has developed a charter for postgraduate medical education and training. It emphasises training priorities such as time to learn and reflect on learning while recognising doctors' in training employment responsibilities– read it in Annex X. Employers and doctors in training should consider using this compact (or a similar one) to set out what is be expect from each other during their training period.

Time to learn

95. All doctors are now limited in the number of hours they work because of the Working Time Regulation (WTR) which both doctors in training and Local Educational Providers (LEPs) have found it challenging to comply with, particularly when managing rotas, gaps in rotas and work load intensity for all doctor grades.[25] We know doctors also have less access to senior doctors and consultants, particularly in the evenings and on weekends.[26]

96. We discussed in section XX how the training structure and content might improve the quality of training. Revised curricula that delivers broader specialty training, more targeted supervision and a more personalised outcomes based approach to assessment and progression would take away some of the pressure on training hours.

Doctors will have to provide acute care

97. Although the review is looking at producing a medical workforce to meet future needs, restructuring training to produce a more broadly trained specialist might ease some of the current workforce pressures. The current structure of the medical workforce often results in no or few senior staff working on weekends or evenings. Employers then rely on locum doctors and doctors in training to meet service needs, raising patient safety concerns and providing poor levels of supervision.[27]

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[23] Francis and Keogh
[24] GMC National Training Survey 2012 http://www.gmc-uk.org/education/surveys.asp
[25] WTR research by GMC – unpublished until end of October 2012. Summary available at: http://www.gmc-uk.org/04___Working_time_regulations_research_update___report_of_the_primary_study.pdf_49994882.pdf
[26] AoMRC, Report on consultant-led care, 2012; John Temple, *Time for training*, Medical Education England, 2010; GMC National Training Survey 2012.
[27] GMC, State of medical education and practice, 2012; AoMRC, The Benefits of consultant-delivered care, 2012.

98. The government has reported that the crisis in emergency care will likely deepen and put patients at risk.[28] The GMC has also identified concerns with training in emergency medicine, including poor staffing levels, a lack of supervision by senior doctors and a high work intensity and workload. We were told that doctors do not want to train in acute and emergency care because it is perceived as too stressful - ultimately resulting in few doctors able to cover acute care. But we know, for example, acute wards managed by doctors trained in general medicine result in better patient outcomes.[29]

[CASE STUDY MEDICAL REGISTRAR]

99. By training more doctors capable of managing acute and emergency care, there will be a larger pool of medical staff to cover acute care. The training structure should ensure acute care is embedded as a core feature of specialty training in both community and hospital settings.

100. We expect doctors to be able to demonstrate quite early in their training that they are emergency safe and capable of dealing with the patient in front of them – see section XX. Employers will be able to rely more on doctors in training to provide acute care during their training, provided changes are made to how they are supported and supervised. Although doctors may become more specialised through credentialing, most doctors will continue delivering some acute or emergency care throughout their careers – and will need to keep up to date in these areas through CPD.

Recommendation 12: The Sponsoring Board organisations must ensure all doctors are able to provide acute care in their specialty.

A trained medical workforce is valued

101. The Academy of Medical Royal Colleges suggests a consultant led service would mean better management of day to day rotas, access by patients to senior doctors at all times and better support for doctors in training..[30]

102. But there are implications for this approach such as the loss of training opportunities as trained doctors take on more responsibilities currently undertaken by doctors in training. There might also be cost implications to employ higher numbers of highly trained doctors. The Centre for Workforce Intelligence estimates the number of fully trained hospital doctors will increase by over 60% to 60,000 by 2020, if the number of medical students remains the same or increases and there are no substantial changes to the way doctors are trained and employed. [31] The charts below break down the current salary cost of the medical workforce, based on

[28] Govt report on emergency care; GMC report on emergency training
[29] Report on medical registrar
[30] AoMRC consultant led service
[31] CFWI, *Starting the debate on workforce numbers*, 2012.

assumptions that consultants are paid similarly in the four UK countries.[32] It seems the salary cost for doctors in training is about half that of consultants.

Salary cost of current consultant workforce			
Region	**Number of consultants**	**Average annual earnings**	**Annual cost of consultant workforce (excl.pension and NI contr.)**
England	42,345	109,676	£4 billion
Scotland	4,426	109,676	£485 million
Wales	2,182	109,676	£239 million
Northern Ireland (Medical and Dental)	1,411	109,676	£154 million
TOTAL	**50,364**		£5 billion

Salary cost of current doctors in training workforce in England				
Doctors in Training	**Workforce numbers**	**Mean annual basic pay**	**Mean Annual earnings**	**Annual workforce cost (based on annual earnings)**
Registrars	38,440	37,146	53,173	£2 billion
Others doctors in training	14,038	25,997	36,685	£515 million
TOTAL	**52,478**			**Over £2 billion**

103. Employers have raised the idea of introducing a more flexible approach to trained doctors through different employment contractual arrangements.[33] Evaluation of this or any other contractual model falls outside this review. The BMA and NHS Employers are currently in negotiation about contracts and salaries for consultants and doctors in training.

Training and education driven by service needs

104. Since April 2013 in England, the healthcare workforce's education and training is being commissioned and managed by employers. Providers now have greater accountability to plan and develop their workforce within multi-disciplinary teams. Local organisations, linked to Local Education and Training Boards (LETBs) for strategic oversight, have responsibility for deciding what learning is necessary to

[32] Department of Health, 'Managing NHS hospital consultants' National Audit Office, 6 February 2013. ;NHS Staff Earnings Estimates to March 2013 These statistics do not include primary care staff; NHS Scotland Workforce, 28 May 2013 '*Staff directly employed by the NHS, 30 September 2012'*, First release, Statistics for Wales. '*The Northern Ireland Health and Social Care Workforce Census'* March 2012,

[33] CFWI models paper

make sure their staff are competent and meet the needs of the local community.[34] Discussions are happening in the other UK countries about aligning medical education and training more closely to service structures. A training structure driven by employers and linked to local needs is one mechanism for injecting more flexibility into the medical workforce.

105. However, there are potential risks. Doctors may not be able to transfer competencies if training is devolved entirely to local needs. Training must be within a regulatory framework to maintain standards and make sure doctors are fit to practise anywhere in the UK. When implementing the recommendations, the Sponsoring Board organisations should consider how employers will coordinate and fund training within regions in the UK countries and nationally. Doctors may have to work with different employers to gain adequate training experience or for credentialing.

Recommendation 13: The Sponsoring Board organisations and employers must consider how training arrangements will be coordinated and funded to meet both local and regional needs and to maintain national standards.

More flexibility in training

106. We were asked by the Sponsoring Board to consider how to make postgraduate training more flexible – a key recommendation from previous reports.

107. Dame Julie Moore, Chairwoman of the NHS Future Forum's education and training group, summed up one of the main difficulties facing employer organisations[35]:

> *'The problem with workforce planning is I can say next year that I need more ENT surgeons, but it takes 10 or 12 years to make one and by the time you make one somebody might have invented a cure. There has always been that tension in the system and we have never been very good at workforce planning. One of the ways to get round that is that we believe there should be more flexibility in training so that, if somebody did invent a cure that meant you did not need a certain specialist, or you needed far fewer, then it would not take for ever to retrain somebody.*'

108. Some specialty training becomes very focused very quickly, which makes it difficult for doctors to change specialties. Doctors who need or want to move into other areas take a long time to retrain – during which they may not be providing service delivery. Pressures on the service would be lessened if we adopt a training

[34] DH, Liberating the NHS: Developing the healthcare workforce, January 2012 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_132087.pdf

[35] Dame Julie Moore giving evidence to the House of Commons Health Committee, 24 January 2012.

structure that allows doctors to transfer more easily across specialties and programmes. As workforce needs change, doctors could retrain relatively quickly to fill any potential gaps. We discuss how this might be achieved in section XX.

109. The medical workforce has to be much more adaptable to local pressures and to changes in service delivery. A move towards broad based specialty training will result in a larger number of doctors able to deliver front line services – the areas that tend to struggle with frequent gaps in staff coverage.

> '*A more easily adaptable system with recognition of core skills and competencies between specialties (so when we get our workforce planning wrong, as we inevitably will, a trainee does not have to start all over again).*' (Employer)

Changing work patterns

110. A more flexible training structure would also meet the changing nature of the medical workforce. The medical profession is shifting towards more flexible work patterns and part-time working. This trend, driven to some extent by increasing numbers of women becoming doctors, will become more prominent. Flexible working helps keep highly trained doctors working effectively within the NHS throughout their careers.[36]

111. But the current, rigid training structure is unable to cope with growing numbers of people seeking flexible work arrangements and career breaks.[37] For example, some specialties, particularly those with a higher proportion of female doctors in training, face workforce difficulties. The Royal College of Paediatrics and Child Health has reported problems in filling middle grade rotas, with consultant paediatricians increasingly having to cover middle grade duties as a result.[38]

112. There should also be more way and exit points in and out of training. This would be aided by transferable competencies and more cross-specialty opportunities and experiences.

[NEED TO EXPAND?]

[36] Royal College of Physicians, Women in medicine, 2009.

[37] D. Roland, P. Dimitri, V. Walker: The extent and effect of the recruitment crisis in the UK trainee paediatric workforce. *The Internet Journal of Healthcare Administration*. 2010 Volume 7 Number 1.

[38] Royal College of Paediatrics and Child Health (2009) *Modelling the Future III: Safe and sustainable integrated health services for children, young people and adults* London, RCPCH, p94

More flexibility to support clinical academic training

113. Academic doctors need a training structure flexible enough to allow them to move in and out of clinical training while meeting the competencies and standards of that training. They must develop broad enough knowledge and skills to allow them to undertake clinical work competently as well as opportunities to specialise within their academic area.

114. Current clinical academic training will fit easily within stem specialties as a specific pathway that gives doctors scope to pursue both academic and clinical training. (Annex X describes current clinical academic training arrangements in the four UK countries). Doctors on this pathway would be able to focus their academic training in their academic or research area while also undertaking broad based stem training. Where possible, they will also deliver general care in their specialty. Time spent in academic experiences will still be counted within training. It will have to be recognised that these doctors may take longer to reach the exit point of postgraduate training. To make sure doctors are able to work more flexibly within this pathway and to encourage more doctors to think about building academic and research into their careers, they will be able to move in and out of academic training at any point within their training.

115. This group also accounts for many doctors who decide to take a break from training, often to give them time to consolidate their skills. With a more flexible approach to progression, longer placements and apprenticeships, most doctors should no longer need to be out of programme or leave training.

Recommendation 14: The Sponsoring Board organisations and postgraduate research and funding bodies must support a flexible approach to academic training.

A more structured approach to continuing professional development

116. Doctors as part of their professional obligations must keep up to date and maintain their competence in all areas of their practice. Although doctors are personally responsible for their CPD, the GMC expects -in *CPD guidance to all doctors* - that professional learning must address patient and service needs identified through appraisal and job planning. Doctors must have access and opportunities to carry out their CPD, including protected time for that learning explicitly agreed in their job plans.

117. As generic capabilities become more explicit within postgraduate training, CPD should be used to maintain and enhance these generic areas alongside clinical and technical specialty knowledge and skills. Doctors and employers must structure this learning within the *Good Medical Practice* framework.

Recommendation 15: The Sponsoring Board organisations and employers must structure CPD within a professional framework so that it meets patients

and the service needs, including mechanisms for all doctors to have access, opportunity and time to carry out the CPD agreed through job planning and appraisal.

118. In our proposed approach to training, some specialty training and all subspecialty training will be acquired through credentialed programmes once doctors have completed their postgraduate training. These programmes will be regulated and quality assured and meet specialty standards and requirements.

119. Employers along with postgraduate institutions will develop these qualifications to meet local requirements. [EXPAND]

Recommendation 16: The Sponsoring Board organisations and employers should agree mechanisms to develop, regulate and quality assure credentialed programmes for some specialty and all subspecialty training.

SAS doctors/salaried GP/locums

120. About 20% of the medical workforce is composed of doctors who are not in training or on the specialist or GP registers. These doctors range from some who are only emergency safe to highly trained and specialised doctors. There are many reasons why doctors work in these roles, for instance, they may not have met the GMC's requirements for entry onto the GP or specialist registers or they may have made decisions to work in staff or trust level jobs for a better work/life balance.

121. Many of these doctors should be supported and supervised at the level appropriate for their competence and skills similar to doctors in training. They should also be offered opportunities to enter or return to training throughout their careers.

Recommendation 17: The Sponsoring Board organisations should review barriers faced by doctors outside of training who want to enter a formal training programme or access credentialed programmes.

Reforms to postgraduate medical education and training

122. So far we have discussed the current state of postgraduate training and possible implications for a new structure based on the themes set out in the Terms of Reference. Many of the issues also cut across themes and brought together suggest how training should change over the next 30 years.

Characteristics of a new structure of training

123. Regardless of how training is reformed, the system must incorporate certain characteristics and achieve certain objectives if doctors are to be able to meet the needs of patients and the service in the coming decades.

Principles for changes to postgraduate medical education and training

- The overarching objective of the system of medical education and training must be to equip doctors, and instil in them the professionalism needed to deliver safe and high quality care which will meet the future needs of patients and the service.
- Any new model of training must be designed to deliver this objective through the minimum structural change necessary.
- Education and training should be based upon the demonstration of capabilities, not simply time served, although time and experience remain important elements.
- Any new model of training must reflect the need for doctors to continue their learning and development throughout their working lives.
- Any new model of training must incorporate the elements of flexibility which acknowledge the uncertainties of future healthcare and workforce needs and the aspirations of trainees.
- The outcomes of training must provide transparency for patients, the public and the service about the levels of capability doctors have attained.
- The principles for implementation of any new model should enable the existing workforce to be incorporated into the new system so as to avoid co-existence of parallel systems.

New approach to postgraduate training

Structure of postgraduate training – Model narrative

Comment [GD5]: This should be extended and placed right at the front as part of our Executive Summary

- Doctors will complete medical school after 4 to 6 years and enter the Foundation Programme.
- Full Registration will happen at the point of graduation. Measures will need to be put in place to make sure graduates are fit to work as fully registered doctors. They will also be restricted to working in approved training environments in the early stage of their careers.
- Doctors will complete the Foundation Programme. Currently it is a two year programme but as changes to postgraduate training take hold, the second

year could be moved into the first year of broad based stem training (described below). The Foundation Programme will continue to give a wide range of training opportunities in different stem specialty areas. Doctors must have placements in both acute and community settings. Each placement should aim to be 4 to 6 months long. Doctors must have opportunities to support and follow patients through their entire care pathway either in the Foundation Programme or during medical school.

- After the Foundation Programme, doctors will enter broad based stem specialty training. Specialties or areas of practice will be bundled together into stems. These groupings will be characterised by patient care themes such as women's health, child health, adult health and be defined by the dynamic and interconnected relationships between the specialties. Stems will have common clinical objectives which will form a core part of specialty curricula. An Implementation Group will define the specific stems following these characteristics.

- Across all stem specialty training, doctors will develop generic capabilities that will make sure professionalism is embedded into their medical practice. Training will become less driven by the need to meet lists of competencies, described as 'tick-boxing exercises'. Key generic capabilities will include a focus on patient safety through quality improvement, the ability to decide how best to communicate with colleagues and patients in different situations, the capability to work within multi professional teams and where appropriate take on management and leadership roles as well as the ability to evaluate and apply evidence and research in clinical circumstances.

- Broad based stem specialty training will last between 4 to 6 years depending on stem or specialty requirements. For example, GPs will likely complete four years of training to meet the outcomes of training and enter professional practice while some of the craft specialties will need longer to develop the necessary technical knowledge, skills and experiences. The specific duration of training within specialties will have to be developed by the Implementation Group. During stem specialty training, doctors will have an option to spend up to a year working in a related specialty or undertaking academic, research or management work (similar to specialty fellowships). This year, which can be taken at any time during stem training, will allow them to gain wider experiences that will help them become more rounded professionals. Doctors will be able to train across the breadth of a stem similar to core training but will also be able to theme their training within patient groups at any point in the training. During training, doctors will work within the service by providing general care within that stem in both hospitals and in the community.

- When doctors want to change specialties either within or between stems, they will be able to transfer competencies in relevant areas, including learning during the optional year and generic capabilities. By recognising previous

learning and experiences, retraining in new areas should be shorter than entering postgraduate training for the first time.

- Clinical academic training will be a specific training pathway within stems. Doctors on this pathway would be able to focus their academic training in their academic or research area while also undertaking broad based stem training. Where possible, they will also deliver general care in their specialty. Time spent in academic experiences will still be counted within training but these doctors may take longer to reach the exit point of postgraduate training. To make sure doctors are able to work more flexibly within this pathway and to encourage more doctors to think about building academic and research into their careers, they will be able to move in and out of academic training at any point within their training.

- The exit point of postgraduate training will be the Certificate of Specialty Training. It marks the point where doctors are able to practise with no or limited clinical support within multi professional teams and networks. This means they must be able to make safe clinical and professional judgements. Doctors at this point will be expected to have the capacity to seek further support and advice when necessary.

- Most doctors will work in the general area of their specialty based on patient and workforce needs throughout their careers. They will be expected to maintain and enhance their specialty area and generic capabilities through continuing professional development (CPD) and credentialed training experiences. Experiential learning and reflecting on their practice and patient outcomes will help to give them the depth of knowledge and skills necessary to master their specialty area. Doctors will also have options to move into education, management and leadership roles.

- Some doctors may want to gain expertise in areas equivalent to some specialty special interest areas and sub specialty training through formal and quality assured training programmes leading to a credential in that area (credentialing). These programmes would be driven by patient and workforce needs and may be commissioned by employers as well as current postgraduate education organisers. These areas would need to be quality assured by the regulator to ensure appropriate standards and portability.

124. [MODEL BEING DESIGNED BY DESIGNER –PLACE HERE]

Recommendation 18: The Sponsoring Board organisations should put in place broad based specialty training (described in the model).

Realisation Plan

125. In order to develop these recommendations, we focused this review on discussion and public consultation. We looked at the implications of future

educational and service needs and how these will impact on the postgraduate training structure. But the group that puts these recommendations in place will have to consider the value of money and cost implications for the new structure in the long term.

Delivery plan

Change needed	Responsibility	Timescale	Recommendation
Formation of group to coordinate and oversee changes; Evaluation of value for money of changes	Sponsoring Board organisations, Employers	Immediately	**29**
Review curricula to determine the stem specialties; broad based training for specialties; generic capabilities; areas for credentialing	Implementation group	Immediately	**3, 12, 13, 18, 19, 22, 26**
Make regulatory changes necessary for Certificate of Specialty Training (CST) and review Registers	GMC	Immediately	**17, 18, 19, 21**
Review educational, legal and regulatory requirements to move full registration to end of medical school; Consider introduction of a national licensing exam	Implementation group	Immediately	**5, 6, 8, 9, 10**
Review assessment and progression to meet requirements of stem training	Implementation group	Immediately	**11, 14**
Review how to quality assure training environments and limit where training can be delivered	GMC	Immediately	**8, 10**
Consider medical school variation	GMC and MSC	Immediately	**4, 5, 6, 9**
Consider how to develop career advice and outreach to secondary schools around medical careers	MSC	Immediately	**4, 5**
Shift curricula towards broad based training; training to begin to be themed on patient needs		2 – 5 years	**3, 12, 13, 17, 19, 20, 22, 26, 27, 28**
Implement generic capabilities within curricula	GMC, AoMRC	2 – 5 years	**1, 2, 12**
Legally award CST with recognition that doctors are judgement safe and able to practice safely within small clinical teams	GMC	2 – 5 years	**17, 18, 21**
Demonstrate that effective processes are in place to assure the GMC that students no longer need a period of provisional registration	MSC	2 – 5 years	**5, 6, 8, 9, 10, 11**

Doctors will have longer placements and different supervision arrangements	GMC; employers; NES, HEE, NIMTDA, NHS Wales; CoPMED	2 – 5 years	**15, 16, 19**
Local and regional arrangements to be in place to support specialty training and credentialing including agreements on funding and release from work etc.		2 – 5 years	**7, 17, 18, 19, 20, 21, 22, 23, 24, 26**
New training structure based on broad based training in place	HEE, NES, NIMTDA, NHS Wales, AoMRC, CoPMED, GMC	2 – 5 years	**7, 11, 17, 18, 19, 20, 22, 27, 28**
Demonstrate training is meeting patient and service needs	HEE, NES, Wales Deanery; NIMTDA;GMC;	5 – 10 years and beyond	**1, 2, 3, 12, 18, 19, 20, 23, 24, 28**
Credentialing of subspecialties	GMC, AoMRC	5 – 10 years and beyond	**18, 19, 23, 24, 25**

Recommendation 19: The Sponsoring Board organisations should immediately set up a group to take forward recommendations in this report.

Annexes

Terms of Reference
List of EAG members
Description of current training including academic training in 4 Uk countries
Comparison of previous inquiries
Regulatory Framework
International comparison
Mapping of current work relevant to Shape
Literature review,
Scenarios and assumptions about future – Delphi exercise
Synthesis of evidence
Engagement and coms plans
Equality analysis