SHAPE OF TRAINING

To consider **3**

How can we make sure doctors are prepared, confident and competent at different points in their careers?

Issue

1. Common concerns raised by respondents to this review relate to the preparedness of doctors for medical practice and to the need for more support during career transitions. This paper looks at possible solutions to better support doctors in their training.

Discussion point 1: To note the risks and challenges facing the future of the Foundation Programme and their potential impact on the review (paragraphs 7 to 17).

Discussion point 2: Do we want a training system that continues to balance competence and time but emphasises at its core generic professional capabilities and flexibility of progression through training (paragraphs 18 to 23)?

Discussion point 3: Do doctors need better supervision and support through longer rotations and an apprenticeship based relationship with trainers (paragraphs 24 to 30)?

Discussion point 4: Are these the right descriptions for the levels of competency and capability expected in doctors as they move through training (paragraphs 31 to 35)?

Further Information

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Background

2. We agreed to collect evidence against five main themes to inform this review:

   a. Patient needs

   b. Balance of the medical workforce – specialists or generalists

   c. Flexibility of training

   d. The breadth and scope of training

   e. Tensions between service and training

3. We held a Call for ideas and evidence from 8 November 2012 to 8 February 2013 about postgraduate education and training, structured around the themes and received over 380 written responses. We have also discussed changes to training through seminars, workshops and meetings. We are now gathering oral feedback from about 40 organisations about possible principles and approaches to training.

4. In March, we discussed the principles and three possible approaches to postgraduate medical education and training. These have formed the basis of our discussions at oral evidence sessions and workshops. We have summarised some emerging trends on the models in Item 2.

5. Looking at the data we have gathered so far, we noticed patterns in some issues cutting across the themes. Common concerns raised by respondents relate to the preparedness of doctors for independent practice and their need for support during career transitions. This paper sets out possible ways these issues might be addressed by changing how training is delivered. They would fit within any wider system reforms represented in the models and principles.

6. The ideas in this paper are to stimulate discussion. They don't represent any particular view or direction of travel for the review.

Discussion

Foundation Programme

7. Although the original focus of the Review was post-foundation training, a number of respondents have challenged how it will fit in any postgraduate reforms. A further review of the Foundation Programme is unlikely in the next few years. As such, we need to consider the entire continuum of postgraduate medical education and training including the transition from medical school. It is particularly relevant to our views on career development and the way doctors are supported through transitions in their training.

8. The Foundation Programme was introduced in 2005 to address, among other reasons, concerns that patients were being harmed by medical errors and delays in recognising the acutely ill patient by doctors. Many reports argued that support during the transition from graduation into the workplace would reduce these patient safety issues.

9. Following the Collins Review, the purpose of the Foundation Programme is to enable 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. of the Foundation Programme provides generic training to bridge the transition from medical school into specialist/general practice training. According to the National Training Survey (NTS) 2012, 77% of doctors in the Foundation Programme are satisfied overall with their training, up from 73% in 2011.[1] On entry into the Foundation Programme, only about 50% of graduates felt prepared for their first Foundation Post. However, 76% of F2 doctors felt they were ready to take on GP and specialty training.[2]

10. Given our assumption that patients and the service would benefit from doctors with a broader approach to patient care, the Foundation Programme affords doctors a wide range of experiences although medicine and surgery predominate especially at F1. The top three CCT specialties experienced by F1 doctors are general surgery (82.3%), general (internal) medicine (58.9%) and geriatric medicine (23.1%). The top three CCT specialties experienced by F2 doctors were emergency medicine (43.8%), general practice (43.8%) and general (internal) medicine (22.9%).[3]

11. The Foundation Programme appears to have some influences over career destination choices. 36% of F2s enter directly into GP training, although only 5% decided to go into general psychiatry.[4] In their written response to us, NHS Scotland (a pan response from NHS Education for Scotland, employers and deaneries) explained: '*The existing two year foundation programme following graduation is overall viewed positively, and should be retained more-or-less in its current form. All trainees should have the opportunity to spend time in community/primary care and hospital/secondary care settings, both during foundation, and subsequently.*' NHS/Employer organisation in England agreed with this view: '*Foundation training has been an excellent introduction. We often have very good foundation trainees, who more than make up for their lack of experience.*'

Risks and challenges

[1] GMC National Training Survey 2011 and 2012 - http://www.gmc-uk.org/National_training_survey_2012_key_findings_report.pdf_49280407.pdf

[2] GMC National Training Survey 2011

[3] The Foundation Programme Annual Report 2012 - http://www.foundationprogramme.nhs.uk/pages/home/keydocs

[4] The Foundation Programme F2 career destination survey 2012 - http://www.foundationprogramme.nhs.uk/pages/home/keydocs

12. Although the principle of a generic and broad based foundation in medicine seems to have consensus across the UK, there are emerging rifts in how this may be structured. Some organisations, particularly in England, would like to see the Foundation Programme reconfigured to take account of recommendations from the Tooke Inquiry. *Aspiring to Excellence* advocated that the first year move back into medical schools, although it would still focus on clinical experiences. Graduates in the UK would finish undergraduate medical education at the point of full registration. The second year would then be absorbed into core specialty training.

13. This proposal has received renewed attention due to the challenge of oversubscription. The UK Scrutiny Group is considering a number of options to ensure that all UK medical graduates are enabled to complete basic medical education and apply for Full Registration. 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. If some UK graduates did not get F1 posts in the future, this would limit their career options because they would not be recognised as a fully qualified doctor in other countries. However, changes would not address the competition bottleneck at F2 or within going into GP and specialty training. Despite the attraction in merging medical school and F1, we have not heard any educational or service case for this change.

14. 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.

15. Indeed, many respondents, including the feedback at the London Deanery workshop, suggest these two years are important for doctors to gain experience in working in the NHS and help them internalise their professional responsibilities as employees within the service. A possible consequence of shifting F1 into medical school would be that doctors would continue to be students (and possibly even funded through bursaries) rather than employees taking on responsibilities as working professionals. This may impact on their capacity to meet the needs of the service and employers. Others have suggested some doctors in training would benefit from a third year before making choices about their specialty.

16. As an alternative to amalgamating F1 with the medical degree, there is some interest in exploring the possibility of full registration on graduation. Even if graduates were unable to access UK training, they would posses a portable qualification which would be accepted abroad. This is an option that would involve fundamental change and raise significant questions around patient safety and the current regime for provisional registration The value of provisional registration should not be set aside lightly. It was introduced after the second world war precisely because of concern around the preparedness of graduates to practise unsupervised. While systems of educational and clinical governance are now much better, the enduring benefit of provisional registration is that it places the onus on the F1 doctor to demonstrate

their fitness to be fully registered. This is not a theoretical issue: successive UKFPO reports show 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. As such, any major changes to the system must be underpinned by good evidence and impact assessments.

17. We could find ourselves in a situation where our evidence is pointing towards one approach while one or more of the UK countries are moving in another direction.

> **Discussion point 1:** To note the risks and challenges facing the future of the Foundation Programme and their potential impact on the review.

Competence and capability based training

18. Over the course of this review, a number of respondents have suggested postgraduate medical education and training should be based purely on outcomes rather than completing a specific period of time. For example the British Medical Association's response to our written call for ideas and evidence suggested '*[T]he completion of training should be based on competencies rather than length*'. The Joint submission from funders and supporters of medical research expanded on this: '*The current system of time-based competency certified through the CCT generates a rigid system in which nearly all trainees move at the same pace and may not accurately reflect the skill or proficiency of the individual trainee*.'

19. 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 an important in terms of moving beyond competence and into 'mastery'. The time component means the length of training is relatively predictable, albeit many doctors take longer than the predicted length of training. This regular check in point means we are assured that doctors are competent to provide clinical care at their training level.

20. We have heard that the competence, preparedness and confidence of doctors continue to raise concerns within our current system. These issues are being translated into calls for either training without progression deadlines or lengthening training time to meet curricula requirements. Removing time as a factor in training is an attractive way of introducing much more flexibility into the system. Doctors and their supervisors would have more control over their progress depending on their ability to demonstrate relevant competencies and capabilities. Some candidates would move more rapidly through training while others would be able to consolidate their learning and deepen their experiences. This would also take some of the bite

out of the reduction in working hours brought about by the Working Time Regulations as deadlines at each stage of training become irrelevant.

21. But competency and capabilities based approach has serious limitations. With nearly 40,000 doctors in training, it would be complicated to plan and develop training for each doctor at their own pace and could potentially cost more as doctors stay in training longer. As the NHS Employers explained in their oral evidence: '*[A] personally designed pathway through the system…It is hard to see quite how that could be achieved because training is always a balance with patient care that has got to be delivered*'. A substantial number of doctors would likely take longer to feel prepared and competent to work independently at the point of the CCT. In 2011, 85% of doctors felt ready to take up a consultant or GP post.[5] As inexact as workforce planning is now, it would be impossible to predict or speculate how many and what kinds of doctors would be ready to practise within a specialty at any given time.

22. More doctors in the future will need to care for patients with complex health needs and across different settings. A training structure that emphasises specific skills or abilities at particular points in time may not give us this kind of doctor. Respondents have told us, particularly in the workshops and seminars, that the current system seems to be producing doctors who are reluctant to make decisions and are being infantilised. Competency based training does not necessarily capture how doctors make well informed and safe judgements in complex and unpredictable situations. Yet most respondents identified this broader insight as critical for doctors now and in the future. As the Academy of Medical Educators explained in the oral submission to the review: '*The professional capabilities – judgement, situational awareness, conflict management, the ability to negotiate, to influence – these high level, very complex psychosocial capabilities, take years and decades to develop…So these high level professional capabilities are a function of experience, a function of appropriate reflective experience'.* We have also heard that nothing can replace repetition and experience when mastering aspects of a specialty and these can only be gained through time. By focusing more on generic professional capabilities rather than competencies, we would develop doctors with a broader view of medical practice.

23. Recognising a full shift to a competency based training structure is neither feasible nor desirable, are there ways we can build in more control and flexibility for doctors to manage their own progression while reassuring employers and patients that their doctors are competent as well as meeting future workforce demands?

> **Discussion point 2:** Do we want a training system that continues to balance competence and time but emphasises at its core generic professional capabilities and flexibility of progression through training?

[5] GMC National Trainee Survey 2011 - http://www.gmc-uk.org/NTS_trainee_survey_2011.pdf_45270429.pdf

Making supervision and support central to training and service delivery

24. In the NTS 2012, only 81% of doctors felt the quality of their clinical supervision was excellent or good.[6] A shift to an approach that puts supervision and support at the centre of training and service delivery would address this significant challenge in the current structure.

Longer placements

25. Confidence and preparedness issues might be mitigated by doctors training longer in one place. Longer time within a placement would help them to integrate better within teams, have closer relationships with trainers, consultants and the multi professional team 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. Most respondents strongly supported this idea in both the written and oral feedback. As respondents from the National Association of Clinical Tutors (NACT) told us in their oral evidence: '*[I]f you really want people to embed good skills and be able to take them forward they need long enough within that environment to develop not just competence but confidence and experience.'* Longer placements would also allow teams and trainers to build up their trust in the abilities of their doctors in training and therefore give them more opportunities to contribute to improvements in the service.

26. But some respondents warned that broad understanding and basic medical skills often come from the different and varied opportunities and experienced on the Foundation Programme and in Core training. Many even harkened back nostalgically to the pre-MMC years when doctors worked as Senior House Officers (SHOs) for many years and had opportunities to experience different specialties. They were more closely linked to consultants within a 'firm' structure. But this approach had serious flaws including a lack of transparency for jobs and training, less structured training and assessments, limited opportunities for flexible working and a high risk of negative role modelling and undermining.[7]

27. The solution then may be in balancing different experiences with time to bed down competencies and capabilities. This could be done without necessarily increasing the length of time in training. Doctors could, for example, in the early stages of training (such as the Foundation Programme and early core/stem 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 determined by the relevant specialty). One respondent from Health Education North

[6] GMC National Trainee Survey 2012 - http://www.gmc-uk.org/National_training_survey_2012_key_findings___final.pdf_49303306.pdf

[7] Sir Liam Donalson, CMO England. Unfinished Business: Proposals for reform of the senior house officer grade. August 2002. http://www.mmc.nhs.uk/Docs/Unfinished-Business.pdf

West explained that their doctors remain within the same team or departments for at least six months when they move into their next training stage to make sure they have time and space to consolidate their new responsibilities and requirements while still relying on the team support and relationships built up from the previous year. This idea of longer placements was also supported by the Royal College of Obstetricians and Gynaecologists in their oral evidence: '*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 in O&G and so reducing the frequency of rotations, provided you can have appropriate quality of service and quality of training, would be something we would support*.'

Apprenticeship

28. With longer placements, we may be able to re-introduce some elements of apprenticeship back into medicine, more common during the previous SHOs era. Although doctors in training would not be supernumery and would continue to deliver a large part of the service, they would not fill rota gaps in quite the way they do now. The pan- NHS Scotland written response puts it succinctly: '*The service needs to move away from the primary concern in workforce planning being sufficient doctors at junior and middle grade levels to allow for rota compliance. This could be achieved in a number of ways but all involve bringing other doctors of different grades or in some cases advance nurse practitioners into the cover arrangements to reduce dependence on doctors in training*.' We need to create a much closer link between service and training so that all service delivery provides meaningful learning and training experiences. The Academy of Medical Royal Colleges made this clear in their oral evidence: '*I think no one unlinks service and training… So I think people want to see something a bit more bespoke…[T]here is a large cohort that want to turn the clock back, not in terms of hours but in terms of that apprenticeship model…[the supervisor] would see me more than once a week and would know my weaknesses and my strengths and work on them and actually train me, as opposed to being pushed and pulled around different consultants*.'

29. More appropriate support and supervision throughout doctors' career would help embed patient involvement within training. This is discussed more in item 4. 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. We heard from the National Association of Patient Participation that *'In general people are quite amenable to [being seen by trainees] if they know the person is there being supervised and they know in advance…So I think you actually communicate that that is going on and give the patient the option [be to seen by a trainee]*.

30. We would have to consider carefully how an apprenticeship based approach would be implemented.

a. Supervisors and trainers need to be recognised and supported in their roles including the time and resources to provide quality training. The

Recognition and Approval of trainers is already formalising and recognising these arrangements.[8]

b. Local education providers would need to make sure negative role modelling, undermining and personality conflicts don't derail the training relationship.

c. 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.

d. Given the resource implications for employers, this may mean not all doctors and local education providers should be involved in training. The GMC's response to the Call for ideas and evidence emphasised: '*The characteristics of a good training environment need to be described and training organisations evaluated for their ability to meet those criteria. Above all, organisations which train must demonstrate their commitment to delivering high quality training.*'

Discussion point 3: Do doctors need better supervision and support through longer rotations and an apprenticeship based relationship with trainers?

Meaning of the exit point from training

31. One of the key outputs for this review is more clarity about what level of competence and capability doctors will need at different points in their careers. Much of that work will have to be done by stakeholders like the Academy of Medical Royal Colleges, the GMC, COPMeD and employer groups outside the Review's timeframe. There has to be a review of curricula to consider questions around broader and more general training within specialties; to look at embedding generic professional capabilities, and aligning competencies to aid their transferability and to consider length of training within specialties.

32. While there may be formal points of recognising competence levels, respondents have also asked for more way and exit points in and out of training. This would be aided by transferable competencies and more cross-specialty opportunities and experiences. Indeed, some respondents to the Call for ideas and evidence have argued that doctors would benefit from training in areas relevant to patients rather than in specialties, especially in the early years. For example, people would train in caring for women, children, elderly people, people with long term illness or disabilities.

[8] More information about the GMC's approach to the recognition and approval of trainers is at http://www.gmc-uk.org/education/10264.asp

33. But before that, we need to think about the meaning of the exit point from formal postgraduate training (known at the moment as the Certificate of Completion of Training – CCT). This is one area where there are quite a lot of differing opinions from respondents, based primarily on perceptions of the roles of doctors in training and consultants. There seem to be three particular points in training picked out in the evidence:

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.

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 would call 'independent practice', but doctors work in multidisciplinary teams and relying on peer and collegial groups for support and advice (and should be encouraged and even required to do so). At this point doctors would receive a certificate in general training. We would 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.

c. Doctors who are judgement safe but have in addition acquired more in-depth specialist training in a particular field of practice. But they would still have to be able to assess and treat patients with multi morbidities. This would equate with the level of a specialist.

34. We have discussed in previous meetings the issues with doctors who are not in training but are not consultants. This is a wide and diverse group ranging from doctors who are only emergency safe to highly specialised doctors practising in narrow areas. This group also accounts for many doctors who decide to take a break from training, often to give them time to consolidate their skills without a progression deadline or to do academic work. With a more flexible approach to progression, longer rotations and apprenticeships, most doctors should no longer need to be out of programme or leave training. Other doctors working in staff or trust level grades should be supported and supervised at the level appropriate for their competence and skills similar to doctors in training.

35. Although outside this review, a review of assessment and assessment systems would help define and measure doctors' learning, development, and progress better. Professional Exams, for example, could be revamped to signal that doctors have met the requirements of a generalist.

Discussion point 4: Are these the right descriptions for the levels of competency and capability expected in doctors as they move through training?

Resource Implication

36. There are no resource implications for this paper. We will be evaluating the feasibility and value for money of the recommendations.

Equality

37. As we evaluate the evidence collected in this review, we will consider how the recommendations may impact on the different protected groups. For example, we know that many women are stepping out of training to raise families. This is impacting on their training and service delivery. Are there ways we can mitigate this pressure by changing how training is structured and delivered? We will pick this up in more detail at the next meeting.

Communication

38. This paper will go on the website.