SHAPE OF TRAINING

To consider **4**

Possible approaches to postgraduate education and training

Issue

1. This paper looks at the principles that should inform changes to the structure of postgraduate medical education and training and some possible approaches to training based on these principles.

Discussion point

2. We would like you to consider some of the underlying principles that should inform any future approach to medical education and training. We would also like you to reflect on whether the different models accurately capture a possible approach to training. These approaches are by no means recommendations or proposed ways forward. Rather they give us a way to debate and test out some of the details that we need to understand as we go forward in this review (paragraphs 6 to 23).

Further information

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Overview

4. At the last Expert Advisory Group meeting, we looked at a possible approach to medical education and training based on a mixed model of general specialty training and run through specialty training. It evolved from early discussions with leaders within postgraduate medical education and training. Apart from minor changes, the group thought this model would produce a training structure with more flexibility than our current approach. You asked us to develop it further.

5. Through analysing the feedback from the Call for Evidence and other review activities, we have identified possible variations on the general specialist model and indeed a couple of approaches based on more specialisation. A draft summary of the evidence is set out in Item 2.

Principles of medical education and training

6. Feedback from stakeholders suggests some underlying principles that could form the basis in any future structure of training. People have told us that regardless of how training is reformed, these elements should be reinforced in the new system if we want to train doctors who will be able to meet the needs of patients and the service in the coming decades. Doctors, doctors in training, patients, employers and those involved in medical education and training agree:

a. People have better outcomes and are more satisfied with their experiences when there is continuity in their care. Care should be delivered by multi professional teams, who facilitate access to the right interventions by the right health or social care professional for each patient as an individual (often called the patient journey or care pathway). Doctors, particularly general practitioners and general specialists, should provide leadership and support throughout a patient's journey to patients/carers, colleagues and teams as a whole. Doctors as part of their training should have opportunities to follow patients along a care pathway.

b. Patients are likely to need more general specialty care and expertise as healthcare shifts into the community. Most doctors will have to be skilled in caring for patients with undefined or complex conditions in local and community settings. This means doctors will be expected to provide both acute and non-acute care.

c. Doctors are providing care to individuals and their community as a whole. They, along with their teams, should be empowered to make decisions about how to provide that care, in collaboration with their patients and other professionals. Their training should reinforce the caring side of the profession and their professional responsibilities to their patients.

d. Doctors need support and advice about their careers throughout all stages of their education, training and practice. Learning and development never ends and value should be given to training and development throughout doctors' careers. Doctors should be encouraged to take on management, leadership and education roles as they progress in their careers. All doctors would be either in training or trained.

e. Doctors should have flexibility to move between roles and specialties at any point in their career. Training should have different points where doctors have built up a broad range of skills, capabilities and experiences that show they are competent to provide care at their level of training. Doctors should be able to transfer their competencies across specialties and roles as they move through their training.

f. Doctors during their training should have support and supervision that is right for their individual learning needs and level of training for their specialty. Far more direct supervision and support is needed when doctors are building up their knowledge, skills and competence. But the intensity of supervision may shift to more indirect support and mentoring as doctors begin to work more independently. Doctors have better learning outcomes when there is continuity in their training and they work with specific trainers and within consistent teams.

g. Doctors when training should be given time to learn, train and reflect on their training even while providing care to patients and working within the health service.

h. Training doctors must be cost effective but should consider how to deliver the best and safest patient care, how it will integrate with the training and practice of other healthcare professionals and the value of that training across doctors' careers.

Possible approaches to medical education and training (see attached graphics)

7. The following paragraphs (and attached graphics) describe a series of possible models for medical education and training which emerge from the feedback we have received. At this stage we are not in a position to recommend one model over another. We are simply attempting to show what stakeholders have reflected back to us.

Approach A: Training more generalists

8. This approach addresses the need to train more doctors with general specialty knowledge and skills. It builds on the models recommended by in the Final Report of the Tooke inquiry into Modernising Medical Careers. The key features of this model are:

a. Most doctors train to become generalists within a small number of specialties, which will be identified in discussion with specialties and other stakeholders.

b. Doctors would move into general training from the Foundation Programme. In the first few years, doctors would focus on the broad knowledge, skills and generic capabilities within the specialty including research and academic requirements. Training would take place in different settings and alongside other healthcare professionals. They would work in both acute and non-acute care and within the community and hospitals. Where the balance of training takes place will depend on the specialty.

c. Most of these competencies would be transferable to other core general specialty areas if doctors decide to move into another field. Doctors would also have opportunities to experience some of the other specialties where training and roles are able to overlap. As doctors progress through the general training, they would begin to focus more on specialty areas such as general practice.

d. At the end of the general training, probably between four to six years depending on the specialty, doctors would be able to work independently within a supported environment or with a named mentor. They would receive some form of recognition of their achievement such as a certificate of general training.

e. All of these doctors would then work as general specialists within the health service. Many will work in both the community and hospital settings and provide support to patients during transition points in their care (such as going from primary care into hospital and back to primary care). Doctors would continue to learn and develop their skills through modular learning, credentialed training and continuing professional development (CPD). Doctors would also be able to move back into the core training in a different specialty if they want to retrain. Relevant competencies would transfer with them, which would reduce the time needed to retrain.

f. Some doctors might decide to train further in particular specialty areas, while providing general care. These opportunities would be based on patient and service need as well as professional interest. As they build up competencies, they will be credentialed in specific specialty areas. A smaller number of doctors would go on to gain credentials, including in areas currently defined as subspecialties. Doctors would also be able to move back into providing general care throughout their careers as their personal or professional circumstances change.

g. Alongside this general approach, a small number of doctors would enter specialty training directly with less emphasis on the broader general

specialty training. They would be limited based on workforce and patient needs. Doctors in this stream will have to be aware that they will have much less flexibility in retraining or moving between specialties, although some of their competencies will be transferable.

h. Some doctors may also enter academic training directly from the Foundation Programme to allow them to focus on their academic or research area. But doctors who want to develop a career in academic medicine will also be able to move into the academic stream at different points in their training. Some may value a broad general training before narrowing down their field.

9. The approach has a number of benefits over the current system. It would produce a medical workforce that is predominately able to provide general specialty care in both the community and hospitals. It also has the flexibility for doctors to move around specialties as well as providing a way for some doctors to go directly into specialty training or academic work. Although training would still take up to eight years (or possibly longer) before doctors would be able to work independently, it would provide them with a broad skill set that would benefit both patients and multi professional teams.

10. But this approach has a few drawbacks. In particular, it has a less structured and recognised career path for doctors. Doctors, along with their employers will have to plan their professional development carefully and make sure adequate opportunities for credentialing and CPD are available and accessible. It will also only work effectively if employers are willing to restructure shifts and rotas to embed doctors in training into specific teams and make sure they work regularly with a small number of trained doctors. This model also relies on a shift in perception and attitude towards generalism and generalists (and the way the role is incentivised) if we want to encourage most doctors stay within general specialty.

Approach B: Training specialists with more general capabilities

11. This approach has many of the same features of Approach A. It would still see most doctors moving from the Foundation Programme into general specialty training as described above. But it differs in how specialists would train.

a. Some doctors would go directly into specialty training from the Foundation Programme. Again, these opportunities would depend on employer and patient needs and would be highly competitive. They would still have some general specialty training, but for a shorter period of time before they begin to train in specific areas. At the end of their specialty training, they would receive recognition of their competence in a specific area, called a certificate of specialty training. These doctors would still be able to move into the broader based general training but may have to retrain for longer periods depending on their acquired competencies.

b. Like Approach A, a small number of doctors would have opportunities to move directly into more narrow specialty training as a run through programme. Some doctors would also be able to train directly in their academic and research areas. Doctors who train in this more specialised and focused manner would have less flexibility to shift to general training or work as generalists.

c. In a very small number of discrete medical areas, doctors would be able to move into specialty training from medical school, bypassing any general or broad based training. These specialties and the number of doctors allowed to train in this way would have to be carefully controlled. These doctors would likely have to retrain from the beginning if they decided to change specialties.

12. The approach has some appealing elements. It would still train mostly generalists working across care settings. But it would also provide opportunities for specialists to train faster into their particular fields, making it easier for employers to plan their workforce. It also has more flexibility in how doctors train by offering broad based general training, more specialised general training and highly specialised training. It would give academic doctors different training options.

13. But this approach would make it more difficult to emphasise the importance of generalists to care in the future. Many doctors may continue to see specialty training and attaining a certificate in specialty training as the epitome of their careers. It would also provide less flexibility for doctors who train in narrower specialty areas to move across specialties or roles.

Approach C: Consolidating training

14. This approach would work almost exactly like Approach A. But would introduce a period of consolidation for the majority of doctors once they have completed formal general specialty training but before receiving their certificate of general training. Doctors would be able to work independently with some support and mentoring and would be able to provide both acute and non acute care. This consolidation time would be optional to give doctors opportunities within their training period to build up their experiences and confidence. It would also allow them to take on academic, management or education work without compromising their progression. Doctors could decide to not do the consolidation period.

15. There are two main advantages to this approach. First it would build in time for doctors to work in a more supervised and structured way if needed before they begin to work independently. This may be particularly advantageous to some craft specialties where practice of the craft and experience are necessary to gain mastery. Second, it would allow doctors longer training times to counter some of the drawbacks of the Working Time Regulations (WTR) while providing care and

service outside of formal training. This might help mitigate some of the tensions between service and training pressures.

16. But many stakeholders are concerned this approach would inevitably lead to a group of doctors who are neither fully trained nor in training – sub-consultants. They would still need substantial support and supervision but would not have the benefits of formal training opportunities, assessments and feedback (beyond the normal appraisal cycle). There is a risk that financial constraints could potentially prevent doctors from moving into further training if only a small number of further training posts are created.

Approach D: Credentialing – 'connect 4'

17. This approach again provides a variation to Approach A. But once doctors have met the requirements for the certificate of general training, they would build up further training in any number of areas or specialties through modular learning and credentialing. As the modules rack up, it would lead to a credential in specialty training. During this time, doctors would provide general specialty care across different care settings. They could then go on to further specialise or subspecialise through more modules. Opportunities for modular learning and credentialed training would be available based on service and patient needs with local areas.

18. This is the most flexible training model and would give both doctors and employers control over what training would meet individual ambitions and service requirements including academic, research and education opportunities. But workforce planning would need to carefully manage this approach to make sure we would have an adequate number of doctors trained in different specialties in both the short and long term. It would also require a sophisticated quality assurance system to make sure doctors are meeting the right level of competence for their credentialed specialty area and that the accredited programmes are fit for purpose. Curriculums would become increasingly difficult to rely on as doctors mix and match credentialed learning to develop more portfolio careers.

19. We would also have to give careful consideration to how doctors will access training and make sure it is equitable and fair across the UK. This approach may require doctors to travel more for their training depending on where programmes are available rather than training based on posts within particular regions.

20. Some people have suggested a more radical version of this approach in which all training outside of the Foundation Programme is based on credentialed and modular learning. Training would cease to have a time element and become entirely based on competencies stacked up towards an accredited outcome. But this approach could result in doctors who could be perpetually in training rather than moving towards independent practice. It could be difficult to demonstrate all doctors are trained to a UK wide standard. It could also be difficult to assure patients and

employers that doctors have met a broad based level of expertise to match their cared service needs.

Other approaches (no graphics)

21. Some people have suggested that we should explore approaches that mirror training in other jurisdictions, particularly where doctors are able to specialise and subspecialise quite quickly out of medical school.

22. Many speculate that patients will increasingly demand access to specialists, often without reference to GPs. Others suggest that as medicine becomes increasingly more complex, only specialists trained in narrow areas will be able to deliver care safely and cost effectively. A training structure based on hyper specialisation (*the USA approach*) would need very careful workforce planning and high levels of competition for training posts to make sure enough doctors are working meeting the needs of patients and the service. This approach would have almost no flexibility for doctors to retrain into other specialties or indeed within specialities if their field is very narrow.

23. Some people have suggested a training structure completely reliant on competition and local employer workforce needs (*the German approach*). We would train a surplus of doctors at medical school to the point of full registration. Then doctors would have to find training posts through a competitive process based on what kinds and numbers of doctors will be needed in their local area in the future. Doctors who do not secure training posts would have to work in service posts linked to their level of competence or leave the UK.

24. Another possible approach is to develop a training structure that trains healthcare professionals as a whole with specific streams for the different disciplines. Training would be far more integrated with a multi professional care within a team structure.

Discussion Point

25. We would like you to consider some of the underlying principles that should inform any future approach to medical education and training. We would also like you to reflect on whether the different models accurately capture a possible approach to training. These approaches are by no means recommendations or proposed ways forward. Rather they give us a way to debate and test out some of the details that we need to understand as we go forward in this review.

Communications

26. We will shortly be collecting oral evidence from a number of organisations and individuals. We would like to explore with them how training should change in

the future and how these reforms should be implemented. We would like to share the models and narrative to help structure that feedback.

27. We would like to include the narrative and approaches in the summary of evidence that we plan to publish in April based on the seminars, site visits and call for ideas and evidence. See Item 2 for more details.