Medical Schools Council response
February 2013

Call for ideas and evidence

Why we are reviewing the shape of medical training

The purpose of the Shape of Training review is to make sure we continue to train doctors who are able to provide high quality and safe care which meets the needs of patients and service now and in the future. The review will look at what sort of doctors we will need in the future and the training needed to develop them.

We are focusing on postgraduate medical education and training. However, in doing so, we will also consider the transitions from undergraduate medical education to the Foundation Programme, and from that into specialty training and on into continuing professional development (CPD). More information on the current structure of medical education and training in the UK is available here:

The review is UK wide. We are looking at the way postgraduate medical education and training should be organised at a national level and at any specific training issues in England, Northern Ireland, Scotland and Wales.

Who is carrying out the review?

This review is independent of Government. It is jointly sponsored by:

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

These organisations have formed a Sponsoring Board that provides the strategic direction and oversight for the review. To lead the review, the Board has appointed Professor David Greenaway, Vice-Chancellor of Nottingham University.

Professor Greenaway has put together an Expert Advisory Group 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.

You can read more about the review at www.shapeoftraining.co.uk

When will the review finish?

A final report with recommendations will be given to the Sponsoring Board in autumn 2013. It will look at:

- any immediate changes
- changes in the medium term (2-5 years)
- changes in the long term (5-10 years and beyond)
- how any changes should be implemented.

How we are gathering evidence for the review

In this document we are inviting all those with an interest in the future shape of training to provide written evidence on some of the key issues. This call for written evidence will run from 8 November 2012 until 8 February 2013.

We will use the feedback from the written answers to help us in two ways.

- To help identify information or points of view that we would like to hear more about in oral evidence sessions. These sessions will take place between February and June 2013. We will be inviting a broad range of representative groups and individuals to give oral evidence.

- To build up evidence about the ways postgraduate medical education and training should be reformed.

Alongside the written and oral evidence, we are discussing the review with key groups through seminars, workshops and meetings, as well as visiting a range of settings where training takes place. We have also commissioned research to help us better understand how postgraduate medical education and training and the medical profession may need to change over time.

You can read more about the review's activities at www.shapeoftraining.co.uk

What we want to know about

This review takes place in a rapidly changing environment. Medical and scientific advances, evolving healthcare and population needs, changes to healthcare systems and professional roles, the push towards more care provided in the community, the information and communications technology (ICT) revolution, and changing patient and public expectations will all affect how doctors will practise in the future. We therefore need to consider what these changes mean for the way doctors are trained.

To help us understand how doctors should train and work over the next 30 years we have broken the issues into themes:

- balance of the medical workforce
- flexibility of training

- patient needs
- the breadth and scope of training
- tension between the needs of the health services and training needs.

We are also looking at how doctors move between the different stages of their careers and whether the training structure can better support these transitions.

Balance of the medical workforce

This review is looking at whether we have the right balance between generalists and specialists needed to deliver care over the next 30 years.

The workforce should include a mix of doctors, trained as generalists or specialists, who can provide care in different settings and in a range of ways. Studies show that more specialists involved in community care as well as the use of generalists in coordinating hospital care results in better patient outcomes, higher levels of patient and staff satisfaction, and reduced hospital stays and emergency readmissions of acutely ill patients.[1]

We are thinking about a move towards more general training during the first phase of a doctor's postgraduate career. A more general approach to training would allow most trainees to choose one of a small number of broad specialty stems/families rather than pursuing a narrower specialist career immediately after foundation training. An example of such a broad speciality stem might be surgery. Doctors would train to the point where they could deliver competent general care within the community and acute admissions settings. GPs would also train within this broad specialty structure, but would focus on specific elements related to primary care towards the end of this training period.

However, this approach should not preclude opportunities for some to move more directly into narrower specialist training. It must also ensure opportunities for doctors to become experts in particular fields where care needs to be provided for those with rare or specific conditions. In other words, what is needed is a different balance between doctors with generalist and specialist skills, along with the ability for doctors to retrain or acquire further training to meet changing needs, and an approach to training which makes this possible.

Questions:

1. Over the next 30 years, how do you think the way patients are cared for will change?

Scientific advances, made possible by medical research, have brought about a greater understanding of the molecular basis of disease, which together with rapid technological developments offer significant opportunities to evolve clinical practice. In an age of increasing informatics comes ever increasing patient awareness and expectations. Care will be delivered over an increasing range of different settings, and it is likely that there will be a greater pressure on acute care, care of long-standing conditions and co-morbidities, and care of the elderly more generally. Advances in precision medicine will require medical students and doctors to have a more profound understanding of the scientific basis of medicine to drive improvements in patient care. Technological developments will make frequent re-training essential in order to take advantage of developments.

[1]Chris Ham et al. *Transforming the delivery of health and social care*. The King's Fund, 2012.

2. What will this mean for the kinds of doctors that will be needed in primary care? In secondary care? In other kinds of care?

The Government has recently made strong commitments towards health and innovation, and to solidifying the links between the NHS and academia, with statutory duties across the reformed NHS to engage in and promote research. Achieving the Government's commitments to health and innovation to advance patient care will require wider recognition throughout the medical – and indeed healthcare – workforce that academic values and a spirit of enquiry must pervade the medical workforce. This is especially the case with a move towards a longer period of generalist training, as much of medical research is in narrow sub-specialties. It is vital that there is an academic underpinning to all training, both generalist and specialist.

New training paradigms are required that can equip all trainees with the professional judgement to interpret, apply and embed research findings and the output of innovation and thus contribute fully to the development of service. A strong group of academic leaders needs to be developed and maintained.

We strongly advise that the final recommendations 34-45 of the MMC Inquiry (2008, p126 – p136, http://www.mmcinquiry.org.uk/Final_8_Jan_08_MMC_all.pdf) be implemented, such that postgraduate medical training comprises the Foundation Year 1 linked to medical school education; followed by core generalist training (3 years, comprising 6 month rotations within 'families' such as medicine/surgery/family medicine); followed by competitive selection to higher specialty training (including GP specialty training). Flexibility must be embraced to support and encourage the brightest young academics and to maintain the integrated academic training pathway across the UK.

3. What do you think will be the specific role of general practitioners (GPs) in all of this?

General medical practitioners often provide the first contact for patients and ongoing, continuous integrated care for a comprehensive range of problems to all members of the population for whom they are responsible. With an increasing, and evolving, co-morbidity of health conditions and complex pharmacology, longer GP training will need to incorporate more time learning about the less common and more challenging aspects of care for chronic conditions. Research has shown that medical generalists working in a well-developed primary care system improve the quality and efficiency of overall healthcare by triaging their patient community, referring only those patients likely to need specialist help into the secondary care system, and thus optimising the use of resources (Starfield, B (1998) *Primary Care; balancing health needs, services, and technology*. Oxford University Press, Oxford).

An academic primary care base is vital. Whilst it is difficult for academics in sub-specialties to maintain a community footprint, all practitioners need to be involved in research into the clinical and health service implications of generalist practice for example helping to recruit patients for clinical trials.

4. If the balance between general practitioners, generalists and specialists will be different in the future, how should doctors' training (including GP training) change to meet these needs?

The development of the future medical workforce begins with the medical student population. Indeed, whilst careers advice and competition ratios do direct an increasing number of students into GP training rather than specialist training, the Medical Schools Council recognises that the focus on generalism needs to be further embedded within the undergraduate curriculum. Medical students, trainees, specialists and generalists need to grasp the need for generalism and higher specialist care in terms of optimising the use of resources. They also

need to understand the values needed to practise as a generalist. NHS payments for clinical placements in primary care for medical students should be set at a level adequate to allow an increase in such placements over time as undergraduate curricula move out of more traditional secondary care settings. In practice, this means that the primary care placement tariff needs to be equal to the secondary care tariff.

There needs to be a solid generalist foundation to medical training, to ensure that trainees develop sufficiently broad clinical expertise before choosing a speciality including GP specialty training. As in the Final Recommendations of the MMC Inquiry, a three year core training programme should reflect the core requirements of a small number of specialty 'families' (ie medical disciplines, surgical disciplines, family medicine etc), immediately following the completion of FY1. This would support doctors in making more informed decisions about their career trajectories. It would also introduce greater flexibility for doctors to retrain and move between specialities as healthcare needs change, thus creating a more adaptable workforce.

The MSC recommends that robust training in research awareness, critical appraisal, and the evaluation of evidence should be a fundamental component of all foundation training programmes to embed a greater awareness of how to apply research across the medical workforce. This will allow doctors to interpret data to plan investigation and treatment and explain the advice to patients, and to evaluate the effectiveness of healthcare delivery in the modern health service. Research awareness should be fostered by including more formalised academic components in the postgraduate curricula, which should be rigorously assessed. There must also be greater capacity to evolve specialty curricula in response to the changing nature of medicine. There is an opportunity for the Royal Colleges to take forward such flexibility and to accredit relevant prior learning and indeed further learning through CPD in different specialties.

5. How can the need for clinical academics and researchers best be accommodated within such changes?

A well-defined yet flexible career path is essential to nurture future clinical academics. We have seen significant improvements in the structure of postgraduate academic training, such as those provided by the National Institute for Health Research Integrated Academic Training Programme. It is vital that the recommendations of the review do not create disincentives to academic careers in the constituent countries of the UK. We consider that to advance patient care the review should seek to ensure that the whole NHS is underpinned by a wider research awareness and involvement and to protect and enhance the academic training pathway.

The MSC and AMS wrote jointly to the Shape of Training Review Board in July 2012, and we strongly believe that the principles in that letter should be recognised and reflected within the outcomes of the review.

The Government has outlined its priority to develop a responsive workforce equipped to meet future health needs. Many aspects of the recommendations made in the report by Sir John Tooke PMedSci, 'Aspiring to Excellence', are still relevant and would go a long way towards introducing the flexibility required for academic trainees, and the requirement for an evidence based, research aware foundation to all training. In particular there needs to be:

Flexibility for all doctors to access research experience

The current binary divide between academic and clinical training should be abolished. A flexible approach which allows all trainees to gain research experience, as well as providing support to those who wish to pursue more focused research training, should be encouraged. Barriers to flexibility must be addressed; for example, trainees

who are awarded academic grants and fellowships should have a right to take these up, through inter-deanery transfers if need be. They should be supported to balance their clinical and academic duties. There should be consistency in good practice across the UK's Postgraduate Deaneries and LETBs in England. To attract greater numbers of trainees into broader based research experiences, appropriate exit routes should be well defined for those who decide not to progress further along the academic pathway. It is important that this is not perceived as 'failure' but that the research experience gained by these doctors is recognised as a valuable asset in promoting research awareness within the NHS.

Competency-based systems of credentialing for specialty training

A coherent mechanism for assessing skills as trainees progress along the training pathway should be developed. 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 does not accurately reflect the skill or proficiency of the individual trainee. In the craft specialties, for example, this is exacerbated further by requirements around the number of procedures. This creates particular difficulties for those trying to balance academic and clinical training experience, further compounded by the European Working Time Directive, and often family commitments. The comparatively small number of female clinical academics does concern us, and it is vital that there is sufficient flexibility to enable *all* trainees to balance their clinical and research commitments with commitments outside medicine. Naturally, all trainees, irrespective of their training portfolio, must be equitably assessed and only passed as 'competent' when merited.

The current system creates a lack of transparency as to what clinical service trainees at different levels are professionally competent to perform. The existing simple distinction between 'in training' and 'training completed' can cause confusion to patients, and inadequately reflects the competence of trainees to provide a given service or procedure. In a health service that is being reformed based on the principles of greater transparency and patient involvement, patients and their families, as well as the doctors themselves, must have clarity on professional capabilities and competencies.

To meet these concerns, further thought needs to be given as to how credentialing can more accurately reflect both the professional competence of the trainee and the skills required by a specific position. A more refined approach to competency certification or credentialing would allow career clinical academics to pursue specialist practice in areas of particular relevance to their research, without necessarily demonstrating competence across the broad range of the specialty. Clinicians may choose to vary in the breadth of their expertise and a more refined approach to competency certification or credentialing would facilitate the pursuit of more specialist practice.

Continued flexibility post CCT

Continued learning and development throughout an individual's medical career is essential. The opportunities to enhance experience post completion of training (CCT) merit consideration, perhaps leading to the attainment of an 'enhanced specialism'.

Maximising the opportunity of the NHS reforms to deliver research awareness and training

We have seen significant improvements in the structure of postgraduate academic training as a result of important efforts by the National Institute for Health Research (NIHR) and a multitude of research funders. However, challenges remain and it is crucial that the new education and training architecture is taken as an

opportunity to create a research-aware workforce that encourages and rewards academic excellence across the UK. There is a real risk that unless these considerations are seen as important, past successes may be compromised. Opportunities must also be grasped to link with other disciplines, in particular informatics and engineering.

The postdoctoral academic training 'pinch-point'

More clearly defined structures and processes are needed to enable trainees to integrate specialty with high quality academic training at the postdoctoral level. Managing the dual workload of specialty training with gaining momentum in research through postdoctoral work can be exceptionally challenging; obtaining and maintaining postdoctoral research experience should not act as a deterrent to those keen to pursue this pathway. Limited postdoctoral experience can prevent individuals from developing sufficient expertise to be competitive for prestigious externally funded Intermediate Fellowships/Clinician Scientist Fellowships, which enable the transition from postdoc to independent researcher. Consequently, this limits the numbers of individuals who go on to apply for senior clinical academic posts. Consideration needs to be given to the volume of postdoctoral opportunities available.

Opportunities for developing a coherent and consistent approach to academic training

The Government has recently made strong commitments towards health and innovation, and to solidifying the links between the NHS and academia, with statutory duties across the reformed NHS to engage in and promote research. Academic values must pervade the NHS. The NHS recognises that clinical academics make significant contributions to the NHS at a national as well as a local level. Proposed changes in contractual and pay arrangements must continue to support and incentivise careers in clinical academia and we have some serious concerns about the current proposals in this regard.

There needs to be an academic underpinning to, and integration of, research experience throughout all education and training programmes. The current binary divide between academic and clinical training should be abolished. A very much more flexible approach that allows trainees to gain research experience, as well as providing support to those who wish to pursue more focused research training, should be encouraged.

A clear and well-defined 'line of sight' is essential to nurture future clinical academics. However, for individuals to be able to balance competing clinical and academic commitments, a flexible approach is necessary. Effective dialogue and cooperation between Deaneries and funders is essential and there are many examples of best practice. However, unfortunately there is inconsistency in how flexibility is applied across the country, primarily because the Postgraduate Deaneries work in a highly regulated environment where flexibility is not always easily achieved. Periods of training overseas, for example, have become much more difficult. Such experiences are crucial to maintaining the UK's status as a leader in health research and as a mechanism for forging collaborations; effective dialogue would again be helpful here.

Flexibility

One of the main criticisms of the structure of postgraduate training is lack of flexibility for doctors in training and established practitioners to move between specialties. The current structure focuses on moving trainees quite quickly from a level of general knowledge and skills into specialties, some with very narrow areas of practice.

But trainees and trained doctors find it difficult to move into another specialty to which they may be better suited, or when the nature of medical practice or patient or service needs have changed. In general, they have to begin again in a training programme for the new specialty or subspecialty rather than focus on gaining additional knowledge and skills required for the new area. Coupled with this are difficulties in moving in and out of programmes to gain complementary experience in areas such as research or leadership.

Questions:

6. How would a more flexible approach to postgraduate training look in relation to:

a. Doctors in training as employees?

Whilst current regulations do allow out of programme activity, this should be positively facilitated and encouraged – including relabeling such experience as, for example, 'Programme Enhancing Activities'. The term 'out of programme' should be abolished. It is accepted that employers need to have the financial capacity to facilitate this – for example employing sufficient doctors to backfill rotas to allow for research time. Employing an academic trainee should not be a disincentive from a clinical perspective. Barriers to flexibility must be addressed; for example, trainees who are awarded academic grants and fellowships should have a right to take these up, and should be supported to balance their clinical and academic duties.

b. The service and workforce planning?

National governance and strategic control are necessary in determining the number of training posts and for quality control and selection processes. It is critical that short-term service pressures do not detract from the importance of postgraduate training. The current changes to education and training structures are a valuable opportunity to generate greater consistency in best practice by promoting academic flexibility as a right at a national level. Rotations must allow for this flexibility. Due consideration should be given as to whether this should be made a statutory duty on Health Education England.

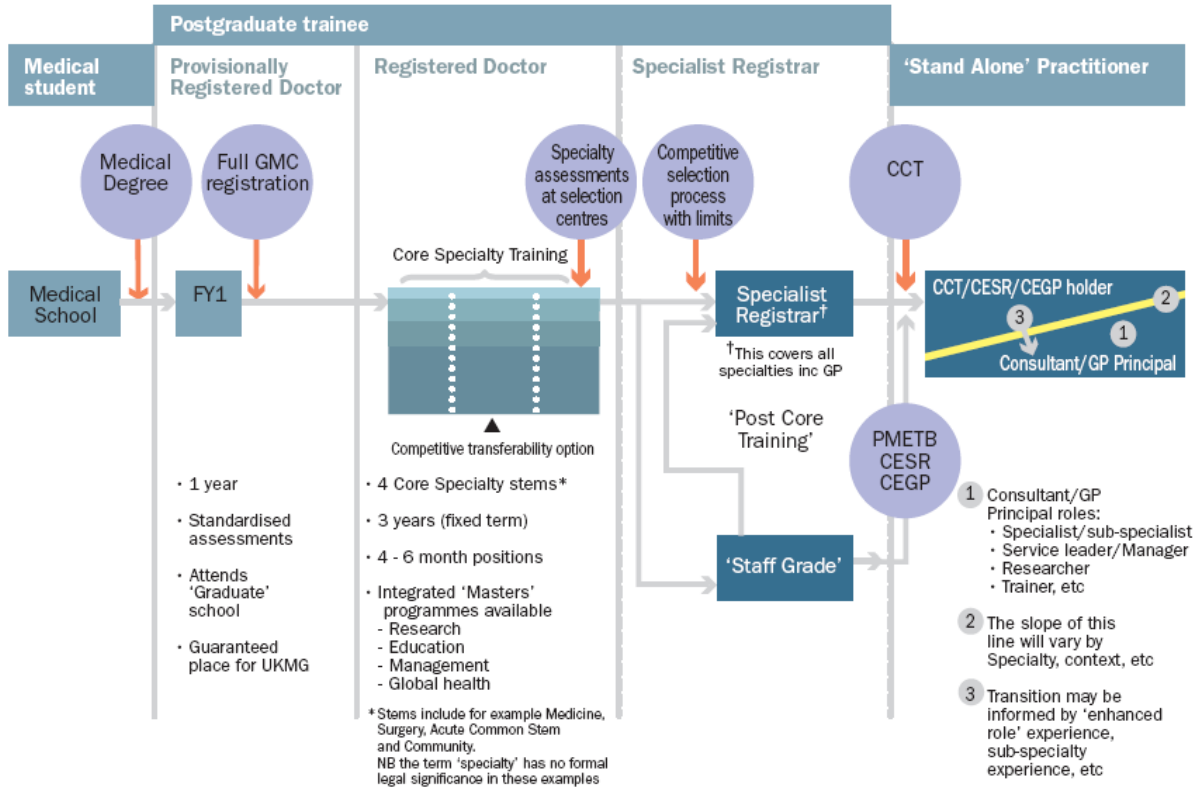
Around 60% of trainees are women, and there must be greater flexibility to accommodate Less Than Full Time (LTFT) training. Workforce planning needs to balance the pressures of service delivery and provide a sound training pathway for all trainees and protected research time for clinical academics.

c. The outcome of training – the kinds and functions of doctors?

Medical undergraduate and postgraduate training must provide a strong grounding in relevant science and in clinical practice as well as providing opportunities to develop an appreciation for research. Doctors must have the ability to assimilate new knowledge critically, have strong intellectual skills and grasp of scientific principles and be capable of dealing effectively with and managing uncertainty, ambiguity and complexity. Their practice should be evidence based and they should demonstrate their leadership and team working skills.

In funding 42% of clinical academics, the NHS has recognised that their function and purpose is national and international rather than simply local - although clinical academics certainly do make a substantial contribution to direct, innovative medical care. Almost all clinical academics commit 50% of their job plans to direct clinical care and supporting activities. They play a key role in contributing to the life sciences strategy and to UK plc. They identify tractable problems in their patient population, undertake the research to resolve the issues and introduce innovative approaches and solutions. It is a role to be protected and nurtured.

d. The current postgraduate medical education and training structure itself (including clinical academic structures)?



We strongly advise that the recommendations of the Independent MMC Inquiry are now taken forward, as they provide the structure to embed both broad general training and the flexibility for retraining. They facilitate greater flexibility for movement into and away from academic training pathways.

Furthermore, it is imperative that the FY1 year becomes coupled with medical school, instead of the current open competition. Approved posts as provisionally registered doctors need to be guaranteed for all UK medical school graduates to enable them to achieve full GMC registration. This can be achieved by uncoupling FY1 and FY2 in the employment sense, and matching the number of FY1 places with the number of UK graduates. This would allow UK universities to fulfil their obligations to the recent graduate (universities retain responsibility for the FY1 year), and would eliminate the scenario whereby a graduate is left with tens of thousands of debt but unable to work. The point of free and open application from the EU would be the point of application to medical school.

Staff within medical schools have profound expertise in medical education, which, coupled with the specialty expertise from the Medical Royal Colleges, would enable us to develop, in collaboration, an appropriate generalist curriculum. We recommend that the MSC and AoMRC work together on this for accreditation by the GMC.

There must be a move away from the binary divide between clinical and academic training, with competency-based credentialing, rather than time-based credentialing, and the opportunity for an academic underpinning for all medical trainees.

More clearly defined structures and processes are needed to enable trainees to integrate specialty with high quality academic training at the postdoctoral level. Managing the dual workload of specialty training with gaining momentum in research through postdoctoral work can be exceptionally challenging; obtaining and maintaining postdoctoral research experience should not act as a deterrent to those keen to pursue this pathway. In the current system, this has created a 'pinch point'. Limited postdoctoral experience can prevent individuals from developing sufficient expertise to be competitive for prestigious externally funded Intermediate Fellowships/ Clinician Scientist Fellowships, which enable the transition from postdoc to independent researcher. Consequently, this limits the number of individuals who go on to apply for senior clinical academic posts. Consideration needs to be given to the volume of postdoctoral opportunities available.

Patient needs

The UK population is ageing with more people living longer than ever before. We are also living with increasingly complex and long term health conditions such as dementia and acute and chronic mental illness, cancer and heart disease. Some diseases that used to kill quickly, such as HIV, have recently become chronic, long term conditions.

According to the King's Fund, patients and service users now expect health and social care to be more service focused.[2] They are willing to do more for themselves and will use technology more to access services. Patients expect to be offered choice and have more personalised and convenient experiences when using the health service.

Patients are not interested in the lines of demarcation between professionals, such as the boundaries between primary and secondary care, health and social care. What they want are integrated teams that can meet all their health and social care needs effectively without letting something slip through the cracks. But the roles of those caring for them should nevertheless be clear to patients by identifying, for example, whether someone is a trainee and what, in practice, this means.

Questions:

7. How should the way doctors train and work change in order to meet their patients' needs over the next 30 years?

There will need to be flexibility – both for education and training to respond to evolving patient population needs, and also for trainees themselves, recognising that careers will lengthen as retirement is delayed. Opportunities need to be provided for careers to evolve and for new challenges to be available to enhance consultants' careers. Continuing Professional Development (CPD) will need to incorporate the ability to re-train in new areas

[2] Chris Ham et al. *Transforming the delivery of health and social care*. The King's Fund, 2012.

of practice, and to have such learning recognised for example by credentialing. The provision of the highest possible quality of care 24 hours a day, seven days a week has profound implications for doctors' work/life balance. Greater use of technology and remote consultation should help address this issue.

8. Are there ways that we can clarify for patients the different roles and responsibilities of doctors at different points in their training and career and does this matter?

The current system creates a lack of transparency as to what clinical service trainees at different levels are professionally competent to perform. The existing simple distinction between 'in training' and 'training completed' can cause confusion to patients, and inadequately reflects the competence of trainees to provide a given service or procedure. In a health service that is being reformed based on the principles of greater transparency and patient involvement, patients and their families, as well as the doctors themselves, must have clarity on professional capabilities and competencies. Ultimately, patients want to be reassured that their overall care is being managed by a doctor with expertise in that area, and at the necessary level.

Further thought needs to be given as to how credentialing can more accurately reflect both the professional competence of the trainee and the skills required by a specific position. Clinicians may choose to vary in the breadth of their expertise and a more refined approach to competency certification or credentialing would facilitate the pursuit of more specialist practice. This would be of particular benefit to clinical academics, who could pursue specialist practice in areas of particular relevance to their research, without necessarily demonstrating competence across the broad range of the specialty.

9. How should the rise of multi professional teams to provide care affect the way doctors are trained?

Multi-professional teams can both improve the patient experience and offer productivity improvements. There needs to be clarity about the role of each member of the team and work should be apportioned to the team member with the most appropriate skills for the task. As technologies advance, doctors will be able to delegate and to focus on tasks requiring the application of their scientific knowledge in areas where protocols cannot deal with the problem they are facing.

Breadth and scope of training

The current system focuses on preparing doctors up to the point of the Certificate of Completion of Training (CCT). Following the completion of the two year Foundation Programme, postgraduate training leading to a CCT lasts between three and eight years (full-time equivalent), depending on the specialty in which the doctor has trained.

Forces such as the Working Time Regulations (WTR) and other drivers are limiting the number of hours trainees can work, and the postgraduate structure does not readily allow for longer training periods to offset this.

Pressure to deliver the service, coupled with complex rotas, mean that many trainees, at some time, struggle to get meaningful learning experiences. Linked to this are problems with having time to learn new skills, and to

reflect on and consolidate that learning.[3] Arrangements for the handover of care at the end of the shift can also make the learning experience episodic, hampering trainees' ability to engage with the full narrative of their patients' care. None of this is new and should not be taken to imply that training today is inferior to training in days gone by. But it can affect the ability of doctors coming out of training at the GP and consultant level to work effectively without some supervision and support. Some medical royal colleges are starting to address such issues by introducing specific, post-CCT learning packages aimed at new GPs or consultants. For example, the Royal College of General Practitioners has structured a support programme for GPs during their first five years. Partly for this reason too, many surgical trainees are undertaking post CCT fellowships.

Formal postgraduate training is not, in any event, end of learning and development. Medical practice evolves rapidly and doctors must undertake lifelong learning and continuing professional development (CPD) to stay up to date and meet professional standards. Training and development are never really completed.

Questions:

10. Are the doctors coming out of training now able to step into consultant level jobs as we currently understand them?

The MSC supports the DDRB recommendations for three Consultant grades. Currently, consultant status can be attained early on in the doctor's career, and we endorse the recommendation that promotion to senior and then principal consultant grade should be dependent on high performance, expertise and leadership. Clinical teams in teaching hospitals are often led by clinical academics. In implementing the DDRB report equal recognition needs to be given to clinical academics in order that they might access these new grades.

11. Is the current length and end point of training right?

The end point of training may need review, to take account of the need for a longer period of generalist training for all medical graduates.

There need to be competency-based systems of credentialing for specialty training and a coherent mechanism for assessing skills as trainees progress along the training pathway. 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 does not accurately reflect the skill or proficiency of the individual trainee. In the craft specialties, for example, this is exacerbated further by requirements around the number of procedures. This creates particular difficulties for those trying to balance academic, clinical training experience, and often family commitments.

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

The new proposals from DH for three levels of consultant will have a significant impact as the very brightest and best strive to become Principal Consultants with the kudos and additional salary that will accrue. There has long been recognition in the UK that continued personal and professional development is essential throughout an individual's medical career and the EU too has now recognised this. The restructuring of postgraduate training

[3] GMC National Training Survey 2012 http://www.gmc-uk.org/education/surveys.asp

represents a real opportunity for the royal colleges to recognise credentials from other colleges from within their specialty 'family', without requiring doctors to re-train at cost to themselves and the service, recognising the areas of overlap. A deadline for introducing this needs to be imposed.

Academics, with responsibilities for clinical care as well as teaching and research within their job plan, must maintain the same level of CPD as those with full-time clinical contracts. Accordingly, clinical academics need the same full access to CPD as their full-time clinical colleagues, and will need an SPA (Supporting Professional Activities) within their job contract even though only 50% of their time is spent on Honorary contract activities.

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

The ring-fencing of the education and training budget within HEE offers a singular opportunity to specify teaching time within consultant job plans and to ensure that Trust Boards understand that high quality teaching must be provided in exchange for the HEE funds to deliver education and training. If the funds allocated for education and training were actually spent on education and training rather than for service delivery – there would be an immediate and dramatic increase in quality. The Recommendations of the Francis Report with regard to the quality of clinical placements are an important development.

14. What needs to be done to improve the transitions as doctors move between the different stages of their training and then into independent practice?

The MSC took the lead and convened the Transition Group in 2009, to try to improve the transition from student to F1 doctor. There have been significant achievements in terms of transfer of information, work shadowing and modifications to the Foundation curriculum to integrate it more closely with the outcomes required by *Tomorrow's Doctors.* Further work on the integration of curricula would be helpful. Greater flexibility needs to be introduced to permit trainees to modify their clinical training programmes as their research interests change.

Tension between service and training

There is a tension between service and training in a system based on doctors in training delivering a substantial portion of the service, particularly at nights and weekends. They may also at times work in roles with inadequate levels of support and may be asked to undertake tasks outside their level of competence.[4]

Questions:

15. Have we currently got the right balance between trainees delivering service and having opportunities to learn through experience?

[4] GMC National Training Survey 2012
http://www.gmc-uk.org/NTS_trainee_survey_2011.pdf_45270429.pdf

The creation of HEE means that we now have the funds in place and so need to allocate them effectively so that more, and higher quality, teaching can take place during the course of service delivery in order that trainees and patients might benefit accordingly.

16. Are there other ways trainees can work and train within the service? Should the service be dependent on delivery by trainees at all?

Trainees need to be actively involved in service delivery if they are to learn to take responsibility. Effective supervision and structured training programmes can minimise the risks to patients. The opportunities presented by the ring fenced budget for education and training provide a singular opportunity to make a step change in the quality of education and training provided by NHS staff.

General questions about the shape of training

17. What is good in the current system and should not be lost in any changes?

We have seen significant improvements in the structure of postgraduate academic training as a result of important efforts by the Academy of Medical Sciences, the National Institute for Health Research (NIHR) and a multitude of research funders. However, challenges remain and it is crucial that the new education and training architecture is taken as an opportunity to create a research-aware workforce and a system that encourages and rewards academic excellence. There is a real risk that unless these considerations are seen as important, past successes may be compromised. Opportunities must also be grasped to link with other disciplines, in particular informatics and engineering.

18. Are there other changes needed to the organisation of medical education and training to make sure it remains fit for purpose in 30 years time that we have not touched on so far in this written call for evidence?

The following are key when considering the evolution of standard and academic clinical training pathways

- A robust evidence base
- Many consultants lament the loss of the 'firm structure' which allowed consistent teams of doctors to take responsibility for a group of patients. The loss of this approach is detrimental to patient care with lack of follow up. It is also detrimental to learning by junior doctors who often no longer see the effects of their treatment. Despite the EWTD, the issue needs to be re-considered. It would address the Francis Report's recommendation to reinstate the practice of identifying a senior clinician who is in charge of a patient's case.
- Comparisons at the international level and with other professions, particularly in terms of how flexibility and credentialing are handled
- Embracing new learning modalities
- Agreeing the service model: for example 24hr/7 day working for the acute sector would not work without a similar model in primary and social care

- As with other clinical specialties where one PG Deanery, or now, LETB, takes the national lead, there needs to be a lead LETB for PG academic training to ensure that the special needs of academic trainees are understood and that best practice is adopted across the UK.
- Parity of pay between NHS consultants and clinical academics must be maintained.
- Specialist curricula must evolve as traditional boundaries between specialties/disciplines are eroded by the march of science. In addition to the medical Royal Colleges, the Academy of Medical Sciences and the Medical Schools Council have a role here in monitoring progress and initiating change.
- It is essential that the four countries of the UK continue both to adopt a UK- wide approach to medical education and training – but also learn from each other's successful developments. For example the Scottish Clinical Research Excellence Development Scheme (SCREDS), has successfully brought together the PG training system and clinical academic medicine. A partnership between the NHS, Scottish Funding Council, CSO and the Universities is being developed by the Board for Academic Medicine and there is likely to be a new Scottish Senior Clinical Fellowship scheme when the current one ends in 2013