7 February 2013

Council

General Medical Council

Regulating doctors
Ensuring good medical practice

8

To note

GMC response to the Shape of Training Review *Call for Ideas and Evidence*

Issue

1. We are responding to a call for ideas and evidence from this independent review into UK postgraduate medical education and training.

2. This paper provides a brief background. Our response is attached at Annex A.

Recommendation

3. Council is asked to note the terms of the GMC response to the Shape of Training Review *Call for Ideas and Evidence* (Annex A).

The Shape of Training Review

4. The review began in 2012 under the joint sponsorship of the following bodies: Academy of Medical Royal Colleges, Conference of Postgraduate Medical Deans, the GMC, Health Education England (HEE), Medical Schools Council, NHS Education Scotland, Northern Ireland Medical and Dental Training Agency, and Wales Deanery.

5. The Sponsoring Board has appointed Professor David Greenaway, Vice-Chancellor of Nottingham University, to lead the review. He has assembled an Expert Advisory Group and will report his conclusions in autumn 2013.

Call for evidence and the GMC's response

6. The GMC and HEE are jointly providing policy and administrative support for the review. We also have a key interest in the outcome of the review and have prepared a response to the call for ideas and evidence on this basis (Annex A). The paper was prepared in consultation with the Chair and Chief Executive. The closing date for submission is 8 February 2013.

Supporting information

How this issue relates to the *Corporate Strategy* and *Business Plan*

7. Strategic aim 3 of the 2013 Business Plan states that we will 'provide an integrated approach to the regulation of medical education and training through all stages of a doctor's career.' Our participation in, and our response to, the review supports this aim.

How the issues differ in relation to healthcare management and/or regulatory structure in each of the four countries

8. Our response to the call for evidence and ideas highlights the importance of having a single UK regulator overseeing and guaranteeing standards of training across the UK. This is an asset both in terms of patient protection and medical mobility. That single reference point needs to be flexible enough to accommodate different arrangements for healthcare delivery, while preserving the integrity of the whole.

What equality and diversity considerations relate to this issue

9. Our response emphasises the need for a future model for training which is sufficiently flexible to meet the changing demographics of the future workforce and the changing needs of the service and the patient population.

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Annex A

GMC Response to Shape of Training *Call for Ideas and Evidence*

Introduction

1. The General Medical Council (GMC) is the independent regulator for doctors in the UK. Our role is to protect patients by ensuring proper standards in the practice of medicine. In short, our job is to make sure that patients can have confidence in doctors. We do this by:

- Controlling entry to and maintaining the list of registered and licensed doctors.
- Setting standards for all stages of medical education and training and ensuring that those standards are met.
- Determining the principles and values that underpin *Good Medical Practice*.
- Taking firm but fair action against doctors' registration where standards of *Good Medical Practice* have not been met.

Preamble

The role of the doctor

2. The fundamentals of what it means to be a doctor are well known and enduring. They are, for example, articulated in the GMC's Good Medical Practice and in the Medical Schools Council Consensus Statement on the Role of the Doctor.[1] They include, among other things, the ability to assess and manage risk, which requires high level decision making and the ability to work outside of defined protocols when circumstances demand.

[1] Medical Schools Council, The Consensus Statement on the Role of the Doctor, 2008

3. The Statement emphasises the primacy of the doctor patient relationship, but places this in the context of the wider heath needs of the population. As the critical decision makers, doctors have responsibility for significant health resources. They must therefore be capable of both management and leadership and take responsibility for clinical decisions. They 'have a duty to use resources wisely and effectively and engage in constructive debate about such use' and a key role in enhancing clinical services through their positions of responsibility. The Statement concludes that the role of the doctor is changing and will continue to change alongside the needs and expectations of patients.

4. So although the fundamental qualities required of doctors largely remain the same, they way they are applied will be determined by changing patient and service needs over time.

5. We are now on the threshold of major change. NHS restructuring and service reconfiguration, more care being delivered in the community, and rapid technological advance transforming how care can be provided are just some of the changes we are witnessing. If the way that doctors work will need to change, the question for the review is how do we need to change the way they are trained so that they are equipped to meet and lead this transformation?

6. We welcome the chance to respond to this important independent review. We recognise that our view will be one among many. As the UK body responsible for the regulation of medical education and training, this is the focus of our response. Although we have also commented on service issues insofar as they affect the role of the doctor and the implications for training, we understand that others will approach such issues from different perspectives.

Education and training

7. Medical education and training are not about instilling a body of knowledge, competences and behaviours which is complete at a fixed point and which thereafter defines an individual's professional role for all time.

8. Instead, the practice of medicine is about being able to work with change and uncertainty. Doctors' roles will change. Some practices, skills and functions will be left behind and others will be acquired. To take a simple example, a doctor in a craft specialty may over time lose the manual dexterity to perform certain technical procedures, but instead may bring skills to bear in areas such as teaching and clinical leadership. Similarly, some tasks which were once the preserve of doctors are now carried out by other members of the health team, releasing doctors to use their skills where they can add most value.

9. We therefore need to train doctors to be at the cutting edge, both in terms of the ability to develop their own practice and roles to meet changing needs and their readiness to lead change in how care and treatment are delivered.

10. Seen in this context, the Certificate of Completion of Training (CCT) is a misnomer. It is one of a number of punctuation marks along the continuum of professional training that should run throughout a doctor's career.

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

11. There can be no certainty about how things will change, only that they will. The healthcare workforce therefore needs to be trained and equipped to deal with both change and uncertainty.

12. There are, nevertheless, some indicators which suggest how the demands on healthcare services may develop – in particular the continuing growth in the elderly and very elderly population, the rising prevalence of long term conditions, the major impact of the digital revolution and of genomics, and rising expectations from patients and payers.

13. For a host of reasons the nature and location of what is now hospital care is likely to change – in particular the evidence suggests that some services will become increasingly centralised around specialist expertise while others will demand more generalist care. Overall the need for generalist medical expertise is likely to increase.

14. Weaknesses in the current model of provision include an emphasis on daytime and weekday working which does not match patient need. The benefits to patients of their care being delivered by, or under the direct supervision of, senior doctors at all times has been recognised and should influence future training and deployment. There is also considerable scope to develop more integrated services which reflect the patient's journey through the healthcare system and which create a smoother interface between primary and secondary care.

15. To achieve all this there is a growing body of clinical and managerial opinion that there will need to be a fundamental re-alignment of the way care is delivered.[2] The demise of the District General Hospital model of the 1960s, in which healthcare is structured around secondary centres providing treatment for most conditions has long been predicted but there are now stronger forces than ever which should prompt fundamental change. In particular the pull towards more community based care on one side and, on the other, greater centralisation of specialised care suggest that reform is both inevitable and desirable.[3]

16. To create a sustainable 24/7 model of high-quality care would also require a system in which patients no longer had to be admitted to hospitals when they do not need to. That points to more care being delivered in the community and better availability of services outside of hospital settings.

[2] Academy of Medical Royal Colleges, *The Benefits of Consultant Delivered Care*, 2012. Royal College of Physicians, *Hospitals on the Edge*, 2012. Royal College of Paediatrics and Child Health, *Facing the Future: A Review of Paediatric Services*, 2011. Royal College of Obstetricians and Gynaecology, *Tomorrow's Specialist: Working Party Report, 2012.*

[3] Nigel Crisp, 24 hours to save the NHS, OUP, 2011

17. As the Academy of Medical Royal Colleges has noted, while secondary care is increasingly contemplating a seven day a week model[4] this is not currently the case in primary care. If more care is to be delivered in the community we need to consider the implications for the current model for primary care and how far it will meet the expectations of future patients and the needs of the service overall.

18. The way health systems are structured is not a matter for the GMC, but the way medical training works within the healthcare service is central to our work. Recent years have seen growing divergence between the healthcare systems in the four UK administrations and we can expect that to continue. The system for training doctors needs to be able to accommodate the different UK delivery models, whatever form they take.

Question 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?

19. The uncertainty about the future requirements across the UK points to a need for greater flexibility in the medical workforce. Doctors will need to be trained less for narrow specialty or sub-specialty areas of practice and instead develop more skills that can be transferred across specialty boundaries and settings in response to changing patient and service needs.

20. The Royal College of Physicians (London), among others, has noted that the continued growth in the number of patients with chronic and complex co-morbidities will require more doctors with generalist skills that enable them to deal with a wider range of conditions.[5] There is, after all, limited value in the health service organising doctors into narrow specialist silos if patient illness doesn't respect the same boundaries. On the other hand, a move towards greater generalism cannot be to the exclusion of specialisation and there is a balance to be struck. Most doctors will work where the service need is greatest.

21. At this point it is worth being clear about terminology. The concepts of generalism and the generalist in medicine include, but are not confined to, general practice. Generalism is relevant across a range of primary, community and secondary care settings. In hospital and community settings, for example, it would refer to a doctor working in one of a number of broad specialty areas such as medicine, surgery or anaesthetics. Individuals would be trained to a level which equips them to take responsibility for managing and delivering safe and effective care across the full range of conditions common to that discipline. More complex or rare presentations would be referred to specialists within the hospital or other specialist centres. Clear criteria and evidence would need to be developed to allow decisions about when generalist as opposed to specialist care was appropriate for patient need.

[4] Academy of Medical Royal Colleges, *Seven Day Consultant Present Care*, 2012
[5] Royal College of Physicians, *Hospitals on the Edge*, 2012

22. There is an almost universal assumption that in future more care will be delivered in the community rather than in hospitals. This may indicate a need either for more general practitioners or more doctors in traditional hospital specialties with the skills to work outside of hospital settings, or both. It certainly suggests the need for a stronger interface between the two. We would therefore envisage generalists being able to work across the interface between primary, community and secondary care where that will help to smooth the patient pathway. For example, GPs may undertake some of their work in hospital settings.

23. If, as seems likely, the health service develops so that not all hospitals provide care for the full range of medical conditions, we might expect some to become centres of specialist care while others focus on generalist medical care. This role for the generalist has an obvious and particular relevance in remote and rural settings.

24. While generalists and generalism have relevance across specialties and settings, it will be vital to avoid a 'one size fits all' application of the generalist principle. The degree of specialisation that is appropriate will vary between settings and specialties.

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

25. Whether there are more GPs or more generalists and specialists working in community settings, the role of the GP will be key. As the recent RCGP report on Generalism argues, GPs will not be experts in every disease they encounter but they are experts in the patient in his or her context and should be best placed to manage and support the patient through their care overall.[6]

26. This of course raises fundamental questions about continuity of care and the extent to which GPs can and should have 'their own' patients – a link which many patients, especially older ones, value enormously but which others see as much less important than being able to access a GP quickly and conveniently.

27. For most of the time most patients in general practice are managed and supported within primary care, but as the Academy of Medical Royal Colleges has pointed out a key challenge lies in creating an effective interface between primary and secondary care.

28. This has long been a challenge but as more emphasis is placed on community support, and in preventing unnecessary hospital admissions (or re-admissions) it is becoming more critical than ever that there is effective communication, absence of duplication and a seamless service in which patients get the appropriate support in the appropriate setting.

[6] Royal College of General Practitioners, Medical generalism: Why expertise in whole person medicine matters, 2012

Question 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?

29. It we need more generalists, training for most doctors should focus more on the knowledge, skills and attributes necessary for generalist disciplines and to level at which they can deal safely and competently with the common conditions in their discipline.

30. At the same time there will continue to be a need for some doctors to pursue more specialty focused training. For most of them this more specialist training would take place after they have trained and practised as a generalist, but there may be advantages in enabling some doctors in training to acquire specialist skills more quickly, depending on the area of practice and service need. Conversely, for those pursuing a generalist path there may be arguments for less differentiation between disciplines in the early stages of training such that, for example, GPs and other disciplines train together and begin to breakdown the boundaries between primary and secondary care. These are just some of a number of complex issues that will require more discussion and careful planning.

31. In this new dispensation, continuing professional development will assume greater importance as a way of maintaining, adapting and developing knowledge and skills to meet service needs. Our initial work on credentialing suggests that it could also be used to give formal recognition to the acquisition of those additional skills and should create greater workforce flexibility.

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

32. It is important that academic and research skills are not treated as requirements exclusive to those pursuing academic or specialist careers. The 'doctor as scholar and scientist' is one of the outcomes for graduates in Tomorrow's Doctors and is thus relevant to all doctors' training.

33. Nevertheless, a greater focus on generalism should not force those who wish to follow an academic or research career into a generalist pathway. It will be important to ensure that training for the next generation of clinical academics and researchers enables them to acquire the skills applicable to their specialty while allowing them the flexibility to pursue their research interests.

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

(a) Doctors in training as employees?

34. If there is to be a more flexible approach to training we need to recognise that doctors must continue to learn and train throughout their careers in order to meet both changing service demands and their own developmental needs. For example, we noted in the preamble to this response that as medical careers

lengthen with later retirement, doctors in high intensity specialties are unlikely to remain on the clinical front line. Their skills will need to be deployed in other areas in order to achieve the best match between changing aspirations and capabilities.

35. Similarly, within a more generalist approach to training and practice, we would expect to see generalists developing new skills (credentials) to meet the demands of their changing practice.

36. Flexibility also needs to be seen in the context of balancing service and educational needs. Any system of postgraduate training should seek to marry the legitimate demands of service delivery with the need for high quality education and training. While the two things often go hand in hand (poor clinical care often means poor educational support), there is a tension between short term service needs and the longer term interest of making sure the next generation is properly prepared. Institutions which cannot flex to resolve that tension may not be suitable as training environments (see our response to question 13)

(b) The service and workforce planning?

37. A more generalist approach to training in which individuals specialise later in their careers should make it easier to meet changing patient and service needs.

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

38. Doctors' training needs to equip them to move more flexibly between hospital and community settings and to understand that their roles will almost certainly change over their career.

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

39. In our response to earlier questions we have set out why we consider that training needs to be more flexible. We would also refer you to our answers to questions 4, 5 and 12 for our views on how training should be structured.

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

40. It is worth noting that even with more emphasis on care in the community, hospitals will remain vital training grounds for both undergraduate and postgraduate training – they will continue to be the place where care and treatment of the acutely ill patient is managed and as such they will continue provide the experience and learning opportunities needed by both medical students and doctors in training.

41. Wherever doctors work and train, the impact of the digital revolution on the way they practice cannot be underestimated. Direct patient contact will always be critical, but we can expect to see increasing emphasis on new means of communication, remote assessment (telemedicine), more patient feedback, and more and better data about individual and team performance.

42. Above all perhaps, we can expect developments in genomics to transform the way medicine is practised by enabling care to be increasingly personalised. Education and training must equip all doctors for that change, both as part of their formal training and through their subsequent CPD.

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

43. The health service has traditionally been slow to adapt to new nomenclature intended to describe roles and levels of experience. For example, many still refer to 'SHO rotas'. While this may seem trivial, if it means that patients and other members of the health team are unable to distinguish between someone in the first year of core training and the first year of specialist training, patient safety may be compromised. It will be important that attention is paid to communicating and implementing change, as well as determining in the first place the nature of that change.

44. The GMC registers also have a role to play in providing greater clarity about the nature of doctors' practice, their training and experience, though they are not the complete solution. Our proposed development of credentialing, for example, offers a way of providing more transparent information about areas of competence acquired by doctors as their careers progress. If the independent sector grows, with more doctors undertaking training outside the NHS, or working in settings where the traditional nomenclature and career waypoints do not apply, this may become increasingly important.

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

45. It has long been recognised that doctors must be able to work as part of multi-professional teams and this needs to be one of the generic outcomes of their training. The growing importance of integrated medical and social care suggests that this will become increasingly relevant.

46. However, although there are examples of good multi-professional learning it has sometimes served to reinforce professional boundaries and barriers rather than overcome them. To be effective, learning needs to be context specific and built around realistic scenarios. Inter professional learning (which involves learning from a trained and experienced individual from another profession – for example, a midwife teaching a doctor in training how to deliver a baby) may be more effective than multi-professional learning (in which doctors in training from different professions are taught together). The desired outcome is for individuals to be able to function as part of a multi-professional team, but the best means of achieving this may sometimes be through inter-professional, not just multi-professional, learning.

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

47. As the Call for Evidence identifies, initiatives such as the RCGP 'First 5' programme and post CCT surgical fellowships suggest that in some specialties doctors stepping into consultant level jobs for the first time need additional support. We would not accept that training today is inferior to that in the past. In very many respects the evidence suggests that it is superior. But there are issues that need to be addressed about preparation for and transition to consultant-level (including GP) practice.

48. First, ongoing work by the GMC and others is pointing to a need for postgraduate training in all specialties to place greater emphasis on certain generic outcomes such as the development of leadership skills. As the MSC Consensus Statement indicates (see the preamble to this response) doctors have a key leadership role in enhancing clinical services. They must use this role to help drive quality improvement and lead service re-design for the benefit of their patients. The Medical Leadership Competency Framework[7] is an important step towards what should become a core competence for all doctors. In a complex and rapidly changing health system and with fast moving technology, the need for senior doctors to develop such skills will only increase.

49. Second, there has been frequently voiced concern from some craft specialties that doctors in training can no longer access the volume of clinical exposure and experience necessary for them to achieve mastery of their craft. Addressing such concerns cannot involve a return to a culture of working excessive hours. It is not in patients' interests for their doctors to be exhausted or in the interests of the doctors themselves. Other solutions, as suggested by Sir John Temple in Time for Training[8] (now being taken forward under the Better training, better care programme) need to be explored. Among other things, these include better shift and rota design, service reconfiguration, multidisciplinary team working, and better use of technology and simulation.

50. Third, we are also mindful of the recommendation in Lord Patel's 2010 report on the future regulation of medical education and training that the GMC should consider uncoupling the completion of specialist (including general practice) training from the decision to allow a doctor onto the specialist or GP register.[9] This could have significant implications for the meaning and effect of the CCT which would require further debate, but might provide a space in which doctors could hone their skills and build on their experience before taking up leadership roles. We consider this is an idea which merits further consideration, but care would need to be taken

[7] Medical Leadership Competency Framework, Academy of Medical Royal Colleges, 2010 www.leadershipacademy.nhs.uk/discover/leadership-framework/

[8] Temple, Time for Training: A review of the impact of the European Working Time Directive on the quality of training, 2010

[9] Final Report of the Education and Training Regulation Policy Review: Recommendations and Options for the Future Regulation of Education and Training, GMC, 2010

so as not to introduce unnecessary new hurdles to inclusion in the specialist or GP registers.

Question 11: Is the current end point of training right?

51. As we have indicated at the beginning of this response, it is misleading to think of the 'end point' of training since doctors need to be committed to lifelong learning and have, or develop, the capacity to adapt to the changing environment. Their training should equip them to continue developing and greater emphasis needs to be placed on the role of CPD in maintaining and developing doctors' practice. The GMC's recently published CPD guidance provides a framework for how this should be approached.[10]

52. Furthermore, if the training of the majority is to focus on developing doctors who are able to work as generalists, we will need to re-examine the terminology around attainment – for example, 'Certificate of generalist physician training', Certificate of specialist surgical training' and 'registered credential in cosmetic surgery' may be more accurate reflections of a doctor's practice than the current CCT.

53. It is possible to think of the future shape of education, training and learning dividing into a series of blocks or stages (See Appendix A):

- Undergraduate education
- Foundation training
- Generalist training in one of several broad stems and leading to the award of a certificate of generalist training.
- Specialist training leading to the award of a certificate of specialist training
- CPD and credentialing

54. The certificate of generalist training may be an end point in its own right for those pursuing a generalist career or a stepping stone to further specialist training.

55. Those seeking, and capable of pursuing, specialist careers may come through generalist training in the first instance or, in some cases, enter specialist training directly from foundation training. The proportions of generalists and specialists should reflect anticipated service needs.

56. The duration and content of the different stages would be for further discussion.

[10] Continuing Professional Development: Guidance for all doctors, GMC, 2012

57. For both generalists and specialists, the importance of CPD would increase, with credentialing providing a way for both groups to acquire additional accredited skills in particular areas of practice.

58. As we indicate in our response to question 5, those pursuing academic pathways need to be able to acquire the skills relevant to their specialty but with flexibility in their training which facilitates pursuit of their academic or research interests.

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

59. As our response to question 11 suggests, if training follows a more generalist model it will be necessary to revisit the meaning of, and the practising privileges associated with, the current CCT so that it more accurately reflects the outputs of training, whether as a generalist or a specialist. The conclusions will require further debate, but this should include, as we indicate in response to question 10, examining questions such as the relationship between certification and inclusion in the specialist (or any future generalist) register as recommended by Lord Patel in his 2010 report.[11]

60. For both generalists and specialists, some aspects of CPD will become more structured where this involves the acquisition of recognised credentials in different areas of practice as they move through their careers.

Question 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?

61. There are two key issues. First, it is important to ensure the quality of the educational environment in which training takes place. While some institutions may become centres of excellence for training, others may be unsuitable for training because they cannot provide the sort of patient and skill mix which will ensure the necessary breadth and quality of the training experience.

62. But we should not assume that a high quality training experience can only be obtained in certain types of urban tertiary centres. 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.

63. Whether the GMC should regulate the educational environment as a whole is one of the issues under consideration in our current review of the quality assurance of medical education and training.

[11] Final Report of the Education and Training Regulation Policy Review: Recommendations and Options for the Future Regulation of Education and Training, GMC, 2010.

64. Second, As Professor John Temple has previously noted, a high quality learning experience also requires doctors in training to have time to learn and reflect.[12] While progress has been made in restricting the overall number of hours worked, the benefits are lost if the pattern of work and service requirements are of such intensity that doctors in training no longer have time to reflect on what they have learned. A better balance between service and training commitments, facilitated by better rota arrangements which optimise the opportunities for learning, will help to address this.

Question 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?

65. The risks associated with transitions between different stages of training, and between training and leadership roles, are well recognised. Tomorrow's Doctors (TD) acknowledges this, placing a premium not just on the acquisition of competences but on preparation for practice. It highlights the importance of 'shadowing' to support new doctors as they prepare to enter practice, and the four UK health departments put in place a shadowing programme for new graduates in 2012. Mentoring can provide similar support in a doctor's subsequent career. Regulation may have a role to play in establishing frameworks, and influencing provision of resources, that will help to smooth these transition points. The GMC's current pilot programme to help doctors new to the UK to become established suggests one way in which this might be done.

66. We would also query the use of the term 'independent practice' in this question. The concept of 'independent practice' is an anachronism. In today's health service no doctor should work in a truly 'independent' manner. They are all subject to governance systems, most work in managed environments, they undergo appraisal and revalidation, engage in clinical audit and they work in teams. Insofar as the term 'independent' is used to describe consultant practice, it may be more meaningful to refer to those fulfilling 'leadership roles'. Those assuming such roles also take on a higher level of accountability for their own practice.

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

67. We refer you to our answer to question 13.

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

68. Involving doctors in training in providing service is a valuable way of consolidating learning and building experience. However, the service should not be dependent upon doctors in training in such a way that the need to provide the

[12] Temple, Time for Training: A review of the impact of the European Working Time Directive on the quality of training, 2010

service impairs opportunities to learn and reflect. As we indicate in our answer to question 13, the intensity of the workplace experience currently means that some doctors in training have too little time to learn and reflect. As others have noted, increasing the consultant presence will support better training and better care,[13] but will have resource implications.

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

69. It is important not to lose sight of the many strengths of the current system of UK medical education and training. The UK's reputation is high and its expertise internationally acknowledged as demonstrated by the large number of EEA and international medical graduates who have come to the UK to train. There are many reasons for this.

70. First and foremost is the goodwill and commitment to excellence of many dedicated individuals involved in the management and delivery of training. It is vital that this is recognised and that the system supports and continues to motivate these individuals.

71. The introduction of clear standards, curricula and assessment systems now provides a proper framework for postgraduate training and makes transparent the outcomes that doctors in training are expected to achieve.

72. The existence of a clear structure for organising training enables it to be delivered in a coherent way. The continuation of that structure has been a key concern for many with the restructuring of the NHS in England. Its importance has been acknowledged by the Secretary of State through the preservation of the current deanery functions in the transition to the new Local Education and Training Boards and Health Education England.

73. Although our response to this Call for Evidence has highlighted some shortcomings in the current educational experience provided for doctors in training, there are also significant strengths. One of these is the breadth of experience afforded doctors in training across a range of different settings and institutions. This will be important for the future if we are to develop a flexible workforce able to practise in different environments and contexts.

74. Finally, it is a strength that there is a single regulator overseeing and guaranteeing standards of training across the UK. This is an asset both in terms of patient protection and medical mobility. That single reference point needs to be flexible enough to accommodate different arrangements for healthcare delivery, while preserving the integrity of the whole.

[13] Academy of Medical Royal Colleges, *The Benefits of Consultant Delivered Care*, 2012

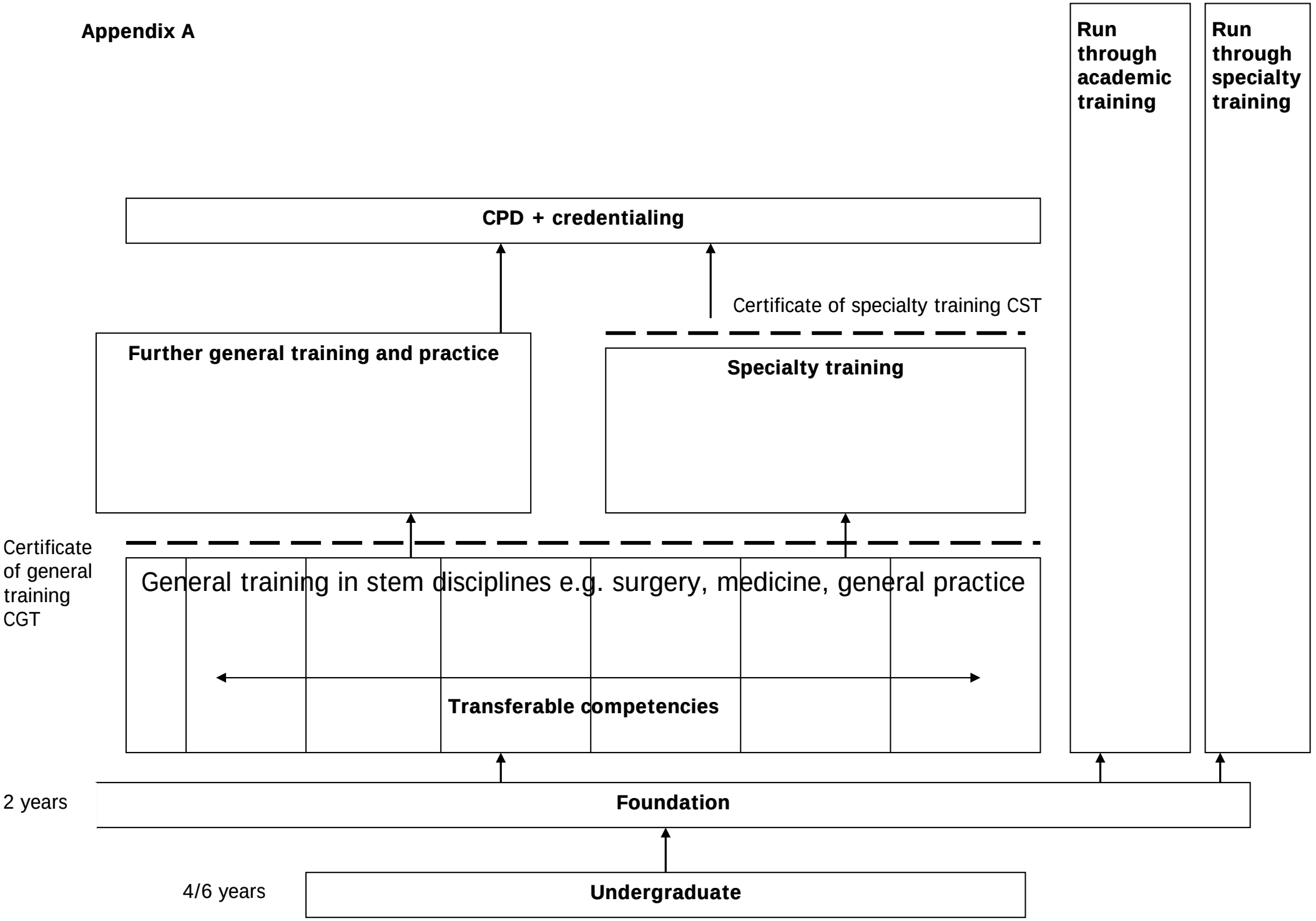
Question 18: Are there other changes needed to the organisation of medical education and training to make sure it remains fit for purpose in 30 years' time that we have not touched on so far in this written call for evidence?

75. Much of the Call for Evidence, and this response, has been concerned with the need for a more generalist approach to training and practice. If this is to be achieved it will be important to provide the right incentives to encourage people to take on these roles and to accord them the status that is currently enjoyed by those identified as 'specialists'.

76. Incentives will also be important in other areas. Some locations and environments are unattractive for doctors in training and trainers. Inevitably, this has an impact upon the quality of the training experience and the quality of care provided. More can be done to enable some locations to attract stronger doctors in training but locations which do not provide a good training experience should no longer be training environments.

77. One further area requires attention - how to enhance the sense of belonging that doctors in training have to the institution, department or team in which they are working. We have identified the opportunity for doctors in training to gain a wide range of experience as one of strengths of our current system. However, where this results in them moving rapidly from one department or hospital to another every few months it means that they have very limited opportunity to become part of a team or an institution. As a result, the hospital has limited incentive to invest time and effort in the development of the doctor as a valued employee. Equally, the opportunity for the doctor in training to become a trusted colleague and integrated member of the clinical team is curtailed. There is a balance to be struck, but one which we have not yet got right.

Appendix A


Run through academic training
Run through specialty training
CPD + credentialing
Certificate of specialty training CST
Further general training and practice
Specialty training
Certificate of general training CGT
General training in stem disciplines e.g. surgery, medicine, general practice
Transferable competencies
2 years
Foundation
4/6 years
Undergraduate