

**Adapting for the future: a plan for improving the
flexibility of UK postgraduate medical training**

Report on our engagement activities

We held a stakeholder roundtable event in October 2016 to explore flexibility from the perspective of trainees, patients, service, colleges and deans. The event was well attended by representatives from across the four UK countries, suggesting that many of the concerns about flexibility were shared. It provided a helpful steer for our review.

Following the roundtable, we produced a [stocktaking paper](#) identifying key areas for development, referencing wider developments from the medical workforce and service perspective which may support flexibility.

Since the roundtable, we have had further discussions with stakeholders across the UK to share and test out our emerging conclusions, invite suggestions and provide written submissions. Feedback and information from these activities has informed our report, [Adapting for the future: a plan for improving the flexibility of UK postgraduate medical training](#) published on 31 March 2017.

We have met with trainees, patient representatives, representatives of all the medical colleges and faculties and health education organisations across the four UK countries. The list of engagement activity is at Annex A.

Discussions reinforced the themes which emerged at the event in October and clearly signalled what actions and conclusions we should include in our report to ministers. This paper explores the key themes that came out of discussions and written submissions.

Challenges and pressures across the UK

A range of views emerged about the challenges for flexibility in training.

Tension between service and training

In the UK trainees spend considerably more time on service delivery compared to their counterparts overseas. They are seen as essential to delivering the service and inevitably service pressures do impact on training.

Reflections from trainees indicate that in some specialties it is harder to take time out. We heard that some specialties and localities have recruitment problems; by offering flexibility arrangements to some individuals will impinge on other trainees and on consultants. Any solutions would need to take this into account.

It is hoped the new standards for curricula and assessment will organise training in a way that emphasises the educational expectations for trainees. This will help balance out the service pressures experienced by many of them.

Until there is a system change in the way postgraduate training is funded, designed and managed, there is a risk, according to some colleges and faculties, that the proposals arising from the review will have little impact.

Meeting the expectations of current doctors in training

Discussions at the roundtable in October indicated that many trainees are frustrated with the rigidity of their training arrangements.

Trainees have different expectations compared to past generations about their training and, in particular, the flexibility to organise it in a way that best suits their lifestyles. As one college pointed out we are starting to see trainees who are moving back and forth, from training in the UK to service roles within other countries, not once but several times during training. The system must adapt or risk losing trainees altogether from the UK system.

'There is no point in the UK system trying to hold back the changes that this generation have proactively started to implement. It must instead accept these changes, and find ways to facilitate them, while ensuring that they don't impact on patient safety. So for example, while more trainees might want to be trained on a part-time basis, there may be a minimum number of days training time that needs to be enforced to ensure they can properly engage with their training programmes' – Royal College of General Practitioners

Stakeholders emphasised that it is important that any proposals to promote flexibility must be realistic and workable.

'It is important to ensure that we don't offer what we cannot deliver e.g. Less than full time training on demand. If the demand is high there is a reputational risks if we do not meet it and raise expectations that cannot be fulfilled' – Royal College of Emergency Medicine

Patient safety must be assured regardless of the working arrangements. Representatives from the four UK countries indicated that flexibility in training arrangements was important to attract and retain doctors. Trainees want more choice, more time and more opportunity to experience crossover in different types of training.

Less than full time training (LTFT)

Although there was support for improving access and the organisation of LTFT training, this was qualified by the need for safeguards. For example the RCOG 'recognises significant issues and concerns on retention and equity given too many trainees are now choosing to work p/t, this is untenable for service delivery, continuity and patient safety'.

Colleges/faculties and other stakeholders suggested arrangements could be improved at deanery/local education and training board (LETB) level, to streamline processes and improve transparency.

For example, Annual Review of Competence Progression (ARCP) panels could do more to take LTFT training into account by ensuring the process is fairly managed. Others suggested that the allocation and length of placements need to consider LTFT needs more. This could be helped by raising awareness of options through LTFT advisors, trainee representatives and dedicated webpages.

'The rigidity of the Gold Guide and the current training structure enables little flexibility for these trainees, which is having a disproportionate impact on the psychiatric workforce. By reviewing LTFT training and ensuring Annual review of competency progression process is pro-rata and fairly managed for these trainees would ensure they feel supported within their training programmes rather than penalised. The college suggest the wording within the Gold Guide be amended to reflect this' – The Royal College of Psychiatrists

Legal constraints

The legislation governing medical education and training and the recognition of specialty training is a barrier to transferring between specialties and have previous training and experience count towards training in a new specialty. For those specialties struggling with recruitment having more flexible legislation would help attract trainees to the specialty and facilitate movement between specialties.

'The intention to review the legislative framework governing training is welcome and will go some way to alleviate the frustrations that trainees encounter in terms of the current inflexibility of the rules and regulations' – Royal College of Anaesthetists

There are a number of existing approaches to helping trainees overcome the challenges set down by legal constraints. For example, systems already exist to facilitate them accelerating through the training programme as long as they can demonstrate competence. Previous training and experience gained

overseas, for example, will equip a trainee to demonstrate competence early. Many colleges and faculties have supported trainees and worked with deaneries to re-calculate CCT or CESR (CP) dates, for example in some physician specialties and Obstetrics and Gynaecology.

The Royal College of Obstetricians and Gynaecologists are soon to publish guidance on completing training earlier than the original CCT or CESR (CP) date including trainees requesting accreditation of transferable competencies. The case studies within that guidance will usefully illustrate how transferability and accelerated training can work within the confines of the minimum time set down by the European Directive.

Improvements can be made to ensure there is a common approach for colleges and faculties to signing a trainee off in less than expected time.

Systems that promote transferability

There are clearly systems in place to transfer between specialties, but there is variability in how established they are. The number of trainees transferring between specialties is not high and those who do tend to do so prior to achieving core competencies for example, once a trainee reaches ST3 they are unlikely to want to transfer to another specialty according to the JCST.

The minimum time set down by legislation, previous experience and the nature of the specialty will determine the amount of time exempted for a doctor

transferring to train in another specialty for example, the technical nature of some specialties may limit transferability.

The JRCPTB has identified 13 physician specialties that accept alternative specialty core training route in addition to CMT or ACCS (AM). The CMT curriculum allows the accreditation of transferable competencies from ACCS non-acute medicine routes, using the Academy of Medical Royal Colleges (AoMRC) framework.

'It will be important that reciprocity of recognition of training with other medical specialties is agreed in order not to disadvantage psychiatry. It will also be important to accommodate individual preference for those transferring from other specialties in terms of length of time allowed to complete core training competencies including completion of long-term psychotherapy cases and attainment of written and clinical parts of membership of the Royal College of Psychiatrists examinations' – Royal College of Psychiatrists

But this process would benefit from improvements. The Royal College of General Practitioners have reviewed recruitment to their accreditation of transferable competences programme. This established programme (in its third year) is designed to attract doctors in training into the specialty and contribute to GP workforce expansion. It does this by facilitating movement into general practice from other specialties. Feedback from GP schools is that work remains to be done on improving the administration of the process, such as clarifying the application criteria for doctors in training.

'Clearly there needs to be robust and reliable processes for assessing which learning outcomes that trainees have already achieved are appropriate to carry over when they switch training specialties, but the current processes that facilitate these schemes can be bureaucratic, overly complex and more importantly lack a clear sense of ownership. ATCF has suffered particularly from these issues, with the guidance that is available to trainees often being unclear, with no clear sense of who would be responsible, or able, to deal with the more problematic questions that trainees might have. We appreciate that the guidance for ATCF will be reviewed, but the fundamental issue of who 'owns' the process remains, and is likely to be a central issues for any new systems that might follow this review' – Royal College of General Practitioners

Improving flexibility

There was a lot of discussion with the colleges and faculties about what else would improve flexibility including the proposed actions and conclusions of the review.

Better uptake of equivalence routes

There is broad support for the equivalence routes as a means of promoting flexibility for example, the Royal College of Emergency Medicine said 'some are leaving to follow the CESR route as it allows them to train in one centre and chose what they do'.

The RCOG said that 'the flexibility review is an opportunity to consider decoupling as we are hearing the message strongly from all the forums we are engaged in. Otherwise the implications on our trainees greatly effects the service,

education and training given that there are not enough doctors to fill the rota gaps therefore flexibility in CESR CP is key'.

Although improvements are needed to create less of a paper burden on the applicant and make it easier to recognise equivalence of doctors in training from countries with similar training programmes to that of the UK.

It is clear that trainees are keen to have experience and training outside of the CCT programme count towards their training for example, those who have gained experience and similar competencies overseas. There is broad support to facilitate this however, there are variations in the uptake of the equivalent routes due to workforce numbers and for one college this creates particular issues.

'CESR CP from the college perspective is that we are very limited in England due to HEE regulations in concentrating on numbers. In Scotland, Wales and Northern Ireland they have the potential to recruit equivalent clinicians. We feel strongly about this and would say loudly and strongly we need more flexibility around this real crisis in workforce and one way of addressing the problem is enabling recruitment at different levels, with the appropriate experience.' – Royal College of Obstetricians and Gynaecologists

Stakeholders in Scotland suggested a mechanism outside of the equivalence routes to recognise training and experience gained early on in the training programme. For example, trainees who have gained time abroad after foundation

should have that time recognised before they start the specialty training programme. There should also be wider acceptance of LAT experience (which includes availability in general practice).

Given the intensities of the Foundation programme, many trainees opt to take time out and practice abroad. However, the Training Committee of the Royal College of Physicians in Edinburgh commented that some trainees feel penalised for taking time out and a programme that allows for and values time out to obtain experience in other healthcare settings is needed. This period of reflection would also stop doctors leaving foundation and taking jobs they do not necessarily want.

It is important that the review takes account of four nation nuances for example, any changes to regulation 'out of programme' must translate into Welsh law.

Reintroduce broad based training

Broad based training is viewed as a workable example of how flexibility could work within the system and enable doctors to develop a broad experience base. There is a push to have it reinstated in England. It is still available in the devolved nations and discussions are underway in Scotland to explore whether there is an appetite amongst trainees.

The colleges directly involved in the programme expressed regret that it was disbanded given the appetite amongst trainees.

'We were active participants and remain active supporters of Broad Based Training, which we still believe provides a better model of what trainees will want from a future training system, and indeed a better way of preparing them for future service models' – Royal College of General Practitioners

The role of other healthcare professionals

Other healthcare professionals have a role to play in picking up organisational duties normally undertaken by trainees for example, physician associates and nurse practitioners. The Faculty of Sexual and Reproductive Health are working with Health Education England to explore specific training for nurses and are enthusiastic about the role physician assistants could play.

A potential challenge is that such roles can squeeze the skill set of trainees and some are finding it challenging to build on skills.

The Training Committee of the Royal College of Physicians of Edinburgh commented that Foundation doctors can struggle to be identified as part of the team given that they rotate through the system quickly. Extending the duration of placements may help them to embed into the team more effectively.

GMC postgraduate reforms

In the main there was support for the GMC reforms as well as recognition these will support greater transferability of specialty and professional capabilities for trainees wishing to move to a different specialty. Any move that supports the

diverse needs of patients is to be welcomed.

It is evident that work is already underway in identifying common outcomes and coordinating interdependencies between related specialties and other professions. For example the Combined Infection Training programme was jointly developed with the JRCPTB and Royal College of Pathologists to develop a common pathway and more closely align training in the infection disciplines of infectious diseases, topical medicine, medical microbiology and medical virology'.

'Clinical Oncology curriculum allows for accredited transferable competencies to be brought in from medical oncology training, and we are exploring the possibility of more commonality of oncology training, which we have long wanted to see. For clinical radiology we supported closer integration of nuclear medicine which now has a common recruitment process and first 3 years of training' – Royal College of Radiologists

However, consideration must be given to the nature of specialties. For example, the depth and breadth of general practice can raise issues in identifying common components of outcomes.

There are clear benefits to having an outcomes based curricula in yielding educational results. However, according to the RCGP there does need to be time protected in a GP environment. It is important that trainees undergo a minimum training time in the community and have adequate exposure to GP practice.

Credentialing

There was support by employers, colleges and statutory bodies to introduce a mechanism to support doctors to move into areas where there are patient or service needs. Our approach to credentials will explore recognition of areas of practice where there is a service need but where that expertise is not fully reflected in existing specialties or subspecialties. However, further work is needed to clarify how the process will be managed.

'We recognise the work being undertaken by the GMC and AoMRC on the GPC and SCAR that will enable transferability of learning. We are supportive of the aspiration to develop understanding amongst colleges of common learning outcomes and training pathways which deliver opportunities for meaningful flexibility in training. However, we are concerned there remains lack of clarity with regards to credentials, although we would be willing to engage in developing proposals for credentialing in sleep medicine and pre-hospital EM' – Royal College of Anaesthetists

'You will be aware that there are a range of different possible models of what credentialing could look like. We were significantly reassured by the outcome of your 2015 consultation on regulated credentialing in its acceptance that credentials should not compete with, overlap or undermine CCT training programmes. – we would be grateful for your reassurance that this is a reference to this ongoing and already published work we are familiar with, rather than a further new departure in your approach.' – British Medical Association

UK oversight of proposed changes

There was broad support for the GMC as the regulator to establish a UK oversight group - with representatives from the four countries, including trainees – to ensure system coherence and to coordinate the implementation of the actions that stem from this review.

'As with ATCF, these new systems will require a joined up approach from yourselves as regulator, the training organisations in England and the devolved countries, and Royal Colleges. It will need to be clear which organisation is leading on these processes, and in some cases 'buy-in' or alignment with the organisations governance and objectives may need to be obtained. It will also inevitably require increased resources to implement, and that also needs to be acknowledged by HEE/DOH and its equivalents in the Devolved Nations' – Royal College of General Practitioners

Patient representatives

The public and patient perspective indicated that any moves to promote flexibility to enable trainees to plan their lives and stay within the NHS are welcomed. Discussions focused on how trainees can work more flexibly to meet current and future patient needs, especially in light of an aging population with co-morbidities.

The following key points came out of discussions:

- The changing demographics of the general population, impact and rate of technological change and pressures on staff and the service are significant drivers in the need to adopt a more flexible approach.

- If more flexibility better equips trainees to treat patients with a range of co-morbidities at a more local level, this is welcomed.
- The systems that support training and service delivery need to be agile and responsive, continually reviewed and have strong leadership.
- The duties of a doctor have changed significantly and there may be scope for administration duties to be performed by another role, freeing up the time trainees have to concentrate on direct patient care.
- To retain the workforce more consideration should be given to rolling out LTFT training, with safeguards especially related to continuity of care.
- It should be considered how flexibility can and should deliver the workforce skills to meet patient needs. For example, in the US, 'super GPs' care specifically for patients with chronic conditions. This has proved the cheapest way to keep people out of hospital and is an example of a service that is outcome measured.
- There should be a greater emphasis on patient feedback to identify and proactively address issues. A recent survey exploring patient needs indicated that patients want access to services and for patients with co-morbidities – it was important to see the same GP.

'The envisioned changes to improve flexibility including the use of a 'common' framework, and greater use of APEL, will need to be driven by a lead organization. Whilst the colleges, faculties, Health Boards etc, do good work and undertake a wide range of initiatives and developments, there is limited sharing or experiences or co-ordination of effort within a shared direction of travel. I believe the GMC could provide drive, leadership and partnership to move the agenda forward' – patient representative

Conclusions and next steps

Any initiatives to promote flexibility that would encourage trainees to stay in the UK system and encourage those who have gone abroad to come back are welcomed by our stakeholders. However, if any further flexibility is offered within the training programme there must be safeguards to ensure standards are maintained.

Discussions indicate that the proposed actions and conclusions of the review are welcomed. However, further clarity is needed on operational aspects of the GMC postgraduate reform programme. The review and any proposed actions and conclusions must take account of four country nuances.

The discussions outlined in this paper informed our report on flexibility to ministers. We are grateful to all of our stakeholders who contributed to the review. But we understand given the impact of these proposed changes, further engagement will be critical. We will be holding further engagement throughout 2017 with our key stakeholders.

GMC review of flexibility in postgraduate medical education and training

Annex A

Engagement programme

Following the stakeholder roundtable in October 2016, the review has been informed by a series of engagement activity.

The full list of engagement activity is set out as follows.

Four country engagement

Health Education England

Scottish Government

Royal College of Physicians, Edinburgh

NHS Highland

NHS Education for Scotland

Welsh Government

Academy of Medical Royal Colleges (Wales)

Welsh Deanery

British Medical Association (Wales)

Northern Ireland Medical & Dental Training Agency

British Medical Association (UK)

Conference of Postgraduate Medical Deans

UK Shape of Training Steering Group

Joint Academy Training Forum

Medical Royal Colleges and Faculties

Faculty of Sexual and Reproductive Healthcare

Royal College of Surgeons of Edinburgh

Joint Royal Colleges of Physicians Training Board

Joint Committee on Surgical Training

Royal College of Pathologists

Royal College of Radiologists

Faculty of Intensive Care Medicine

Royal College of Paediatrics and Child Health

Faculty of Occupational Medicine

Royal College of Psychiatrists

Royal College of Anaesthetists

Faculty of Public Health

Royal College of Ophthalmologists

Royal College of General Practitioners

Royal College of Obstetricians and Gynaecologists

Royal College of Emergency Medicine

Employers

NHS Employers

Patients/public

Education and Training Advisory Board

National Voices

Academy of Medical Royal Colleges patient and lay committee