General Medical Council

Flexibility in medical training – where we are

Executive summary

As part of a review into flexibility in postgraduate medical training we held a roundtable meeting on 20 October 2016 where we heard from stakeholders from across the UK.

Discussions focused on what flexibility means; what challenges and pressures across the UK are affecting flexibility; what is happening now or in the near future that could help; where the gaps are; and potential solutions.

Key themes

From a wide ranging discussion some key themes emerged.

- We need to review options for flexibility that are already available as a lot of previous initiatives may offer solutions that are not being fully implemented.
- It is essential to recognise and value the needs and abilities of individual doctors in training and to find ways to make training work for them.
- Plans to improve flexibility in training will need to take account of the needs of patients and service, as well as doctors in training. While it is not the responsibility of the training system to meet the immediate needs of the service, training does need to meet the long term needs of patients and the service, and any solutions will need to recognise service pressures.

Next steps

We will talk to key stakeholders across the four countries over the next few months, and undertake a mapping exercise to see where improvements are possible.

This will be followed by a report for ministers in the four countries in March 2017, outlining actions to be taken.

Introduction

Following talks between the government and the BMA in May 2016 over the new contract for doctors in training in England, the GMC agreed to lead a review with the aim of identifying ways in which doctors in training across the four countries of the UK could move more flexibly between postgraduate training programmes.

While the contract was rejected by doctors in training, we were committed to the review in order to look at some of the deep-seated issues which the contract dispute highlighted. These included the inflexibility of current training pathways as noted in the independent Shape of Training Review.

We held a stakeholder roundtable on 20 October 2016, to allow an exploratory discussion of the issues, challenges, and possible solutions around flexibility in postgraduate training. Attendees were from all four countries, and we heard from representatives of employers, training organisations, patients and public, and doctors in training. A full list of attendees is attached at Annex A.

The roundtable was chaired by Terence Stephenson, who introduced the topic, and spoke about the frustration and disenchantment felt by doctors in training across the UK, and the need to work collectively and across all four countries to find solutions. Following the roundtable, he wrote a blog post outlining his thoughts.

This is a stocktaking paper exploring where things are at the moment with flexibility in postgraduate medical training, based on presentations and discussions at the roundtable, and on comments submitted by attendees afterwards.

What do we mean by flexibility?

Discussions revealed a range of views about what flexibility means in postgraduate training. Comments described the different ways training could be flexible to support the needs of doctors in training, why flexibility is needed, and the ways flexibility in training can be for the benefit of patients or the service.

Ways training can be flexible

There are many different ways training can offer some degree of flexibility. These include:

- slot sharing / less than full-time training (LTFT) – can be helpful in a number of circumstances, such as childcare needs, family or health reasons; but slot sharing can mean uncertainty if one person's circumstances change
- time out of programme (OOP) – sabbaticals, working abroad, career breaks, taking time out to do other things, eg research – and these being valued so that they may count towards training – would be more helpful to describe as 'additional/alternative/supplementary'

- enabling doctors in training to try out different areas – allowing more 'taster' sessions at foundation (F1 or F2) level

- flexibility around who does what for patients – as training has become less clinical and provision of care more complex, other roles could step in to take on some of a doctor's duties related to organisational issues

- competency- or outcomes-based training, not time-based – so that training can be completed in shorter or longer periods as needed – without being penalised

- Certificate of Eligibility for Specialist Registration (CESR) or GP Registration (CEGPR) – could become more popular – and should be easier than it is currently.

Why flexibility is important for doctors in training

There are a number of reasons flexibility is so important for doctors in training:

- enabling excellence – tailoring programmes for what people need

- needs of doctor in training – recognising personal needs, for quality of life / dealing with normal life – caring responsibilities, maternity/paternity leave, being co-located with spouse; professional needs – getting exposure to different areas, getting time for clinical placements, being able to pick up competences needed

- perception of rigidity/lack of personal control over lives – training is currently extremely regimented, rather than treating doctors in training as independent, not having to get authorisation for things, like managing their own rotas

- being able to move between programmes – or moving in and out of programme, post, or between environments – or some want to train in two specialties or another area in their spare time – while making sure competences are achieved and prior learning recognised – which doesn't always happen – generic professional capabilities (GPCs) and broad based training (BBT) should decrease time if already qualified – otherwise it is wasteful for system not to acknowledge skills already picked up.

Flexibility to benefit patients or the service

There are also ways in which flexibility can be for the benefit of patients.

- To serve diverse patient needs and empathise, the service needs a diverse workforce of well-rounded professionals who can see the patient's perspective. The more doctors are supported by flexible training, the more they can empathise with patient diversity and support the patient as a whole person.

- Training needs to be flexible to public and patient needs in relation to changes in medicine and in other areas eg population health over the duration of a long training course, so that doctors are ready at the end.

- From an employer perspective, overspecialising at an early stage can be an issue eg it can deprive patients of a generalist view at the stage in their care when they're seen by a doctor in training who may not have generalist skills.

- Continuity of care, particularly for long term conditions, is an important need for patients which must be accommodated within any flexibility initiatives.

Challenges and pressures across the UK

During the presentations and discussions at the roundtable, we heard about a range of challenges for flexibility in training, as well as some potential areas for solutions.

Need to consider both service and training

It is clear that the needs of individual doctors in training can conflict with patient or service needs in an under-resourced NHS, so we need to be smarter about education in the workplace, and consider the whole workforce. We need to be pragmatic – it's not safe to have people extending training for 25 years, and we can't have everybody part-time without considering service, patients, and peers.

It is known that in some specialties it is harder to take time out, and some specialties and some localities have recruitment problems, so offering flexibility to some individuals will impinge on other doctors in training and on consultants. Any solutions would need to take this into account.

A possible increased attrition rate could lead to a pool of wasted talent and impending workforce crisis if the system cannot respond to the trend towards LTFT and flexible working. There is a real financial and personnel loss to burnout if doctors in training are not supported, and research including post-exit interviews could shed light on how much is due to lack of flexibility, and how to address the problems.

Relying on doctors in training to meet service needs can be to the detriment of training, with slow skill acquisition and relative inexperience becoming more apparent at every level. It was noted that other developed countries train specialists more quickly than the UK with as good or better outcomes, largely due to less reliance on doctors in training for service provision.

Rigid systems

Many doctors in training feel a frustration with rigid systems which don't allow for the reality of their lives, and don't appear to value their experience.

Administrative arrangements can be an issue for flexibility eg getting in and out of training, enabling transfers, notice of deployment, and rotas.

Rotas allow different amounts of LTFT during training, and can be difficult to organise. Short rotas affect continuity and confidence. A solution could be to move to team structure, support identity and individuals. On-call commitments need to be proportional to commitment to work, which can be difficult to organise but should be possible.

The amount of movement doctors in training undertake can be counterproductive. There has been no assessment of the negative impact of loss of continuity, in terms of quality improvement, service design or audit. People work better in familiar environments, and with less movement, more time could be spent learning medicine, instead of learning about systems.

Some of these issues may be a reflection of local factors and pressures, and could be improved by injecting a little bit of humanity and creativity. Dissatisfaction and disengagement with the workplace among doctors in training could be improved by conversation across all levels about the responsibility of employers, and this could be a suitable topic for research.

Challenges around LTFT

Many find there is a lack of support around LTFT and that a cultural shift is needed.

Improvements could be made at deanery/local education and training board (LETB) level, to streamline processes and improve transparency. ARCP panels could do more to take LTFT into account, and allocation and length of placements need to consider LTFT needs.

Solutions could include appointing LTFT champions, defining what's involved, who's responsible, and how it will facilitate flexibility; supervisor training; and improved guidance.

Meeting individual needs

Doctors in training need to feel they have personal control over their lives, and to be enabled to identify their own needs, where they are confident, and where they need development.

It is difficult currently for those who are able to train faster, and for those who need to take longer. One size doesn't fit all, and thinking in terms of competence/incompetence, and 'squaring the normal distribution' doesn't promote or reward excellence, or allow people to spend less time doing what they can already do.

There are challenges around equivalent recognition for equivalent work eg a clinical fellow, a doctor in a national training number (NTN) post, and a locum could all be gaining the same experience, but the difficulty is in the supervision needed. Lead time in retrospective approval could be minimised, and retrospective recognition of work done could be considered. When people return from working overseas, penalties for returning more experienced could be removed.

Trainees who want to work in lower- and middle-income countries (LMIC) report difficulty accessing deanery support for OOPE activity, and that it can be difficult to meet criteria for LMIC experience counting as OOPT.

It could be helpful to think about time in training in terms of hours, instead of months, to allow more flexibility.

Difficulties transferring across specialties

More could be done for recognition in broad competencies eg similarities in emergency medicine, acute medicine and general practice. This would allow doctors to deliver care in a range of environments, and to feel empowered to make decisions in each of them.

A lack of generalism can lead to problems around clinical ownership of complex patients. Focusing on the patient experience, and simulation training for professionalism and ethical reasoning, could be part of a solution which may help doctors feel empowered.

There is a narrow focus on clinical technical competencies instead of broader workplace capabilities such as investigating incidents, complaints, working across service boundaries, root cause analysis, and risk management. Possible solutions such as governance training, placements with corporate managers, or roles in local team governance would improve training doctors to do the work of a consultant, and contribute to flexibility.

What is happening now, and what's on the horizon?

There is a lot happening already to facilitate flexibility in postgraduate training, and several ongoing projects in development which will support further flexibility.

The Academy of Medical Royal Colleges (AoMRC) produced the Accreditation of Transferable Competencies Framework (ATCF) in 2014, though there has been limited uptake to date from specialties that accept ATCF.

Other areas currently supporting flexibility include out of programme arrangements, reasonable adjustments and less than full time training arrangements for those with disabilities and caring responsibilities.

GMC projects underway

We are updating our standards for postgraduate curricula and assessment, which will embed generic professional capabilities (GPCs) into curricula. The standards require organisations to identify and address any interdependencies between specialties, and outline our expectations for an outcomes-based approach which aims to reduce rigidity and allow more flexible progression through training.

We will be introducing regulated credentials over the next 18 months with a small number of early adopters. This will allow us to recognise areas of expertise outside of specialties that are important to service and patient care.

This year we will be involving doctors in training in the development of survey questions which will aim to elicit data on flexibility.

Chief registrar project

The Royal College of Physicians (RCP) has a possible answer to flexibility problems with its Future Hospital chief registrar project which is being piloted with 23 participants, who are ST5 and above and in medical specialties. It involves bespoke training from RCP and the Faculty of Medical Leadership and Management (FMLM) and participants spend 50% of their time in leadership and management activities and 50% in clinical activities.

They work as a 'bridge' between junior doctors and senior trust managers and will focus on quality improvement, workforce transformation and service design. This promises benefits to doctors in training in terms of development and improved morale; benefits to trusts in terms of quality improvements, better communication with and organisation of junior medical staff, and reduced rota gaps and locum costs; and benefits to the wider NHS in retaining a valuable resource, developing future leaders, and disseminating information.

The project has received extremely positive feedback from participants, and will be formally evaluated, reporting in 2017. There are plans to extend the model further.

Developments in England

Health Education England (HEE) has a number of initiatives around flexibility, and enhancing the training experience. These include projects:

- happening now – a major review exploring how we assess training progression and enable doctors in training to pause, step on and off training more easily, and looking at how to progress from non-training posts into the training pathway
- on the horizon – increasing portfolio careers and time out of career pathways, improving flexibility in re-entering training, ability to move between specialty programmes, and support outside of traditional training routes.

Other initiatives

Other recent developments include the junior doctors forum and the role of guardian of safe working hours, which it is hoped will help make relationships, behaviours and environments become more engaging and supportive for doctors wishing to train more flexibly.

HEE is also supporting an agreement with NHS Employers and the BMA to enable doctors in training to know placements and rotas earlier. HEE is also looking at widening access to LTFT, and leading on work on accelerated return to training.

A BMA working group is taking forward deployment initiatives, linking applications for two people, and facilitated swaps / inter-deanery processes are being developed.

The Shape of Training Review which reported in 2013 made recommendations aimed at making postgraduate training more flexible both for doctors in training, and for service delivery and management at local levels. The Shape of Training Steering Group will be updating ministers in four countries about various areas of work.

The RCP has appointed its first Women in Medicine fellow, who will evaluate the role of flexible training.

Other work supporting flexibility includes the AoMRC's Flexible Careers Committee and Later Careers Survey; and colleges having LTFT training leads.

There is also a working group on Improving Junior Doctors' Working Lives who meet to discuss non-contractual matters relating to training and advocate flexible working. Mentoring and coaching are also being done to good effect.

What else is needed?

A lot of the discussion at the roundtable was about the need to make better use of what is already available. It is known that there is a lot already out there to support flexibility but is misunderstood, or not being used widely, or needs to be improved. Many areas for improvement were suggested in discussions about the challenges across the UK.

Better use of existing models

There are existing models for flexibility eg the transferable competencies framework, Shape of Training, which have not been widely implemented, and may have been seen as burdensome. Modernising Medical Careers (MMC) brought opportunities of competency-based curricula, but ten years later, nobody finishes quicker, so we need to be able to move faster on initiatives we know are tried and tested.

ATCF

There was agreement from roundtable attendees that there needs to be recognition of the ATCF, and that we need to ask what the real and perceived barriers are to making it work, and to challenge where it isn't being implemented.

- We need to identify misconceptions – eg most curricula are already competency- not time-based. This needs to be demonstrated to the ARCP panel to prevent a doctor in training being held back from progressing, but this doesn't appear to be widely known.

- We need to look at barriers in areas where it's been hard to implement, to help identify how to make it work.

Some blocks – but not insurmountable – to the implementing the ATCF were noted:

- trainees need to be in recognised posts/ EU regulations/ CCT programmes

- curriculum design – the way curricula are set out and lack of read-across

- how NTNs are allocated.

Culture change

It was noted that there is cultural challenge in some specialties, where flexibility is seen as against the norm and jeopardising progression.

There needs to be a balance between a flexible and adaptive workforce and the requirements of regulation and patient safety, so that creativity, innovation and flexibility are not inhibited.

There is a need to look at the culture around doctors making mistakes. Doctors practise defensive medicine, due to fear of litigation / fitness to practise / judgement of superiors, so the focus is on whether they have the right competencies. However as professionals, people who don't know everything, doctors need to be able to make judgements and offer opinions – so we need to help doctors understand the GMC's idea of competence in relation to fitness to practise proceedings.

Cultural change is also needed so that leadership, management, quality improvement, training, and service research and development, are recognised as important and fundamental to the role of the doctor as clinical work and traditional academia. This would help clinicians become the 'architects' rather than 'construction workers' within the system.

Other gaps

Many roundtable attendees felt that there needs to be better recognition of the value of generalism, which had been promoted in Shape of Training, and earlier.

The foundation programme could be made more flexible, and a limited study leave allocation for F1s could be of great value and improve flexibility. Poor supervision, support and training at F1 level, followed by applying for training pathways only a few months later can lead to many doctors in training choosing locum work or emigration for more experience.

There are doctors in training now doing 'F3' years, between F2 and core training – identical to training jobs, but don't count towards competencies or CCT.

Although not the main concern of this review, increasing medical student numbers is a start but encouraging overseas doctors to work in the UK for 2 years is really needed to plug the gaps.

Working together to find solutions

The roundtable has produced a lot of ideas for areas we can work together on to improve flexibility. We need to look at educational value, how to value what trainees bring, and focus on improving transferability across curricula.

It is imperative that any solutions must be UK wide, and discussions will need to include all relevant stakeholder groups. We will need to share knowledge to avoid duplication and move forward as one whole system, to avoid raised expectations and disappointment.

It may be that there is less of a need for anything additional, but that we just need to be better at things already there, and ensure that people know options. One option would be to identify misconceptions around flexibility, and produce a 'mythbusters' document.

It is clear that there is a lot of potential to improve flexibility by looking at how to improve implementation of the ATCF, which has been available for a while but not embraced. This needs to be revisited and we need to look closely at whether it needs to be promoted more, or if it is fit for purpose.

GPCs offer an opportunity to shed the time-based approach and will start to be implemented in the next year.

HEE has potential solutions involving an extensive programme reviewing barriers to personalised flexibility, and with the HEE quality framework as a lens to identify, benchmark and improve quality of training experience for all learners.

Other solutions suggested included using data to convince of the need for flexible working, such as RCP census reporting which shows increasing trend to LTFT working; looking at when things go wrong and using it as a learning experience; working with colleges to change the culture towards less subspecialisation and more generalism.

In the future we'd all like to see more efficient service delivery, variety of roles, empowered doctors in training, which brings the challenge of lots of work for employers to manage.

Next steps

We will talk to key stakeholders across the four countries over the next few months, and we'll develop a mapping exercise to see where we can make effective improvements.

We will identify where action can be taken, with timescales for implementation, and including assurance considerations.

This will be followed by an opportunity for attendees to review options before we produce a report for ministers in March 2017, outlining actions to be taken.

December 2016

General Medical Council

Annex A

Roundtable agenda and attendee list

Promoting flexibility in postgraduate medical training

Thursday 20 October 2016
13:30 – 16:00

Meeting Room 2.07/2.08
GMC, 350 Euston Road, London, NW1 3JN
VC links to Belfast, Cardiff, Edinburgh
Phone links to Edinburgh, Inverness

General Medical Council

Agenda

Agenda items		*Presenter*	*Time allocated*
1	Welcome and introduction	Terence Stephenson	13:30 – 13:40
2	What do we mean by flexibility?	Table discussion	13:40 – 13:50
		Feedback	13:50 – 14:00
3	Challenges and pressures across the UK	Jeeves Wijesuriya	14:00 – 14:05
		Sheona MacLeod	14:05 – 14:10
		Elizabeth Manero	14:10 – 14:15
		Piriyah Sinclair	14:15 – 14:20
		Jon Bailey	14:20 – 14:25
		Gerrard Phillips	14:25 – 14:30
		Derek Gallen	14:30 – 14:35
		Open discussion	14:35 – 14:55
Break			14:55 – 15:00
4	What are we doing, and what can we do?	Judith Hulf	15:00 – 15:05
	What is happening now? What is on the horizon? What are the gaps? What are some solutions?	Table discussion	15:05 – 15:30
5	Feedback, summary and next steps	Open discussion	15:30 – 16:00

Attendees

Professor Terence Stephenson	Chair, GMC
Kimberley Archer	Education Quality Analyst, GMC
Dr Jon Bailey *	Academy Trainee Doctors' Group Chair
Charlie Bell	BMA MSC Chair
Victoria Carson *	Head of Scottish affairs, GMC
Harrison Carter	BMA MSC Chair
Dr Shiv Chande	HEE Clinical Leadership Fellow
Professor Ian Curran	Assistant Director, Education and Standards, GMC
Professor Jane Dacre	President, RCP
Mark Dexter	Head of Education Policy, GMC
Nick Drew	Education Policy Administrator, GMC
Dr Jane Fenton-May *	AoMRC Wales
Natalie Fine	Education Policy Analyst, GMC
Professor Ian Finlay	UK Scrutiny Group
Jennie Friswell	UCLH Head of Medical Workforce
Professor Derek Gallen	Wales Deanery
Martin Hart	Assistant Director, Education and Standards, GMC
Alastair Henderson	Chief Executive, AoMRC
Professor Jenny Higham	Chair, MSC
Professor Liz Hughes	Director of Education and Quality, HEE
Dr Judith Hulf	Director, Education and Standards, GMC
Dr Muj Husain	ETAB member
Professor Stewart Irvine	Medical Director, NES
Katie Laugharne *	Head of Welsh affairs, GMC
Dr Claire Loughrey	Director of GP Education, NIMDTA
Professor Sheona MacLeod	Postgraduate Dean, HE East Midlands
Ms Elizabeth Manero	Patient/public representative
Dr Nadia Masood	Justice for Health
Dr Ellen McCourt *	BMA JDC Chair
Professor Clare McKenzie	RCOG / Scotland Dean
Dr Sam Mills	Academy Trainee Doctors' Group
Sarah Parsons	Medical Workforce Manager, NHS Employers

Dr Gerrard Phillips	Vice President for Education and Training, RCP
Susan Redward	Education Policy Manager, GMC
Dr Toby Reynolds	Former GMC Clinical Fellow
Paula Robblee	Education Policy Manager, GMC
Dr Alice Rutter	ETAB member
Miss Piriyah Sinclair	ASiT Vice President
Dr Jude Tweedie	RCP Research Fellow
Sam Wakeford	Senior Policy Advisor, BMA
Alan Walker *	Head of NI affairs, GMC
Rose Ward	Education Policy Analyst, GMC
Dr David Warriner	AoMRC Clinical Fellow
Dr Emma Watson **	SMO Scottish Government / DME NHS Highland & Orkney (immediate past Chair Scottish DMEs)
Dr Jeeves Wijesuriya	BMA JDC Education and Training Chair
Mr Adam Williams	ASiT President

* participated by VC

** participated by teleconference

General Medical Council

Annex B

GMC roundtable paper

General Medical Council

How we're supporting flexibility

Background

Following talks between the government and the BMA in May over the new contract for doctors in training in England, we agreed to lead a review with the aim of identifying ways in which doctors in training across the four countries of the UK could move more flexibly between postgraduate training programmes.

While the contract was rejected by doctors in training, we are still committed to the review in order to look at some of the deeper seated issues which the contract dispute highlighted, including the inflexibility of current training pathways noted in the independent Shape of Training Review.

What we want the review to achieve

The review is not about the contract. However it is an opportunity to examine collectively the scope for greater flexibility which better supports doctors in training through the education journey. The idea is that the roundtable will consider key policies already being developed, identify issues still to be addressed, look for common ground, and reflect on how we can drive collective change which promotes and enhances flexibility through training in the UK.

The proposal would be for the GMC to produce a report by the end of March 2017 which reflects this activity and the commitments which stakeholders are making.

We can explore flexibility from two dimensions: supporting doctors to move through training and between areas of practice; and promoting approaches which enable us to respond more effectively to patient and service need.

What we're doing

We already have a number of work areas that support, or will support, more flexibility in postgraduate training. Annex A describes details of work that might feed into this review.

What's already happening

We endorsed a transferable competencies framework by the Academy of Medical Royal Colleges, published in 2014, which we know the RCGP has been one of the few colleges to have applied.

Other areas that are already supporting flexibility include out of programme arrangements, reasonable adjustments and less than full time training arrangements for those with disabilities and caring responsibilities.

Through this review, we can begin to evaluate the extent to which these current arrangements are supporting flexibility.

What's on the horizon

We are consulting on standards for postgraduate curricula and assessment, which will embed generic professional capabilities (GPCs) into curricula. The standards require organisations to identify and address any interdependencies between specialties, and outline our expectations for an outcomes-based approach which aims to reduce rigidity and allow more flexible progression through training.

We will be introducing regulated credentials over the next 18 months with a small number of early adopters. This will allow us to recognise areas of expertise outside of specialties that are important to service and patient care.

This year we will be involving doctors in training in the development of survey questions which will aim to elicit data on flexibility.

Other opportunities

Other opportunities for development – some of which will be outside of the GMC's remit – include part-time training to allow doctors to get broader experience in other specialties; way points in training; and the possibility of longer placements or rotations. The review may also look at some of the workforce or training environmental challenges identified in our trainee and trainer surveys, including concerns with rotas and workloads/intensity; undersubscribed specialties; supervision etc. These issues often result in more rigid approaches to training and learning opportunities.

Next steps

We would like to use the roundtable to decide what the review should consider and prioritise.

Following this roundtable we will produce a stocktaking paper which:

- identifies the key areas for development to enhance flexibility in postgraduate education and training pathways

- references the wider developments related from the workforce and service perspective which may support flexibility.

After that we envisage:

- A closer examination of the various approaches being taken and the scope for further development, informed by stakeholder perspectives and experiences. The proposal would be to develop a picture with members of the roundtable working through email primarily.

- A report by the end of March 2017, summarising what we've learnt, with clear actions stakeholders are committed to, and identification of further work.

Annex A

Work streams

We – and others – are working on number of areas that will develop or already have developed a more flexible approach to postgraduate training.

Postgraduate operational policy

There is already some flexibility available to doctors in training. For example:

- The AoMRC has issued advice on a transferable competencies framework – which we have endorsed.

  http://www.gmc-uk.org/education/approval_curricula_and_assessment_system.asp

- Doctors in specialty training can apply to their postgraduate dean to take time out of their approved programme, which may or may not be counted towards a CCT or CESR depending on the type. Types of out of programme (OOP) include:

  - Out of programme career break (OOPC) – for other interests or ill health
  - Out of programme for clinical experience (OOPE) – to enhance clinical experience or gain experience as a locum consultant
  - Out of programme for approved clinical training (OOPT) – for clinical training which is not part of the doctor's approved programme
  - Out of programme for research (OOPR)
  - Acting up as a consultant (AUC).

  http://www.gmc-uk.org/doctors/approval_out_of_programme_post.asp

Generic professional capabilities framework (GPC)

The GPC framework articulates outcomes and requirements that all doctors must be able to demonstrate. It will become one of our core requirements for programmes of learning (postgraduate curricula and credentials) to show how these requirements are mapped and contextualised into specialty curricula.

http://www.gmc-uk.org/education/23581.asp

Standards for curricula and assessment review

We are currently reviewing the standards we will use to approve postgraduate curricula and the learning requirements for regulated credentials. The review is ongoing but the standards will likely require programmes of learning to be outcomes-based, focus on meeting the needs of patients, service and doctors in training, embed GPC and *Good medical practice* and set out our expectations for valid and reliable programmes of assessment. It aims to create a more flexible operational process which reduces unnecessary regulatory burden, where appropriate. A move to outcomes-based programmes of learning will allow for an easier recognition of previous training (transferable outcomes rather than competencies), a more proportionate approach to progression based on critical progression points and more defined outcomes leading to specialty recognition.

http://www.gmc-uk.org/education/29569.asp

Promoting excellence and our QA processes

Our new standards, *Promoting excellence* (2015) set out requirements for the management and delivery of undergraduate and postgraduate medical education and training. These standards are used as part of our quality assurance processes and help us make sure doctors in training are getting high quality medical education and training that will keep patients safe and meet service expectations. These standards, the supporting quality assurance processes and the National Training Survey allow us to gather information about how training is working in the real world. These processes often highlight concerns by doctors in training and others about supervision, work intensity and work load, handover and other critical safety issues. A more flexible approach to training might provide a lever to address some of these local issues at strategic and government levels.

http://www.gmc-uk.org/education/standards.asp

Regulated credentials

We are introducing a new process called credentialing to recognise doctors' capabilities in particular practice areas. This new system would allow us to provide accreditation of doctors' capabilities in defined areas of practice areas, in particular those that are not currently covered by specialty training. Over the next 18 months, we will work with a small number of early adopters to evaluate the impact of our proposed model on the GMC, stakeholders and the wider system.

http://www.gmc-uk.org/06___Credentialing_consultation___results_and_next_steps.pdf_65711404.pdf

Health and disability

We have an ongoing work stream considering the best way to support medical students and doctors in training on health and disability issues. We have a number of statements including our guidance on health and disability and the advice on less than full time training to help improve how these doctors manage their training. Our approach has ingrained some flexibility into the system already and this review will allow us to continue to provide meaningful support to these doctors.

http://www.gmc-uk.org/education/12680.asp

Progression and data

We are developing reports to show the issues impacting on the progression of doctors in training through their postgraduate training. These reports, published in July 2016, will help us identify any opportunities or barriers for more flexible training and progression.

http://www.gmc-uk.org/education/25495.asp

The Shape of Training Review

The Shape of Training Review, led by Professor David Greenaway, reported in 2013. It made a number of recommendations aimed to make postgraduate training more flexible both for doctors in training and for service delivery and workforce management at local levels:

- Broader training in specialties
- Outcomes-based training programmes that embeds generic professional capabilities and transferable competencies
- A more apprenticeship-based model for supervision and support
- Opportunities for doctors to change, deepen, or extend their careers with recognised credentials.

The report also recognised the need to have more flexible work patterns for doctors in training to work and train part-time. But this would impact on how rotas are currently designed. It emphasised the need for more flexibility in relation to academic training.

The report and further information about the Shape of Training Review is available on the Shape of Training website.

http://www.shapeoftraining.co.uk/reviewsofar/1788.asp.

The UK Shape of Training Steering Group

Since 2014, the Shape of Training Agenda has been overseen by Ian Finlay (Scottish Health Executive), who chairs the UK Shape of Training Steering Group. We are one of the stakeholders on this group. This group has been confirmed and endorsed by the four UK governments to look at how Shape of Training should be implemented, and the review will have to link to this group.

In 2015, the Steering Group considered four areas for the implementation of the Shape of Training recommendations. Ian Finlay is preparing an update to ministers about these areas of work. It will likely cover:

- The outcome of the Academy of Medical Royal College's mapping exercise. We provided secretariat and policy support on this exercise – http://www.aomrc.org.uk/dmdocuments/Shape_Training_Mapping_Exercise_18_12_15.pdf
- An update on Health Education England's work on Shape
- The GMC's work on regulated credentials
- The Scottish and Welsh governments' work on SAS doctors.

The AoMRC mapping exercise group is now speaking with a select number of colleges to explore their responses to the exercise.

The RCS undertook a review of general surgical training that was commissioned by HEE. The outcome of the review proposed broader training with a focus on emergency and acute care in the early years. Any review on flexibility will have to consider the implications of this approach – particularly as it meets workforce pressures and importantly that this will be applied across the UK.

https://www.rcseng.ac.uk/surgeons/supporting-surgeons/regional/events/documents/rr-improving-surgical-training-19-nov-2015