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

30 years is an almost impossible timeframe to predict how healthcare will change. Only when you consider how the NHS and healthcare has developed over the last 30 years, can you even begin to assess the magnitude of potential change.

However, in the employers' vision for the future, it is likely that we will find a range of specialist services being delivered closer to home, 'more local' hospitals providing generalist care and greater mobility to regional specialist centres or treatment hubs.

The patient will have greater information and influence over how their care is delivered. We will see a larger number of 'expert patients', information on quality will drive patient choice and providers will 'compete' for business based on quality and outcomes.

With an ageing population, we will see an increase in complexity of healthcare needs from chronic and complex long-term conditions to neurological and psychiatric illness. Care will be provided by multi-disciplinary teams, including integration with social care, so planning for individual staff groups should not be looked at in isolation. Hospitals will need a greater number of generalists who may take on the role of co-ordinating the complex healthcare needs of patients.

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?

If the provision of specialist services in the primary care setting increase, we will need to see the increased use of hospital trained specialist and properly accredited GPs with specialist skills delivering this care in the community. The requirement of diagnostics expertise in this setting will increase alongside this shift. Some will be drawn out of the hospital setting, others becoming more centralised with improvements in technology.

In the hospital setting, 24/7 cover by specialist doctors will become the norm, changing the concept of on-call from home to a system of full-shift working. For other services, advances in technology will enable more cover to be provided remotely, perhaps over a larger geographic area or across a number of healthcare facilities so IT literacy and the ability to adopt new technology, faster, will be needed.
With an ageing population, we will see an increase in complexity of healthcare needs from chronic long-term conditions to neurological and psychiatric illness. Hospitals will need more ‘generalists’ to ensure that the total needs of a patient are met during in-patient episodes.

Employers expect more hospital-trained specialists and other healthcare professionals to be co-located with GPs, which will require a new way of working for some specialties, with an increased element of community based training required.

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

GPs are likely to adopt a role as the ‘co-ordinators’ of specialist services and care, although the effects of increased patient choice and how services are commissioned will undoubtedly influence how this role is fulfilled. As commissioners, additional management, business and leadership skills will be required, but these would be best be acquired post CCT.

It is likely that GPs will also increasingly act as the providers of these services, working in larger groups, perhaps with trained specialist colleagues providing service, support and training, along with other members of the multi-disciplinary team. As GPs acquire specialist skills above and beyond the core skills required to enter the GP register, it is essential that these are accredited and regulated to maintain public confidence and ensure quality of care.

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?

Employers feel that current training programmes are too rigid and provide little opportunity to redirect doctors as workforce needs change, or where training or personal needs suggested a change in career direction.

Broad, modular, basic specialty training, which covers core medicine, mental health, and surgery, would enable a doctor to safely perform a range of tasks across as broad a range of specialties as possible. Employers envisage that such doctors would be able to support overnight cover, be suitably proficient to enter Specialty Doctor opportunities, embark on higher training across a range of specialties, including general practice, or pursue academic training.

Employers have told us that they expect to see the Specialty Doctor section of the medical workforce grow significantly, becoming the new backbone for the delivery of hospital-based care. A more flexible approach to training will enable doctors to pass in and out of these opportunities and training more easily to follow a training pathway rather than become a new ‘lost tribe’ waiting for rigid training opportunities to arise within restricted timeframes. Given the recent expansion in medical student numbers, the expectation that all hospital based doctors will become consultants and all GP trainees develop into partners is now an outdated and unlikely concept and competition for these opportunities will be fierce. Career guidance needs to recognise this from very early in a doctor’s training and career.
Employers fell that specialisation and, in some cases, sub-specialisation, happens too early in a doctor’s career. It would be worth exploring how the currently approved sub-specialty skills could be acquired, in a regulated way, after an initial CCT in the parent specialty.

5. How can the need for clinical academics and researchers best be accommodated within such changes?
Academic training programmes need to ensure that capacity and opportunity to deliver clinical training, is matched with the academic training elements of the programme. We currently have a mis-match of opportunities geographically and whole time equivalent clinical training capacity being taken up by half clinical time academic trainees. This creates service delivery issues for employers, quality of training issues for trainees and creates a perception of a two-tier system for the profession.

Academic programmes need to use the same selection processes and their clinical colleagues, with an added academic element, and the workforce planning model for clinical academics needs to sit alongside that for clinical training programmes, rather than the current integrated model i.e. academic trainee numbers are planned separately from clinical trainee NTNs.

Academic programmes also need to be planned to ensure that the clinical curriculum can be achieved within the prescribed time. This will inevitably lead to longer training time for these trainees.

Flexibility

6. How would a more flexible approach to postgraduate training look in relation to:
6a. Doctors in training as employees?
Employers need the freedom to determine their staffing structures according to local need but based on the principle that every patient must ultimately be under the care of a specialist. They must also be equipped with the knowledge and freedom to decide the numbers of consultants, specialists, specialty doctors, trainees and others required to deliver high quality, sustainable and cost effective care hand in hand with training.

The national recruitment process for trainees, with consistent standards and a more transparent recruitment system is important. The single, co-ordinated national recruitment timetable is also seen as helpful for recruiting good candidates across a range of specialties. However, greater employer involvement at the medical school recruitment stage could help to ensure that medical student are recruited o their values as much as their potential to progress as doctors - an element of the NHS workforce that is becoming increasingly important.

Many employers would welcome a longer term employment relationship with trainees throughout their entire length of training, clearer options for less than full-time training and clearer wholly equitable route to the specialist register than the current CESR process provides alongside the CCT route.
6b. The service and workforce planning?
Increased flexibility in training needs to enable a more rapid response to changes to clinical practice that result in changes to workforce demand. We need a system that is demand led rather than capacity and supply driven. Employers need to be closely involved in the commissioning of education and training, which should be based on their long term understanding of service needs. The emergence of LETBs will help to deliver this important role.

Medical training needs to be designed with as much flexibility as possible, delaying specialty decisions until as late as is practically possible to ensure that we are truly training the doctors we need as clinical practice evolves and new technologies are adopted.

6c. The outcome of training - the kinds and functions of doctors?
Employers have told us that they expect to see numbers of Specialty doctors grow significantly, becoming the new backbone for the delivery of hospital-based care. Employers recognise the importance of this group of staff and are keen to develop opportunities, which they believe offer attractive and fulfilling career options.

The number of doctors who will qualify as hospital specialists will be substantially greater than those who have historically been employed as consultants – a workforce which has already grown by 30 per cent since 1997, and is estimated to increased by 60 per cent over the next 20 years.

This has stimulated debate among employers over the cost and the nature of what being a consultant will mean, particularly as the relative proportion of trainees is reduced. Some employers are also watchful over the impact of reducing participation rates in the GP workforce and at more senior levels and the effect this could have on overall demand for qualified specialists.

Employers are clear that the future role for doctors on the specialist register, whether achieved through CCT or CESR, is going to be different to the current role of consultant, working as they do today. They will continue to make use of consultant roles where this reflects value for money, but the expansion expected in the number of CCT and CESR holders cannot all be accommodated in the current consultant grade.

6d. The current postgraduate medical education and training structure itself (including clinical academic structures)?
Employers share the concerns expressed by many doctors, that run-through training programmes across all specialties are too rigid and provided little opportunity to redirect doctors as workforce needs changed, or where their training or personal needs suggested a change in career direction.

There is still support for run-though programmes in some areas, recognising that some fields of medicine specialise from the outset and have less in common with other specialties. Run-through programmes make an attractive option for trainees and provide a significant incentive to attract good quality applicants to traditionally hard-to-fill programmes.

There still remains far too much rigidity across training programmes which creates an artificial barrier to workforce flexibility. Employers are keen to see progress on the mapping of transferable competences
that would enable skills acquired in one programme to be more easily accredited when transferring to another whether for individual preference or to meet changing workforce demands.

Employers also want to enable specialty doctors and their trust equivalents to gain recognition for the knowledge, skills and experience they acquire throughout their careers. There is a commitment to offer learning and development opportunities, including, for some, opportunities to learn alongside colleagues in deanery-recognised training posts. There is strong support for the development of a standardised system of recognition, or ‘credentialing’, which would, in time, support doctors to better evidence their skills when applying for entry to the specialist register via the CESR route and achieve greater autonomy of practice where their competence has been accredited.

More aspirationally, a system of ‘modular credentialing’ would facilitate a ‘career ladder’ approach, encouraging doctors to step in and out of training, research, academia and service delivery roles, take career breaks or spend more time on the management of clinical services. This approach could result in the development of a whole range of roles, from foundation programme trainees to senior consultants or GPs, each with a defined range of competences and capabilities. In the longer term, it could remove the need for an artificial distinction between training and non-training posts and so facilitate better movement between the two.

**Patient needs**

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

Changing demographics and increasingly complex healthcare needs will require a more holistic approach to healthcare delivery. Greater emphasis on generalist skills will be required early in training. An integrated health and social care system will require enhanced communication and co-ordination skills in both primary and secondary care as doctors contribute to care provided by larger multi-disciplinary teams.

A greater emphasis on healthcare delivered in community settings will be needed, and not just focussing on psychiatry and general practice as is now being planned, but encompassing an increasing range of specialist care that will move closer to home.

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

There is some evidence that patients are less concerned with doctors’ job titles and more concerned with having experienced, qualified people in place to meet their healthcare needs promptly and effectively. The important point is that it is for individual employers and their clinical managers to decide what is appropriate to their particular circumstances and the healthcare needs of their local population.

However, during training, there need to be clear and understood boundaries of appropriate practice as training progresses. Clear networks of clinical and educational supervision are needed to ensure that support is available and actively sought from the multi-disciplinary team when a doctor encounters challenges beyond their current level of competence. The key to achieving this is about developing a
supportive learning culture within the training environment and for doctors themselves to develop a clear insight into their own abilities and boundaries of practice.

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

Training needs to be delivered in a truly multidisciplinary way. Consultants, nursing staff, SAS doctors and AHPs all have the ability to contribute and add value to a doctor’s education. Their contribution should be planned into the delivery of training from medical school upwards.

Some employers believe that better integration with the ward team from an early stage is required for doctors to truly understand and value the contributions made by the full team. It may be helpful to explore the idea of Foundation Doctors being managed in the workplace by ward sisters and the use of healthcare professionals who come under regulators other than the GMC as education supervisors for this group of trainees.

**Breadth and scope of training**

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

Many employers feel that although CCT holders have achieved the clinical competences set out by through their curriculum, many have not attained, or are unlikely in the short term to be able to attain, the confidence and experience seen in existing consultants who have had longer training programmes, greater experience or both. Some believe these elements could be achieved with a period of employment in a post-CCT career post focused on service delivery. This would provide:

- a quality service for patients delivered by trained doctors,
- an opportunity to acquire more experience
- for some, time to better experience the interface of primary and secondary care
- time to focus on developing leadership and management skills

The period would then enable the doctor to become a better prepared applicant for a ‘traditional’ consultant post after two to five years.

However, employers are clear that the future role for doctors on the specialist register, whether achieved through CCT or CESR, is going to be different to the current role of consultant, working as they do today. Within the current consultant grade differential roles may develop, with some doctors taking on management, teaching, and other roles to varying degrees.

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

The current overall length of training is about right in most specialties, especially if the career framework could develop to include period of post-CCT experience between entering the specialist register and attaining a consultant post. It would be helpful to explore the possibility of incorporating some of the sub-specialty skills training currently delivered pre-CCT into this period to maintain optimum flexibility in the workforce planning for these, often small, areas of the medical workforce.
Curricula should be more outcome, not time, based and responsive to progression rates. Additions to curricula during reviews should be accompanied by appropriate deletions or reductions in emphasis on other elements to ensure that there can be forward progression with attainment of skills and competencies in a timely manner.

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

An increased period of general training post-Foundation Programme will deliver the required level of generalist skills prior to specialisation to CCT level. However, it is essential that work to map transferable skills and competences across generalist and specialty training is progressed so that trainees do not have to repeat training in skills and competences already acquired. A move to an outcome based and not time based training system will support this approach.

While further sub-specialisation is inevitable as the complexity of healthcare develops, it is the speed at which this development takes place that would support an increase in post-CCT sub-specialty training as opposed to incorporating these highly specialised skills into training leading to CCT. Doctors will be able to better demonstrate some of the higher skills required prior to being accepted to train in the sub-specialty and employer would be better equipped to determine the demand for those skills within a 2-3 year timeframe rather than a 5-7 year period as is currently required. However, this will not be achievable without changes to the funding arrangements for such training and a properly regulated credentialing system to accredit the training.

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?

Training needs to be delivered hand in hand with service delivery. Where experience of rare conditions or uncommon interventions is required models of specialist training are emerging where service is delivered primarily by trained doctors with trainees being 'called in' to join their trained colleagues to experience and take part in the care for those patients. This type of innovation is key to the future balance of acquiring both learning and experience thought the training period.

There is also a balance between giving trainees the opportunities to experience different institutions and specialities and the value of spending longer periods in different places and jobs in order to consolidate their experiences and training. Some employers would favour more of an 'apprenticeship scheme' with trainees with better support and more protected time for quality teaching and reflection.

Of particular concern are the shorter rotations in the Foundation Programme that some believe can prevent the trainee from learning and gaining clinical confidence in a stable environment.

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?

There are many programmes in place already to support the move from Medical Student to Junior Doctor to Foundation training. A number of, mostly college led, programmes are also emerging to support the transition from junior doctor to the first few years as a consultant. These will need time to
bed it before assessing what more is required. There are also well established areas of good practice around mentoring, peer review groups etc at a number of transition stages throughout a doctors early career.

A period of employment in a post-CCT career post focused on service delivery. This would provide:

- a quality service for patients delivered by trained doctors,
- an opportunity to acquire more experience
- for some, time to better experience the interface of primary and secondary care
- time to focus on developing leadership and management skills

The period would then enable the doctor to become a better prepared applicant for a ‘traditional’ consultant post after two to five years.

**Tension between service and training**

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

Training and service delivery need to go hand in hand by necessity. Trainees are not going to fully acquire the skills they need to progress through training and the experience of using those new skills under different conditions and with different patients needed to consolidate that learning without being an integral member of the healthcare delivery team. Confidence, leadership and communication skills are also developed through greater involvement with colleagues and patients - all of which would be more difficult to acquire is separated from the day to day running of the ward, department or practice.

Improvements in educational supervision, the expansion of the Specialty Doctor grade and some routine interventions being performed by other trained members of the team can all contribute to ensuring that all doctors have the time to continually learn and reflect on their experiences and learning.

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

Employers have told us that they expect to see the role of specialty doctors in the workforce grow significantly, becoming the new backbone for the delivery of hospital-based care. At the same time recognising that the service contribution from trainees will decrease. However, making trainees completely supernumerary and not involved with service delivery at all would neither be affordable nor would it provide them with the learning opportunities they require.

**General questions about the Shape of Training**

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

Clear curricula, improved supervision and assessments and fairer recruitment practices should not be lost from any changes to the training system.
18. Are there other changes needed to the organisation of medical education and training to make sure it remains fit for purpose in 30 years time that we have not touched on so far in this written call for evidence?

The funding of postgraduate medical education will need to adapt to any new models of training delivery. And obviously, any fundamental change in the structure of training will need to consider the implications for employment contracts and the responsibility of the employment relationship.

19. Any other comments?

Employers believe that greater flexibility in training will encourage more doctors to undertake periods of research or gain valuable service experience before competing for higher specialty training. A small planned oversupply in the medical workforce would facilitate this, while allowing for the flexibility to respond to changing staff and patient demographics. A multi-disciplinary approach to workforce planning is needed and employers, who constantly have to juggle patient expectations with staffing and financial resources, must be central to this. Finally, honesty and transparency about the realistic career opportunities available, the support that doctors can expect from their employers, and employers’ expectations of them, will provide our doctors of the future with clear personal and professional goals to achieve, within multi-disciplinary clinically led teams.

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