SHAPE OF TRAINING

# Annexes to the UK Shape of Training Steering Group Report (UKSTSG)

29 March 2017

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Appropriate organisations must make sure post-graduate medical education and training enhances its response to changing demographic and patient needs.

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Appropriate organisations should identify more ways of involving patients in educating and training doctors.

**Recommendation 3**
Appropriate organisations must provide clear advice to potential and current medical students about what they should expect from a medical career.

**Recommendation 4**
Medical schools, along with other appropriate organisations, must make sure medical graduates at the point of registration can work safely in a clinical role suitable to their competence level, and have experience of and insight into patient needs.

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Full registration should move to the point of graduation from medical school, subject to the necessary legislation being approved by Parliament and educational, legal and regulatory measures are in place to assure patients and employers that doctors are fit to practice.

**Recommendation 6**
Appropriate organisations must introduce a generic capabilities framework for curricula for postgraduate training based on Good medical practice that covers, for example, communication, leadership, quality improvement and safety.

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Appropriate organisations must introduce processes, including assessments, which allow doctors to progress at an appropriate pace through training within the overall timeframe of the training programme.

**Recommendation 8**
Appropriate organisations, including employers must introduce longer placements for doctors in training to work in teams and with supervisors including putting in place apprenticeship based arrangements.

**Recommendation 9**
Training should be limited to places that provide high quality training and supervision, and that are approved and quality assured by the GMC.

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Postgraduate training must be structured within broad specialty areas based on patient care themes and defined by common clinical objectives.

**Recommendation 11**
Appropriate organisations, working with employers, must review the content of postgraduate curricula, how doctors are assessed and how they progress through training to make sure the postgraduate training structure is fit to deliver broader specialty training that includes generic capabilities, transferable competencies and more patient and employer involvement.

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All doctors must be able to manage acutely ill patients with multiple co-morbidities within their broad specialty areas, and most doctors will continue to maintain these skills in their future careers.

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Appropriate organisations, including employers, must consider how training arrangements will be coordinated to meet local needs while maintaining UK-wide standards.

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Appropriate organisations, including postgraduate research and funding bodies, must support a flexible approach to clinical academic training.

**Recommendation 15**
Appropriate organisations, including employers, must structure continuing professional development (CPD) within a professional framework to meet patient and service needs, including mechanisms for all doctors to have access, opportunity and time to carry out the CPD agreed through job planning and appraisal.

**Recommendation 16**
Appropriate organisations, including employers, should develop credentialed programmes for some specialty and all subspecialty training, which will be approved, regulated and quality assured by the GMC.

**Recommendation 17**
Appropriate organisations should review barriers faced by doctors outside of training who want to enter a formal training programme or access credentialed programmes.

**Recommendation 18**
Appropriate organisations should put in place broad based specialty training as described.

**Recommendation 19**
There should be immediate discussion about setting up a UK-wide Delivery Group to take forward the recommendations in this report and to identify which organizations should lead on specific actions.

# Annex 2
# The terms of reference for the UKSTSG

## The UK Shape of Training Steering Group

Terms of Reference and Membership

**Purpose**

1. To oversee implementation activities arising from the Shape of Training (Greenaway Report) on the future structure of UK Medical Training, providing advice and recommendations to UK Ministers as necessary.

**Terms of Reference**

2. The Group's remit will be to:

- consider the implications arising from the Shape of Training report and to report the outcome of deliberations to Ministers
- develop a Policy and structure for implementation (in full or in part) of the recommendations within the report.
- seek approval from Ministers to proceed with Policy and to commission workstreams
- provide oversight, coordination & direction to any Policy for implementation
- identify work to be undertaken in order to deliver any agreed policy and commission relevant bodies to take forward where appropriate
- monitor progress by receiving progress reports from work streams/stakeholder groups, identifying both opportunities and risks which may have an impact on services or patients
- keep under review its membership
- report progress to Ministers as required

**Membership**

3. The Steering group will be Chaired by Prof. Ian Finlay, Senior Medical Officer, Scottish Government, and administratively supported by the Scottish Government's Health Workforce Directorate. Membership will consist of representatives from the following organisations (with future membership to be reviewed as required).

- the 4 UK Departments of Health
- Health Education England (HEE)
- National Education Scotland (NES)
- Wales Deanery
- Northern Ireland Deanery
- the Academy of Medical Royal Colleges
- the Academy of Medical Royal Colleges Trainee group
- the BMA UK
- the General Medical Council
- the Medical Schools Council
- Chair of COPMED
- NHS Employers
- Patient Forum

4. Representatives will be able to nominate substitutes, and shall inform the Scottish Government's Health Workforce Directorate of said individuals at least 24 hours in advance of each meeting.

**Governance**

5. The Steering group operates under the direction of the 4 UK Health Ministers, and will report its views and considerations to the 4 UK Health Ministers as required throughout the period of implementation activity, the initial phase of which was outlined in the statement from the group issued on 17 February 2015.

6. Recognising the current Ministerial commitments to collaborate on matters impacting on medical education and training policies which have UK-wide implications, the Steering group reports to the Medical Education UK Reference Group, whose role is to facilitate liaison between the four UK Health Departments.

**Meetings**

7. Meetings will be held quarterly and, for expediency and where possible, meetings will be linked to meetings of the Medical Education UK Reference Group. Succinct Notes of meetings will be taken, and these and any papers for consideration should be circulated at least one working week in advance of each meeting.

SGHSCD-Health Workforce

April 2015

# Annex 3
# Principles adopted by the UKSTSG

## Principles guiding the Implementation of the Shape of Training Review

Context
Each of the UK's 4 nations has committed to working collaboratively in developing implementation actions arising from the Shape of Training review. In seeking to achieve a consensus position on mutually recognised priorities for change, it has been agreed that implementation activities arising from the Shape of Training review must take into account national strategies, policies and structures. While each UK nation may express, communicate and direct their workforce aims and priorities in different ways, it is broadly recognised that there exist some shared overarching principles that helpfully guide the direction of policy in each nation, as well as specific principles relating to how to implement aspects arising from the Shape of Training review .

The UK Implementation Steering Group has therefore agreed that the following broad and specific principles will guide and inform the development of policy for the implementation of the recommendations contained within the Shape of Training Review. These are set out below.

**Broad Principles**

Person-centred:
- patients to have a stronger voice in shaping the way public services are delivered
- patients cared for with dignity, respect, compassion, openness and honesty

Services:
- services must be better integrated, safe and effective, and informed by best practice and new innovations and technologies
- not change for change's sake, but transformed to deliver better, higher quality outcomes for everybody needing care or support to live well and independently
- models of care to be routinely tailored to individuals' needs in which success is measured by improved patient outcomes rather than by whether processes and systems have been followed
- Ensuring we deliver the right care, in the right places, at the right time

Workforce:
- work in a healthy organisational culture which engages and empowers individuals, in the design and delivery of services, and which values feedback
- staff treat each other with respect and uphold codes of conduct and behaviour
- learning and development systems ensure individuals have the right skills and competencies to work safely and effectively, within multi-disciplinary teams, and is focussed on delivering high quality care and improved health outcomes
- where appropriate, skills and competencies are formally recognised and quality assured

Resources:
- proposals for change must be supported by a cost benefit analysis, assessing proportionality and encompass redistributive considerations

**The objectives of Medical education and training in the UK, and the specific principles that will inform consideration of change are as follows:**

- to train doctors to deliver safe, high quality and patient-centred clinical care
- the outcomes of training must provide transparency for patients, the public and the service about the levels of capability doctors have attained
- to instil in doctors a sense of professionalism and compassion
- to train doctors to meet the anticipated needs of patients and the service including the development of doctor who can deliver more broad-based care
- to ensure that medical training is flexible enough to be able to adapt to the changing needs of the service, patients and scientific innovation. This will include but not be limited to the recognition of previous learning, education and training should be based on the demonstration of capabilities and not simply upon time. Although experience is an important element of training it should be recognised that the demonstration of competencies and experience are distinct entities
- to embed and promote a career long culture of continuous professional development
- be subject to robust governance and quality assurance arrangements
- to deliver these objectives with the minimum structural change and service disruption
- to be subject to a cost benefit analysis and to take account of affordability

# Annex 4
# UKSTSG Interim statement 2015

## UK SHAPE OF TRAINING STEERING GROUP STATEMENT – SHAPE OF TRAINING

The report of the independent Shape of Training Review, led by Professor Sir David Greenaway, was published in October 2013. The review was established to understand whether the way in which doctors are trained meets the current and future healthcare needs of patients across the UK. As the healthcare needs and expectations of patients are changing and the way services are delivered will evolve, Professor Greenaway's review outlined 19 recommendations to the UK Governments suggesting how changes to the structure of medical training can help deliver high quality care for the future.

UK Health Ministers asked officials to consider the recommendations and make policy proposals, where possible, on the basis of a four-nation consensus. A UK Shape of Training Steering Group (STSG) was convened for this purpose. In 2014, the STSG organised six UK-wide stakeholder workshops to explore how the recommendations arising from the report might work in practice.

UK Health Ministers broadly welcomed the report and they have now approved development activity which will explore how medical training might be adapted to meet future patient and service needs under the umbrella of the Shape of Training initiative. This will be taken forward in a planned way, and overseen by the STSG to maintain consistency and ensure appropriate stakeholder engagement. This work will be supported by an impact analysis.

Specifically, the STSG has endorsed the following general and specific proposals:

- those aspects of the current training system that have been shown to work well and are fit for purpose should remain;
- any significant changes to medical training should be consistent with the key principles outlined within the Greenaway report, and taken forward in a measured and incremental way to avoid service and training disruption;
- any significant changes to medical training such as alterations to curricula must reflect the UK basis of medical training and be approved by the GMC;
- Groups should be developed in each country with appropriate stakeholder representation, with the remit to develop proposals as agreed by Ministers through the STSG, taking account of the different strategic priorities and requirements in each country; and
- to expand its membership to include representation from the BMA, Employers, Patients, doctors in training and Chairs of each countries groups.

The next steps will focus on the following specific activities:

a) further work will be undertaken to describe how doctors' training can be more generic to better meet the current and future needs of patients. This will include a mapping exercise led by the Academy of Medical Royal Colleges and supported by the GMC to look at the extent to which Colleges have or can develop the generic components of their curricula

b) measures to be scoped out, based on evidence collected through pilots, how to further develop the careers of doctors who are outside formal postgraduate training and who are not consultants, such as SAS grade doctors;

c) measures to better prepare doctors to work across the interface between primary, secondary care and the community with more flexibility in training between the sectors; and

d) the STSG will support the GMC as they develop and pilot credentialing working with all stakeholders with an interest in this aspect of Shape of Training.

Patients, service users and healthcare professionals should be assured that any proposed changes to training will be properly considered, modelled and costed and consulted upon before any changes are made. Patients' interests will be at the heart of any proposals.

# Annex 5

# The Curriculum Mapping Exercise report to the UKSTSG meeting of November 2015

ACADEMY OF MEDICAL ROYAL COLLEGES

## AOMRC SHAPE OF TRAINING MAPPING EXERCISE REPORT OF THE MAPPING EXERCISE PANEL

### 1. Purpose

This report summarises the findings from the mapping exercise conducted by Colleges and Faculties and sets out the key messages identified by the Mapping Exercise Panel which comprises representatives from the four countries, Colleges and the GMC and was established to advise and oversee the process. The terms of reference are attached as Annex A.

### 2. Introduction

The Panel wishes at the outset to place on record its appreciation of the work undertaken by all the Colleges and Faculties participating in the Mapping Exercise. A huge amount of thoughtful and creative work has been put in to the submissions. It was clear that seeking improvement to patient care was the clear driver for change. We know that Colleges sought to engage doctors in training with the work and reflect their perspective and we are confident that the submissions represent a considered and representative view of the each College or Faculty.

### 3. Summary of findings

Individual Colleges and Faculties each proposed ways in which their current curricula might be modified to incorporate the key recommendations of The Shape of Training Review. A summary of the submissions and their common themes incorporating the further comments made at the seminar for Colleges held at the end of the process is set out in Annex B.

### 4. Key messages

The Panel unanimously agreed that the following points constitute the key messages from the Mapping Exercise for the UK Steering Group:

A. There continues to be broad support for the principles behind the Shape of Training report but it is recognised that this is a process of evolution rather than revolution.

B. It is essential that training curricula and programmes align with service need but equally service provision needs to recognise and utilise the opportunities and flexibilities already present in current training programmes.

C. There is acceptance that doctors need to be able and confident to provide safe emergency or acute care within their broad specialty area by the end of their postgraduate training recognising that in a good number of programmes this is already the case.

D. There is support across specialties for enhancing GP training to support continuity of care across primary and secondary care including GP skills in acute/emergency care. There may be differing ways as to how this might be achieved in practice.

E. There is a real readiness from secondary care specialties to explore how they can contribute to continuity of care between secondary and primary care although it is clear from the range of developing service models that this will not fit a single pattern.

F. Curricula and training programme structures should enable and support cross-specialty and cross-professional learning as a way of promoting greater understanding and flexibility across specialties.

G. The GMC's proposed framework for Generic Professional Capabilities could be a key driver for change and also a core part of the future training experience for doctors. Many of the changes required are cultural and attitudinal rather than technical and the GPC should be a vehicle for delivering these.

H. There was little evidence of a desire or need to shorten training and indeed there was a consistent theme of the need for formalised professional support or mentoring for the new consultant in the early years.

I. There is firm support for continued lifelong learning and the principle of credentialing but there is considerable uncertainty on the practicalities of credentialing and how it can best reflect service provision. Extensive further work is required to clarify arrangements.

J. There is a strong desire and requirement to maintain momentum on developing training. Colleges will themselves are keen to take forward a number of the changes identified in the exercise notwithstanding the wider decisions of Government.

**5. Next steps**

The Panel recommends that the UK Steering Group:

- Receives the key messages identified by the Panel.
- Clearly identifies and sets out for ministers the benefits to patients and the service such as more coordinated and seamless care and potentially reduced hospital admissions that would follow from developing post-graduate medical training along the lines set out above.
- Encourages Colleges and Faculties to continue work to develop their curricula in the ways they have set out in their submissions.
- Continues to engage with the Academy to support further the development of further curricula proposals and address the key recommendations of the Shape of Training Review more generally.

24 November 2015

**Annex A**

## Process to receive output from the Academy of Medical Royal Colleges Shape of Training mapping exercise.

### Background

1. The UK Shape of Training Steering Group (UKSTSG) statement issued on the 17th February 2015 said that "further work will be undertaken to describe how doctor's training can be more generic to better meet the current and future needs of patients. This will include a mapping exercise led by the UK Academy of Medical Royal Colleges (AoMRC) and supported by the General Medical Council (GMC) to look at the extent to which Colleges have or can develop the generic components of their curricula".

2. The Chair of the UK Steering Group (UKSTSG) then wrote to the AoMRC inviting them to commence this work.

3. The AoMRC has prepared a document that sets out the scope of the exercise that will be undertaken by their constituent Colleges, Faculties and Specialist Societies. This will not involve a detailed description of curricula at this stage. Rather the exercise, which will be completed by November, will describe how the purpose and principles described in Shape of training for revised specialty training may be incorporated into current curricula or where new curriculum development is required.

4. This work has been commissioned by the UK STSG and will be considered by the UK STSG in December 2015.

5. The UKSTSG has agreed that a sub-group or panel will be convened to engage with the AoMRC during the mapping exercise. The panel will also be the vehicle by which the output from the Academy mapping exercise will report to the UKSTSG.

### Remit, Terms of Reference and Membership of the Panel

6. The Panel will be known as the Shape of Training Curricula Mapping Panel.

7. The Panel is convened under the auspices of the UKSTSG and will report to that group.

8. The remit of the Panel will be to engage with the UK AoMRC as required on all aspects of the curricula mapping exercise. This may include:

- Clarification of the purpose and key principles outlined in the Shape of Training reports
- Provision of on-going advice during the exercise and
- Consideration of the output at the conclusion of the mapping exercise.

The later will include an assessment as to whether the purposes and key principles of the Shape of Training report have been met with the potential for further engagement and challenge as required.

9. Any matters of concern or dispute should be raised with the UKSTSG in the first instance.

### Membership of the Curricula Mapping Panel

10. Given the Panel's primary purpose is to consider revision to current specialty curricula based upon the principles outlined in the Shape of Training Report, membership of the Panel should consist of those with knowledge and expertise in medical training, curriculum development, quality assurance, program delivery and policy oversight.

11. The Panel will be chaired by Dr Paddy Woods, DCMO Northern Ireland. The General Medical Council will provide secretarial and logistic support to the Panel which will include compilation of data on behalf of the Panel.

12. In addition to the Chair, Membership will be drawn from the UKSTSG or AoMRC and will include:

- Representatives from UK Education and Training:
  - Health Education England
  - NES
  - Education representative from Wales
- General Medical Council
- UK Academy of Medical Royal Colleges:
  - Senior Officer
  - Representative of Craft specialties
  - Representative of Medical Specialties
  - Representative of Primary care

13. The Panel may co-opt additional members in the event that specific expertise is required that is not provided by the core membership.

**Reporting to the UK Steering group**

14. The Panel will report the outcome of their work to the UK STSG meeting in December 2015.

**Annex B**

# Report on AoMRC Mapping Exercise

## Background

The Shape of Training Steering Group (STSG) statement issued on the 17 February 2015 said that:

> "*Further work will be undertaken to describe how doctors' training can be more generic to better meet the current and future needs of patients. This will include a mapping exercise led by the Academy of Medical Royal Colleges and supported by the GMC to look at the extent to which Colleges have or can develop the generic components of their curricula*".

On 22 April 2015, the UK Shape of Training Steering Group endorsed the Academy's proposal for a mapping exercise to look at the capacity for specialties to develop more general postgraduate training. The Academy set out plans to:

- Ask colleges and faculties to consider questions and issues related to the extent to which they would be able to develop more general specialty training.
- Constitute a panel to consider the output of the mapping exercise, provide advice and support to colleges and faculties and report the outcome of the exercise to the UK Shape of Training Steering Group in December 2015.
- Provide opportunities to engage with colleges and faculties about the exercise. The Academy has emphasised to colleges and faculties that they should involve doctors in training in this piece of work.

A panel has been convened to evaluate the college submissions and report the outcomes of the mapping exercise to the UK Shape of Training Steering Group. This group is chaired by Dr Paddy Woods, Deputy CMO in Northern Ireland and includes representatives from Health Education England, NHS Education for Scotland, Wales and the General Medical Council as well as from Colleges.

## What the panel is considering?

The panel reflected on four key aspects of the Shape of Training report as part of the evaluation of the college and faculty submissions:

- How the Colleges submissions address ensuring doctors who can provide safe emergency and acute care by the end of their postgraduate training;
- How the Colleges submissions address blurring the boundaries between primary and secondary care;
- How the Colleges submissions address developing a more flexible approach to training and between specialties;
- How the Colleges submissions address fostering lifelong learning including the possible role of credentialing.

We have received ten college and five faculty submissions.

As part of this exercise, the panel held a seminar for representatives from colleges and faculties to consider the issues identified in their submissions. The seminar focused on challenging areas within the four Shape of Training themes. More than 40 people participated in the discussions with representation from doctors in training, patients, a wide range of specialties, and the AoMRC mapping exercise panel.

This report considers the feedback from the college and faculty submitted responses as well as the discussions at the seminar.

**Capable of emergency and acute care**

The UK Shape of Training Steering Group has discussed the recommendations that all or almost all doctors must be able to provide safe emergency and acute care by the end of their postgraduate training. In order to gain insight into this, we asked for feedback on whether current curricula equip doctors at CST level to manage appropriate acute and emergency patients.

*Current training*

All specialties that deal with unselected patient care reported that they already require doctors to be competent in dealing with crises and emergency situations relevant to their specialty at a general level. Most of these 'front-line' specialties reported that they expect their doctors to be able to deal with emergencies and provide general care to acutely ill patients safely by the end of postgraduate training (eg anaesthesia, emergency medicine, intensive care medicine, paediatrics and child health, general practice, internal medicine, obstetrics and gynaecology, clinical radiology, psychiatry and surgery). Other reported that they focus on developing general competence in caring for patients in an emergency or acute setting in the early years of specialty training (eg the faculty of sexual and reproductive health, intensive care medicine and surgical training). Where it is relevant to the specialty, doctors will continue to gain experience in emergency and acute care in higher specialty training.

The specialties that focus on diagnostic or hospital services reported that they tend not to provide training in general emergency and general acute care. But doctors in a number of specialties, such as surgery and ophthalmology, are trained to provide highly specialised emergency and acute care when required. Clinical pathology as well as microbiology and virology require doctors to be able to guide the interpretation of results and advise on treatment where appropriate for acutely ill patients. The Faculty of Public Health pointed out that their doctors do not train in emergency and acute care but their curriculum ensures their doctors are capable of managing the prevention of the transmission of communicable disease.

*Concerns with current training*

Despite the inclusion of emergency and acute requirements in most curricula, many specialties reported that they were concerned that their doctors in training were not getting enough exposure to acutely ill patients because of service arrangements. In particular the anaesthetists suggested their doctors had limited exposure to emergency anaesthesia. The RCGP had similar concerns and reported that their doctors in training do not feel confident in dealing with child and mental health emergencies because not all trainee GPs can complete specialty posts in these areas within their three-year programme. The RCPCH warned that their doctors need to maintain exposure to general paediatric and neonatal emergency care.

The JCST argued that more has to be done than changing training alone. They said '*workforce planning and configuration, recruitment and retention of staff and resource allocation are among other factors above and beyond the design of training that influence the provision of safe emergency and acute care'*.

*Potential areas for change*

A number of colleges and faculties, however, identified ways they might further develop emergency and acute care as part of postgraduate training. The RCPath suggested that specialties like clinical pathology could provide support to specialties caring for acutely ill

patients through more joint training and working opportunities. Similarly the FSRH suggested their doctors in training could be trained to provide more urgent care in the community, but warned they still would not be able to care for critically ill patients. The RCPsy is mapping out cross-specialty psychiatric emergency management in mental health specialties, and intend to make changes to higher specialty training if they find cross-specialty competence has not been attained.

However, three responses made suggestions for potential new ways of training doctors to undertake more emergency and acute care in the early stage of their careers. The JRCPTB described a model in which all their doctors in training will '*contribute to the unselected take in the first three years of training…During specialty training most registrars will continue to train in supporting the acute medical take. This will be defined by patient need*.' In the same vein, the RCGP proposed that doctors in training need targeted training in emergency and acute care skills by gaining more time and experiences in '*the widening range of intermediate and unscheduled care settings'*. Helpfully, the Core Surgery response suggested, when exploring modular training as a potential model: '*This process might well ask the question: "what could be achieved in a four year core surgical training programme?" The answer might be a group of practitioners competent to provide a front door trauma service or emergency surgery*.'

The discussions at the seminar identified similar options for developing more general emergency and acute care training, including:

- Developing a more generic format for training (such as the generic professional capabilities framework), which could set out what emergency and acute care requirements are necessary for all doctors at foundation and core levels.
- Developing more flexibility even in broad based training programmes. For example, the ACCS, whilst successfully implementing broad based training between different specialties, can be quite formulaic and doctors have to make choices about their specialty too early on.
- Developing better mechanisms for service providers to describe what kinds of doctors they want and recognise they need to provide appropriate support to develop those doctors.

### Blurring the boundaries between primary and secondary care

Key strategic policy documents across the four jurisdictions of the UK have identified the need to blur the boundaries between primary and secondary care as an essential way to improve patient care and service delivery. The UK Shape of Training Steering Group has identified the need to facilitate any resultant care models, through postgraduate training ensuring doctors are able to work effectively across different care settings and in multi-disciplinary teams.

Colleges and faculties were asked to consider 'What are the clinical pathways/areas in your speciality which require or will require cross medical specialty working? This may be particularly relevant to the boundaries between primary and secondary care'. Most responses reported that there was a need for a more integrated training and care model when they considered the implications of future population demographics on service delivery.

All submissions recognised the impact of an ageing population on the kinds of care expected from doctors in their specialties. However, most specialties did not describe current approaches in their curricula that will deliver this, which underlines the need for change. But they have identified a number of initiatives that could help deliver more integrated care. For example, Trauma and Orthopaedics report that there are several units where care of the elderly is a key part of the team looking after elderly patients with fractured hips.

*Current approaches*

All responses indicated that their specialties would continue to play significant roles in patient care in the future, and very likely demand for their specialists will increase as patient care becomes more complex. While there was recognition for the need to train more generalists, many submissions also emphasised they would still have to continue to train more focused specialists and sub-specialists to meet patient and service needs.

Most specialties recognised that a likely increase in multiple morbidities in the population as a whole, and an increase in the number of frail older patients or those with complex or long term conditions will require significant changes to how their doctors train and work. For example, most specialties, which contribute to the provision of emergency and acute care already, indicated that these skills will need to be enhanced (eg JRCPTB, RCGP, RCPCH). Similarly, nearly all responses recognised the need to embed more training in elderly care, either in postgraduate training or through credentialing. Specialties like paediatrics and child health as well as obstetrics and gynaecology suggested their doctors will need to be prepared to care for patients with far more complex conditions.

*Concerns about current training in delivery integrated care*

Almost all responses, including many of the laboratory and hospital-based services, fed back that their doctors in training and future workforce must be prepared to deliver care across a number of care settings. But there were few specialties that have already reframed training to support this new care model, again underlining the need for change – although most responses indicated work was in progress to do so.

There was overwhelming support for a much greater role for GPs and multi-disciplinary teams in caring for patients in the community. Specialties such as psychiatry, obstetrics and gynaecology as well as paediatrics and child health recommended a much closer relationship with primary care. There was also strong support for more cross-specialty training between specialists and GPs to improve diagnosis and/or care for people with specific conditions. Indeed the RCOG suggested '*While the service is in transition to greater community/primary care working, RCOG is increasingly working with RCGP to develop training modules. The specialty remains mindful of how other specialty training programmes and service requirements develop as cross specialty working (physicians, surgeons) is common practice now.*' The RCoA suggested '*Increasingly anaesthetists will need to work with GPs to enhance perioperative care at both ends of pathway – shared information, pre-op screening, discharge planning and information*.' Although the RCGP also recognised this same need, it highlighted that the current three-year GP curriculum is already full and this was a significant barrier to development. However, it is worth noting that few specialties suggested opportunities for specialty doctors in training to train in community settings.

A common theme was a desire for postgraduate training to focus more on the generic professional capabilities expected in all doctors and the need for more leadership in service development. A number of responses recommended embedding the GMC and AoMRC's generic professional capabilities framework into curricula. But some submissions indicated that this will require a full review of specialty curricula and in the case of GPs, a longer length of training. The RCGP suggested the '*curriculum currently produces GPs competent to work clinically within primary care, [in its existing form], but, the RCGP has a longstanding strategic aim for longer GP training, because of its concerns that higher professional competences relevant to service development and leadership are not sustainable in the current curriculum*.'

While there was strong support for more integration across primary and secondary care settings, specialties reported concerns about the interface between service and training where they suggested training is limited by service delivery. For example the JCST suggested that '*Core surgical training needs significant improvement, as currently it is not providing trainees with the necessary experience to allow them to progress satisfactorily. This is reflected particularly in the current levels of competence in emergency care of those completing Core, which in turn is a reflection of the service/training tension that leads to most trainees filling service rotas and missing training opportunities. As a result, the current time available is insufficient to meet the requirements of core surgical training*.' Similarly, the RCOpth warned in England that '*Due to the reduction in training times and the introduction of Independent Sector Treatment Centres (ISTCs) there have been some issues in trainees acquiring sufficient surgical experience at the end of run-through training*.' The tension between service and training was echoed by the RCGP, the RCEM and the FICM.

*Potential areas for change*

Some submissions identified potential mechanisms to foster better integrated training and care. For example, a number of comments recommended developing specific roles to manage patients in both community and hospital settings; integrate community care services in hospitals; or facilitate acute care community teams or rapid response community teams.

Most specialties acknowledged the need for their specialty to contribute to the delivery of care in the community (such as the JRCPTB and FSRH). For example, the JRCPTB indicated that some specialties – such as diabetes and respiratory medicine – already have some training (as well as significant service delivery) in the community. But there were very few examples on where training and working already takes place in multiple service contexts. Other responses, such as GPs, paediatricians and psychiatrist, suggested there should be better networks between different specialists and specialist services. This was reinforced by the RCOG's recommendation there could be '*greater co-operation in training with other specialties to deliver improvements in maternal medicine and anaesthetics, particularly with GPs on pre-pregnancy care, psychiatrists in mental health care, and primary care for benign gynaecology. Within the hospital setting, complex surgery will require greater cross specialty involvement with colorectal surgery and urology*.'

Feedback from participants at the seminar was consistent with college and faculty submissions. In particular, the group suggested:

- Using the term 'continuity of care between hospital and community settings' rather than 'boundaries between primary and secondary care'.
- Developing opportunities for doctors in training to support patients throughout the care pathway across community and hospital settings.
- Developing opportunities for doctors to shadow or work for short periods of time with other specialties to facilitate understanding of the wider system.
- Developing curricula to prepare doctors to work both in large acute hospital settings and in more isolate/rural environments. This could be facilitated with more community care training at the foundation level.
- Emphasising to service providers that integrated care and training is dependent on much better IT systems.
- Emphasising that contractual or trust arrangements often raise barriers to training across different care settings.

**More flexibility in training and moving between specialties**

The Shape of Training Review report proposed a more flexible approach to training as essential to delivering a more responsive and agile medical workforce. In order to explore how this might be achieved, colleges and faculties were asked a number of questions that explored how specialties may be able to train more collaboratively.

*Current approaches*

Nearly all submissions suggested that there were aspects in their current training where they already foster cross-specialty working. For example, the RCoA has found that '*An increasing number of trainees enter anaesthetic specialty training through an ACCS route which embodies cross-specialty working within the modern hospital*.' Similarly the JRCPTB suggests '*The majority of specialties already participate in cross-specialty working, whether via formalised routes such as dual-training, or delivery of shared care pathways*'.

Most responses identified general practice as the key specialty that they currently or in the future will need to interface with the most. Generally, responses identified aspects of their curricula that may be relevant for GPs or recommended mechanisms for more specialty support for GPs, such as specialty clinics in GP surgeries For example, the JCST suggest '*There is scope for improved understanding among general practitioners of some of the surgical specialties*.' The RCGP also recognised the importance of cross-specialty working with nearly all the other specialties. But there was little recognition that aspects of GP training might be relevant to their specialty. Where it was acknowledged, specialties called for a closer alignment between specialties through cross-specialty training and care pathways.

Feedback from specialties that already have broad based training programmes identified a number of benefits from these arrangements, including better support networks across the specialties. Some of these specialties, such as those associated with the JRCPTB, FICM and FPH have all recommended expanding these broad based programmes to other specialties, especially where they will help develop better integrated care.

Currently, there was little support for combining or merging specialties. Although some responses identified areas where there may be overlap or where curricula may be able to cross over. For example, Histopathology suggested they could pick up elements of oncology, radiology and Dermatology/Dermatopathology. Similarly the JRCPTB have proposed a model that would offer common core training across their specialties before more specialised higher training. They suggest this will be facilitated '…*following appropriate assessment of transferrable competencies and Generic Professional Capabilities*.'

*Concerns about flexibility in training*

Colleges and faculties were not asked specifically to consider what aspects of training may limit flexibility in the medical career pathway. But a few responses raised concerns that too much focus on generic training might dilute the quality of the specialty training, resulting in less competent specialists at the CCT level. Some submissions also indicated that more general specialty training would take longer to accommodate the broader knowledge, skills and experiences necessary to work safely.

*Potential areas for change*

Most responses limited their scope to identifying ways in which they could change their curricula to develop a more general approach in their specialties. Some like the JRCPTB recommended a model with broader skills in internal medicine for all physicians emphasising complexity, co-morbidities and chronic disease management alongside better acute skills for all. Others like the JCST argued that better core training would produce a doctor in training more prepared for special interest surgical training.

Others identified aspects of different specialties that could be integrated into their own curricula. For example, the RCPCH suggested '*There is potential to combine some aspects of the training of General Practitioners and General Paediatricians as there is some overlap of competences for common childhood conditions*.' And the RCPsy suggested more doctors need a better understanding of common mental disorders whilst psychiatrists need to be prepared better to work in different care contexts.

A number of responses, including the Ophthalmologists, emphasised the need to develop specialties alongside other medical or multidisciplinary teams.

A number of key points about developing a more flexible approach to training were raised at the seminar, including:

- Recognising that one approach to postgraduate training will not fit for all specialties.
- Considering the benefits of a more modular approach to training or a more flexible way of developing training. For example, training could be based on a framework of training modules that sets out expected outcomes or time in training but not content. Curricula would determine how many of these modules would be needed to deliver the required outcomes and develop content to meet those requirements, including generic components.
- Begin to discuss the possibility of combining specialties in some areas – but must be clear what benefit to training and service this would offer.
- Developing a broader approach to core training so that it includes more cross-specialty integration. It has to be a more radical approach to change. For example, specialties should train together based on patient requirements and cut across colleges and faculties where appropriate or with other professionals.
- Considering mechanisms to lessen the reliance on doctors in training to deliver service.
- Recognise that generalist training does not necessarily equate to shorter training.

**Implications on the length of training**

Colleges and faculties were asked how long it would take doctors to acquire the competence in their specialty to meet training requirements, post foundation programme. Almost all responses were not supportive of shortening training as a principle. However, some specialties already have a six year training programme including psychiatrists, emergency medicine and clinical radiology. Indeed, the single specialty training programme in internal medicine is five years, but the college has indicated that only small numbers of doctors in training undertake this programme.

A number of the responses set out possible models for training that will help them deliver more general training, albeit none of them suggested this could be done in less than six years after the Foundation Programme. Generally submissions suggested between seven to eight years after Foundation Programme would allow them to develop competent and safe specialists who could work in the general areas of their specialty. For example, JRCPTB proposes a new training model that would produce doctors with expertise in both internal medicine and another specialty in seven years.

Others such at the RCoA, RCPCH and RCOG argued that their training was set at the length necessary to train safe generalists at the level of a consultant. The RCoA stated that there was '*Anecdotal evidence…that trainees are already undertaking post CCT fellowships in order to equip themselves for certain aspects of anaesthetic practice, or to enhance their experience prior to taking up a consultant post or even to gain competencies in highly specialised areas of practice*.'

Colleges and faculties were asked to consider what would happen if shorter training was mandated. Most suggested that doctors who be able to care for most patients safely but would not be able to work without supervision on complex or critically ill patients. Many of the craft specialties indicated that shortening training would further erode experience and exposure.

*Potential areas for change*

However, a few responses recognised that there may be aspects of the current curricula that could be revised or implemented elsewhere by either broadening out foundation and core training or moving aspects of the training to credentialing. This type of restructuring may allow some specialty areas to reduce training time to some extent. Simulation or Technology Enhanced Learning has a key role to supplement learning not only to support development of technical skills but also to enhance training in human factors in multi-professional settings.

According to the JRCPTB, several specialties suggested that a shift to outcome-based curricula would be more authentic for educators and allow greater flexibility in curriculum delivery. This possible approach was supported by the JCST. But the RCOG suggested that '*While, educationally, there is sympathy for allowing flexible length of training, dependent upon the rate of acquired competencies, the reality is that only a handful of trainees would benefit from this within our specialty*.'

**Feedback on other areas of training**

*Academic training*

Colleges and faculties were also asked questions about the importance of academic medicine. There was unanimous support for all doctors to have generic training in research and education, with many responses describing how this is already being addressed in current curricula. Some responses also recommend a more established and accessible approach to academic medicine.

*Undergraduate and Foundation Programme*

A number of responses commented on both undergraduate medical education and training and the Foundation Programme. Key observations included:

- Medical education and training at the undergraduate and Foundation levels must be more responsive to service and population demands.
- Education and training at these levels has too much variation, resulting in specialties assuming doctors only have basic knowledge when entering specialties.
- Too few doctors entering GP training.
- More clinical experiences across all care settings.

**Fostering lifelong learning and Credentialing**

The UK Shape of Training Steering Group is considering how to encourage lifelong learning throughout doctors' careers, including the potential role for credentialing. Colleges and faculties were asked to consider areas that might be suitable for credentials about credentialing.

*Current approach*

Many specialties train doctors in specific or narrow areas of practice through sub-specialty programmes.

Almost all responses identified aspects of their current training that could be developed as a credential. The GP responses pointed out that they don't have sub-specialties so welcome credentials as a way of further developing GPs expertise.

Some specialties identified either the need to continue to train doctors in currently recognised sub-specialties or potentially develop new ones. Many responses linked these to access to training fellowships.

A few responses comment that training never ends – the CCT is not an ending but a way point. Doctors need life-long learning opportunities through CPD and credentialing

*Concerns raised about credentialing*

There is support for the idea of post-CCT credentials from many of the specialties (eg RCGP, RCPsy, some pathology specialties, JCST, RCEM, FPH, RCPCH). For example the JRCPTB suggest, subject to caveats about how credentials fit with training, that '*credentials were viewed positively…as an opportunity to increase the flexibility of post-CCT training and experience in a range of medical specialties both for physicians and, in some cases, other colleagues such as surgeons, paediatricians and GPs.*' Similarly, the FSRH, RCPCH and many of the pathology specialties were positive about developing number of credentials based on specific aspects of their current curriculum. However, there was very little support for pre-CCT credentialing. Most responses indicated that training defined as pre-CCT is essential to make sure doctors are prepared to work safely in their specialty without supervision.

However, a number of responses indicated further work must be done by the GMC and others to provide detail about how credentials will work, including the terminology, entry criteria, quality assurance, funding and exit criteria need to be fully articulated (eg RCoA, RCOG, JCST). Some specialties, such as the Forensic histopathology, clinical radiology and the FICM, did not think credentials would add value to their area of practice because they are already general in nature. Others such as the RCOG were concerned that credentialing would not add value to patients and may put pressure on resources for organisations developing credentials.

Some responses suggested that credentialing should only be available to doctors that have completed the necessary postgraduate specialty training or its equivalent (eg JRCTB, Clinical Oncology). Other colleges, such as the RCGP, indicated that holding credentials should not become a requirement in order to undertake core General Practice. But for some areas of core General Practice, credentials would be a way of giving GPs enhanced skills. For example, all GPs will need to be able to carry out work in child health, but some might develop more enhanced skills in this area through a credential.

A few responses recommended that credentialing should not be developed in isolation from Shape of training (eg RCoA).

Feedback from the seminar was consistent with college and faculty submissions. Key suggestions included:

- Scoping out further how credentials would work across the system, how they would be funded and quality assured as well as how they would fit with postgraduate training. Some suggested that the colleges were best placed to offer credentials
- Considering the opportunity for credentials in, for example, physicianly, surgical, psychiatric, reproductive specialties. Some participants suggested some specialties would not lend themselves well to credentials but this was not universally held.
- Recognising that introducing credentials would not lead to shorter training. But if training is broaden or made more general, doctors would need a mechanism like credentialing to develop mastery in some areas.
- Considering how other mechanism like fellowships, mentoring and CPD should be used to foster lifelong learning.

## Maintaining momentum

Many colleges and faculties are already considering models to improve flexibility in their specialty training. Some of these models are focusing on developing more doctors in training as generalists and/or providing them with broader training at core level. College and faculty submissions, coupled with feedback at the seminar, indicate that there is a desire to press on with these advances, regardless of government decisions on implementing the Shape of Training model.

# Annex 6
# UKSTSG assessment of tangible benefits that would arise from implementation of the SoTR

## Tangible benefits arising from the implementation of the Shape of Training Review

**Background**
The Shape of Medical Training Review (SoTR) was established by UK Ministers to consider how medical training could better meet the present and future needs of patients. The review group reported their findings in October 2013 making 19 recommendations. (http://www.shapeoftraining.co.uk/reviewsofar/1788.asp)

It recognised that the needs of patients in the UK are changing, and identified that measures are required to meet the needs of an ageing population who are more likely to have chronic illness and multiple co-morbidities. The SoTR acknowledged that strategic policy commitments were focused towards more integrated care models, and suggested that in order to meet this challenge more doctors will be required to have and maintain generic rather than specialists skills that enable them to work within and across care services. It also noted that medical training in the UK is longer than in any other comparable Country and perhaps it could be shortened.

Although Ministers accepted the report in principle it was recognised that it was a broad framework for future medical training rather than a detailed description of curricula and structures. For example, the recommendation that training might be organised into broad patient care themes lacked detail and required further consideration. As such, further work was required to understand the implications of implementing the recommendations and to consider how they would work in practice. The UK Shape of Training Steering Group (UKSTSG) was convened for that purpose and to provide policy advice to Ministers. A key role of the UKSTSG is to maintain a UK consensus on medical training while recognising that specific strategic priorities may differ across the UK.

In the first instance, the UKSTSG sponsored 6 workshops involving a wide range of stakeholders to consider the Review's key recommendations. This led to the publication of a UKSTSG position statement in February 2015 that outlined the next steps. This included a request that the Academy of Medical Royal Colleges should undertake a mapping exercise of current training curricula and consider how these may be modified to fulfil the key recommendations of the SoTR. The draft report arising from this exercise was presented to the UKSTSG in November 2015.

The SoTR has described in broad terms the current and anticipated future needs of patients and the types of skills doctors will need to respond to such needs. In considering the output from the Academy Mapping Exercise, the UKSTSG must be satisfied that any proposed changes to current curricula and training pathways will meet the needs outlined in the SoTR, thereby delivering tangible benefits for patients and rewarding, more flexible and sustainable careers for doctors. Identifying these tangible benefits will also be important in providing policy advice to Ministers.

This paper describes the tangible benefits for patients and service providers that would be expected to accrue from implementation of the SoTR recommendations. It has been developed primarily as a resource for use by the UKSTSG but may also be of assistance to other stakeholders.

**The Key Recommendations**
Although the Shape of Training Report made 19 recommendations these were précised at the beginning of the report to the following key recommendations:

1. "Patients' interests and needs must be considered first and foremost as part of changes to medical education and training"

The SoTR is clear that meeting patient needs must be pre-eminent in any consideration of changes to medical training. Consequently this is also a key principle of the UKSTSG. In implementing the recommendations from the SoTR the UKSTSG must be satisfied that first and foremost benefits will accrue for patients.

**Tangible Benefit**

- **Recommendations for implementation of any aspects of the SoTR will describe the benefits that will accrue for present and/or future patients.**

2. "Patients and the public need more doctors who are capable of providing general care in broad specialties across a range of different settings. This is being driven by a growing number of people with multiple co-morbidities, an ageing population, health inequalities and increasing patient expectations"

3. "Postgraduate training needs to adapt to prepare medical graduates to deliver safe and effective general care in broad specialties"

Over the past 25 years hospital doctors have become increasingly specialised and this has weakened the provision of generic/holistic care to patients. Many specialists now state that this is why they cannot contribute to emergency on-call rotas. Since >50% of all hospital admissions are unscheduled, staffing sustainable on-call rotas has become a major challenge for service providers. Although other factors such as the implementation of the European Working Time Directive has contributed to this, sub-specialisation within the traditional general specialties has played an important role.

A key recommendation of the SoTR was that the Service needs more doctors with generic skills while recognising that there will still be a requirement for specialists. It is important therefore to understand where within the Service doctors with generic skills are required and where the requirement for specialists will remain. Understanding the correct balance in each area of medicine is critical.

There are at least three clinical areas where the UKSTSG has identified a clear requirement for more "generalists".

**(a) The provision of care for unscheduled patients in secondary care**
The greater concentration on narrowing specialism in acute hospitals has reduced the number of doctors available to provide both immediate and ongoing general care for unscheduled patients. This is most evident in the broad disciplines of general surgery and of general medicine. Implementation of SoTR must be driven by meeting the needs of patients and ensure that doctors in appropriate clinical areas have and can retain the general skills to provide unscheduled care throughout most of their careers.

**Tangible benefits**

- **patients, and their families, receive the highest quality of care from skilled, knowledgeable and compassionate doctors who listen and involve them in treatment and care decisions**
- **equips doctors with the skills and capabilities to work in integrated care services of the future**
- **enables service providers to achieve sustainable working patterns**
- **will support the design of work schedules for individual doctors that provide for a focus on training requirements while ensuring that doctors avoid fatigue and practice safely with a view to improving the quality of patient care doctors provide when on duty**
- **will create a pool of doctors who are trained to treat those elective patients who do need generalist care rather than specialist interventions (such patients constitute a large proportion of the elective clinical workload) allowing the delivery of more efficient elective services impacting favourably upon patient outcomes and experience**
- **allows for a more adaptable and flexible medical workforce as patient needs change**
- **ensures medical trainees have clarity on the expectations of their medical career pathway, and arguably creates a more interesting and flexible career for doctors**

**(b) Continuity of clinical care in Acute Hospitals**

Specialism in hospitals has contributed to a loss of continuity of care especially of unscheduled patients. This is occurring because when declared specialists contribute to on-call rotas they often transfer the care of the patient to another doctor the next day. This can result in the patient having several responsible doctors over a short time period. Independent reviews of poorly performing hospitals have identified this as an important contributory factor in the delivery of poor patient care that requires urgent action. It has been recommended that all hospital patients should have a single named consultant who is responsible for their care throughout their hospital admission. A tangible outcome of implementing SoTR must include a requirement for clinicians in appropriate clinical areas to have and retain the general skills to provide ongoing clinical care for unscheduled patients.

**Tangible benefits**

- **will reduce the "pass the patient phenomenon" – the handing off of patients to other clinicians – that has been identified to be detrimental to patient care and clinical outcomes**
- **will ensure clarity of the role of the named clinician with responsibility for continuity of patient care which will improve patient care overall**
- **will enable the provision of a single point of contact for patients and those supporting patients thus improving communication. Failure of communications to and from patients is the most common cause of complaint**
- **will ensure effective multi-disciplinary team working benefiting both patient care and improving junior doctors' training experiences**
- **contribute to the improvement of the engagement of junior doctors with their workplace and colleagues**

**(c) Doctors who can work at the interface between primary and secondary care**

In addition to increased specialisation of hospital doctors, over the past 30 years there has been significant growth in hospital admissions, a significant proportion of which might have been better dealt with in the community. For more than a decade Hospital admissions have been rising at unsustainable rates of 4-5% per annum. Although this has been driven in part by increased technology and complexity of care, the King's Fund has reported that at present 25% of patients in acute hospitals could and should have been treated in the community. A large proportion of this later group is elderly with multiple co-morbidities. Given the demographic trends for the elderly population, and in view of Governmental policies to transform health and social care delivery, it is necessary to achieve an appropriately trained workforce to provide care for this group of patients in the community.

General practitioners already undertake "general training" and have been described as the only "true generalists" in as much as they treat all conditions at all ages. In order to facilitate more care in community-based settings, GPs will require appropriate support and to have the opportunity to enhance their skills in the management of patients with complex co-morbidities. This was described in the Shape of Training Workshops as a "community physician" role.

**Tangible benefits**

- **will reduce hospital admissions and increase timely hospital discharges. This is key to the future sustainability of acute hospitals. Will contribute to ensuring that hospital admissions are more often the best option for patients who require the services of a high technology hospital**
- **will enable more patients to be treated more appropriately nearer to home. Patients repeatedly say that this is their preferred option**
- **has the potential to improve the structure and delivery of out of hours (OOH) services**
- **should enable innovative redesign solutions for OOH services and care in the community with stronger links to social care services**
- **has the potential to enhance care in the community in a range of clinical areas.**

4. "Medicine has to be a sustainable career with opportunities for doctors to change roles and specialties throughout their careers"

The SoTR identified the rigidity of the current medical training pathways as an important area for attention. The future medical workforce must be adaptable and responsive to changing patient needs, innovations and the introduction of new technologies. Medical training must also be responsive to a workforce that requires the opportunity for part time working, periods of leave and a desire for portfolio careers. A tangible output from the implementation of SoTR should include the incorporation of flexibility within and between curricula in both primary and secondary care.

This lack of flexibility in training pathways is most marked between primary and secondary care. At present this is an impediment to developing policy solutions to "blur the interface" between primary and secondary care as recommended in the SoTR. Consideration requires to be given to developing a range of options including training doctors who can work both in the community and in hospitals. The UKSTSG may wish to commission further work to consider this.

**Tangible benefits**

- **will better use the entire medical workforce offering better opportunities for flexible working options throughout careers**
- **will better encourage the return to work of doctors who have taken career breaks**
- **will more flexibly respond to local and National service needs**
- **the development of doctors better able to work at the interface will be valuable for service providers in better meeting the needs of patients**
- **recognising previous learning will reduce the current overall training time for doctors who wish to change career**

5. "We will continue to need doctors who are trained in more specialised areas to meet local patient and workforce needs"

The SoTR recognised that there will continue to be a need for specialist and sub-specialist doctors, but did not indicate which specialties will be required and how these should be deployed.

On the basis of studies drawn mostly from complex craft specialties, there is evidence that specialisation improves patient survival. As such, the UKSTSG will want to identify and support specialisation in these areas (e.g. neurosurgery, cardiac surgery, pancreatic surgery, cardiology etc.). It should be noted however that those studies did not examine the detrimental consequences of specialisation – the improvements arising from specialisation may disguise consequential disadvantages in other service provision. The challenge for the UKSTSG will be to identify from the AoMRC mapping exercise those areas within traditional "general specialties" that merit sub-specialisation given the proposal that most doctors in future must remain "general enough" to provide unscheduled care.

**Tangible benefits**

- **patients will continue to have the services of specialists when it is required**
- **specialist doctors will be able to focus upon their specialist skills, while recognising the context of the whole patient care and treatment needs**
- **will provide opportunities for service planners in reconfiguring specialist services**

6. A clear explanation why all training programs cannot be undertaken within 6 years.

The SoTR suggested that specialty training programs that predominately comprise generic components should normally be achievable within a maximum of six years. The UKSTSG has noted that many training pathways are already 6 years or less.

There was a clear consensus in the SoTR workshops that progression through training should be predominantly based on the achievement of necessary competences and that prescribing a time period for training was less important.

It is the case that all comparable Countries in the World can train hospital-based doctors in 4-5 years and the clinical outcomes in these Countries are equivalent or superior to those achieved in the UK. The principle argument against shortening training in the UK is that while doctors can achieve the required competencies within 6 years they may lack the clinical experience to progress directly to the independent consultant grade. Others may progress to the consultant grade soon after completing training but feel in transition to the more senior role

in need of coaching and mentoring to better support them in working towards more senior and autonomous practice. Concern about lack of clinical experience has been expressed in some specialties as a result of the implementation of the EWTD.

In considering this issue the UKSTSG noted that a proposal for instituting a period of formalised mentorship/supervision after appointment as a consultant was offered as a potential solution within the workshops and during the AME. Mentoring is already considered to be good practice and happens under various informal arrangements in employment and within Royal Colleges. The institution of more formal mentoring with a common and consistently applied structure as a component of a training pathway would also fulfil recommendations 8 and 9 of the SoTR which state:

> "Appropriate organisations, including employers must introduce longer placements for doctors in training to work in teams and with supervisors including putting in place apprenticeship based arrangements"
>
> "Training should be limited to places that provide high quality training and supervision, and that are approved and quality assured by the GMC."

Although the SOTR did not recommend formalised mentorship, UKSTSG has suggested that further work be undertaken to understand the implications of instituting a period of formal mentorship, particularly at times of career transition such as on promotion to consultant doctor grade posts.

**Tangible benefits of formal mentoring**

- **mentoring is recognised to be good practice. Formal mentoring would reassure patients that CST holders would have formal support from more senior colleagues to help them through the rigours of the early years of a consultant post**
- **this will improve patient confidence, care and safety**
- **mentoring should also help mitigate stress at times of career transition and improve retention and engagement of doctors**
- **formalising mentoring would potentially allow training pathways to be shortened while safeguarding patient care and supporting doctors in early years practice as they gain experience. This would improve patient care and safety**
- **during the period of mentoring as doctors gain more clinical experience in a senior role they would be contributing to patient care in the workplace**

7. "Appropriate organisations, including postgraduate research and funding bodies, must support a flexible approach to clinical academic training"

Doctors in academic training pathways need a training structure that is flexible enough to allow them to move in and out of clinical training while meeting the competencies and standards of that training.

It is important for patients that medical training produces doctors who can teach and inspire future undergraduate students and postgraduate trainees. There is also a requirement to develop a cohort of doctors who can undertake clinical and scientific research. The major risk to this group of doctors at present is that current training pathways may not be flexible enough to permit both clinical and research training. A clear outcome from the implementation of this SoTR recommendation must be that training pathways are flexible enough to accommodate this group of doctors.

**Tangible benefits**

- **reassurance that the UK will continue to have doctors who can deliver high quality medical education and training**
- **the continued development of doctors who can undertake work that may lead to innovative scientific advances**

8. Local workforce and patient needs should drive opportunities to train in new specialties or to credential in specific areas.

SoTR recommended that a process is required to ensure that local patient needs should influence the opportunity to train in the various areas of medical practice. A structure to permit this to occur requires to be developed.

**Tangible benefits**

- **patient and Employers' needs would influence the planning of the numbers and design of training opportunities**
- **patients will be able to influence GMC and Medical Royal Colleges' curricula design and scrutiny arrangements. This will require to be better promoted by these organisations**
- **patient representative groups involved (perhaps by developing networks of 'Lead' individuals) in the development and scrutiny of local workforce plans**
- **assurance that locally determined need is met to a consistent National standard**

9. "Implementation of the recommendations must be carefully planned on a UK-wide basis and phased in. This transition period will allow the stability of the overall system to be maintained while reforms are being made"

10. "A UK-wide Delivery Group should be formed immediately to oversee the implementation of the recommendations"

**Tangible Benefits**

- **the scrutiny and implementation of SoTR recommendations will be overseen on a UK-wide basis during the transition period. This will ensure the maintenance of a UK consensus**
- **implementation plans in each UK Nation should be developed, and overseen by stakeholder participation and scrutiny. This will allow for strategic priorities in each Country to be pursued while maintaining an overall UK consensus**

Note:
In the recommendations, appropriate organisations must include the Sponsoring Board organisations, the four UK departments of health, employers, and both patient and professional interests.

# Annex 7
# Principles for the development of Clinical Academic Training

## Principles for the development of training of Clinical Academic Careers in Medicine and Dentistry

**Purpose of this paper**
This paper is submitted for consideration by the UKSTSG as a suggested response by the "academic community" to recommendation 14 of the Shape of Training Review (SOTR). It describes principles that it is proposed should underpin the future development of academic careers. The UKSTSG are invited to note and support these principles.

**Background**
Recommendation 14 of the Shape of Training Review (SOTR) report (http://www.shapeoftraining.co.uk/reviewsofar/1788.asp) stated that:

> "Appropriate organisations, including postgraduate research and funding bodies, must support a flexible approach to clinical academic training"

It is important for patients and service providers that medical training equips doctors with the skills to teach and to undertake clinical and scientific research. It is equally important that doctors are able to participate in research activities throughout their careers on either a full time or part-time basis. The doctors who focus on this aspect of medicine are known as "clinical academics".

The current training pathways are considered not to be flexible enough to permit the acquisition of both clinical and research skills, to prepare for an academic career or to allow trainees to undertake a period of research without jeopardising their clinical training.

In response the following work groups have been convened to consider the issue and to formulate solutions.

1. The UK Shape of Training Steering Group (UKSTSG) sponsored a workshop that was chaired jointly by Medical Schools Council and Academy of Medical Sciences and was held on September 26th 2014 at the Academy of Medical Sciences. Stakeholders who attended included the 4 Departments of Health, Members of the UKSTSG, Representatives from HEE, NES, Wales and N.Ireland, NIHR, GMC, LETBs, Deaneries, BMA MASC, Employers/ NHS Board, Colleges including AoMRC trainees, Medical students involved in the INSPIRE programme, Trainees, The Wellcome Trust and other AMRC representatives (BHF, CRUK).
2. A short life task force working group was commissioned in England by CMO Dame Sally Davies under the auspices of UKCRC (Chair Professor Paul Stewart) that focussed on issues such as inconsistencies in training, flexibility of approach, supervision and mentorship, equality and inclusivity.
3. The BMA Medical Academic Staff Committee (Mark Walport ) discussed this at their 10th anniversary event held at Goodenough College, Oxford in October 2015
4. COPMeD (Conference of postgraduate Medical Deans) discussed the issue at an event held in Durham in February 2016 that was chaired by Professor William Reid.

5. Contributions have also been obtained from the following research funding bodies; The Wellcome Trust (Jeremy Farrar, Anne-Marie Coriat), MRC (Joanna Robinson, John Savill) and NIHR (David Jones as Dean for Faculty Trainees).

Based on the output from these various forum, principles have been developed that it is proposed should underpin the future training of clinical academics.

**The Proposed Principles:**
Clinical academic training[1] must operate within a trainee centred and mentored framework jointly overseen and implemented by the university Medical or Dental Dean, through a designated academic lead, and the Postgraduate Dean[2]. Clinical academic trainees will normally be employed by an academic institution and will be conducting their academic research within an NHS Trust/ Board/ local authority. This training tripartite[3] structure involving the academic institution (where appropriate), the NHS and the trainee is responsible for ensuring high quality clinical academic training and should have the following key features:

- Clinical academic training must be personalised, planned and integrated across both clinical and academic areas. Immersion in academic research for periods of time should be valued and appropriately approved. Although this is time away from clinical training, it is a key aspect of career development. Trainee-centred flexibility in training should be the norm with sufficient protected time for research, to support the research competencies required in all clinical training curricula.
- The University Medical or Dental Dean, Postgraduate Medical or Dental Dean and academic lead should work collaboratively to ensure barriers to integration across academic bodies and deanery functions are addressed.
- Where individuals, on nationally competitive training awards, are required to change employers to pursue their clinical academic career pathway certain accrued employment rights, which are linked to continuous service of employment, must be protected. This includes any changes in employer from a NHS trust/board to an academic institution or vice versa, in principle there should be no detriment to moving in either direction. These include as a minimum all family and care-related leave and pay (not limited to gender or sexual orientation) and sick leave and pay (irrespective of disability status or health history).
- Institutions must have a clear plan for promoting and achieving a diverse clinical academic workforce, along all protected characteristics and in all clinical specialties. Similar plans must exist with respect to the composition of the supervisory and mentoring pool as well as the management structure.
- Trainees must be provided with clear expectations on performance. These expectations should form the basis of assessments of progress. Tools used to manage and assess performance must meet the General Medical Council (GMC) statutory requirements for the approved clinical training and local academic assurance systems.
- Trainees must have access to high quality mentorship, leadership and support to help the trainee pursue their next career steps.

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1 Including population and public health clinical academic training.

2 The Postgraduate Dean is directly responsible for the management of the trainee's clinical training programme, in line with criteria and standards defined by the General Medical Council (GMC) and other healthcare regulators.

3 The training tripartite must consist of: (i) strong academic oversight via a designated clinical academic training lead to the University Medical or Dental Dean, or NHS Trust/ Board/ local authority equivalent, (ii) the Postgraduate Medical or Dental Dean who is directly responsible for the management of the trainee's clinical training programme, in line with criteria and standards defined by the GMC and other healthcare regulators, and (iii) the trainee.

- Where relevant, trainees must have access to appropriate programmes of research and management skills training including but not limited to informatics, robust research methods, experimental design, statistics, data analytics, ethics and core aspects of management and leadership training relevant to career stage.
- The clinical component of training should remain competency-based rather than time-based and must be managed appropriately by a postgraduate dean and be subject to the usual governance, quality management and quality assurance processes.[4]
- To participate in and facilitate the collection and sharing of data tracking the careers of academic trainees and those that have passed through academic training.

**Obligations of Trainees:**

- To take responsibility for their career development and performance academically and clinically through attainment of clinical competencies.
- To fully engage with the clinical academic training programme and, in particular, together with advice from supervisors, manage and direct their research project and training in line with their funder's guidance on good research practice.
- To fully engage with the professional responsibilities laid out in Good Medical Practice. To achieve the professional learning outcomes, to participate in local quality management and statutory quality assurance of clinical training.
- To provide feedback to enable effective monitoring and assurance of the application of these principles on request.
- To assist in the collection of data necessary to track their careers.
- Trainees are expected to provide support and guidance to medical/dental students and more junior trainees on the clinical academic training pathway.

**Obligations of the Funder:**

- To ensure that their approach to funding clinical academic careers is appropriately tailored to career stage, clear, accessible and easy to engage with.
- To support trainees during this period of training, consistent with the principles outlined in this document.
- To develop a meaningful approach to assurance of clinical academic training and ways to facilitate and share best practice. Detailed guidance will be developed in partnership across funders to enable effective monitoring of progress with the translation of these principles into practice.
- To include these principles and obligations in their terms and conditions of award.

Note:
The UKSTSG agreed to support these principles with the important caveat that matters relating to terms and conditions of service were outwith the Group's terms of reference. Consequently, the UKSTSG noted that pay and conditions aspects mentioned within principle three above were matters between employers and employees.

4 As laid down in the relevant Royal College and GMC guidelines e.g. *Promoting Excellence*.

# Annex 8
# Notes from the UK Academy of Medical Royal Colleges consensus meeting on mentoring

ACADEMY OF
MEDICAL ROYAL
COLLEGES

## Notes from Shape of Training Mentoring Seminar
## 9 February 2016

**1. Welcome from Professor Jane Dacre, Academy Education Lead**
Professor Dacre welcomed members to the meeting which the Academy was hosting on behalf of the UK Shape of Training Steering Group. She noted that the Junior Doctors' dispute had identified issues regarding junior doctors feeling undervalued and not supported and the Shape of Training Review had identified the same theme. What we are doing to support doctors currently is not enough.

**2. Context from UK Shape of Training Steering Group and Academy mapping exercise**
This proposal has arisen from discussion at both the Shape of Training workshops and during the Academy Mapping Exercise. It was felt that in principle the incorporation of a period of formalised mentoring would appear to have much to commend. It provides support to new consultants at a vulnerable time in their careers and safeguards patients while clinicians gain experience in the workplace. It would also fulfil one of the key recommendations proposed by the Shape of Training that there is a requirement for more apprentice experience in training pathways.

**3. Examples of current models of mentoring schemes**
Brief presentations were given of three current models to inform discussions.

- **RCP London model**
  This is a new scheme offering a "near peer" match. Mentees are F1s to pre consultants. Mentors are ST3 and up. Mentors must be trained and there is online training for mentees. Mentees choose their own mentors. So far the RCPL has not found a way of badging the standards of mentoring training, however the European Mentoring and Coaching Council was suggested as one possible means of doing this. This scheme is working towards excellence not supporting remediation.

- **Academy of Medical Sciences Model**
  It is a light touch scheme. Mentees can select a Fellow – all Fellows are potential mentors. There is some training available. It is not near peer. They recommend choosing a mentor outside their own institution. Mentoring meetings should take place 3-4 times a year and the relationships tend to last 2-3 years. They can have a no blame "divorce "if it doesn't work out. This scheme is working towards excellence not supporting remediation.

- **GPs in Midlands/RCGP**
  Mentors trained and meet 5/6 times a year. Those referred can be "good doctors in a bad place" e.g. health/personal issues and the mentors help them find a way to succeed and continue in the workplace.

## 4. Discussion

Set out below are key points from the general discussion:-

Overarching issues

- The definitions and language need to be clarified. What do we actually mean by mentoring? How does it relate to coaching, supervision, buddying etc.?
- In essence are we talking about
  - Support and guidance sought by a mentee on a voluntary basis on their personal development and career progression or
  - Professional support linked to the workplace and properly resourced to support development of skills and expertise particularly at points of career transition?
- Whether mentoring should be seen as entirely voluntary or a mandatory employer requirement at employer level depends on what is meant by mentoring on what was meant.
- There was broad consensus that the personal development support had to be voluntary whilst workplace transition support should be a requirement for employers and individuals
- There was a clear view that mentoring was not the same as clinical supervision which might be required irrespective of mentoring.
- Mentoring is not a performance management tool
- Employers need to buy in to mentoring – although employers say that mentoring on appointment this may be somewhat ad hoc in many cases.
- Whilst there was support for mentoring a query was raised over the evidence for mentoring being effective/cost effective.

Issues of detail

- Is there support for developing a formal process for mentoring after appointment to a consultant post?
- A selection and matching process is needed
- There needs to be the option of a “no fault divorce”
- Engagement is key and ensures motivation.
- Cross specialty mentoring should be one option.
- Developing coaching/mentoring skills in trainees will have benefits down the road

## 5. Points raised which require further clarification

It was recognised that if proposals for mentoring were to be taken forward the following issues would need to be addressed:

- What is the purpose and objective of mentoring?
- Clarifying the balance between striving for excellence and supporting doctors in difficulty
- What is the offer for the mentee?
  What is the offer for the mentor?
  What is the offer for the employer?
  What is the offer for the patients?
- The voluntary/mandatory tension.
- Who is the offer for? – All doctors, doctors in training, doctors at transition?

- Should there be a pilot/pilots?
- How this will be resourced and promoted needs further clarification?
- Terminology needs to be agreed
- A formalised process with common principles needs to be made available

**6. Conclusions**

- There was general consensus over the value of mentoring with some disagreement on terminology which needs to be unpicked
- There should be a general expectation that mentoring is usual practice especially at transition points. The support needs to be given at employer level but employers will need help to make this a reality.
- Employer based mentoring should not preclude external personal development mentoring provided by professional organisations
- Further work should be undertaken by the group to take forward and develop principles for mentoring schemes

**7. Next steps**

1. A draft set of principles for mentoring (based on the above points) will be developed and circulated for consideration electronically
2. The Group would then to meet again to agree a document and consider how it could be taken forward and promoted by Colleges, UK Governments and employers

# Annex 9
# SAS doctor questionnaire in Scotland

## SAS Doctors in Scotland – Questionnaire

Report from the Shape of Training Implementation Group in Scotland describing the results of a questionnaire that has been undertaken of SAS doctors for recognition of skills acquired through funded workplace based training.

**Background**

1. The Shape of Medical Training Review (SoTR) was established by UK Ministers for Health to consider how medical training could better need the present and future needs of patients. The review group reported their findings in October 2013 making 19 recommendations. (http://www.shapeoftraining.co.uk/reviewsofar/1788.asp)

2. The report recognised that the needs of patients in the UK are changing. In particular an ageing population will lead to more patients with multiple co-morbidities. This in turn will require more doctors to have and maintain generic skills to enable them to work within integrated models of care.

3. The Review considered all aspects of medical training including the needs of doctors who are not in formal training programs. In this context recommendation 17 specifically applies to SAS doctors. It states:

> "Appropriate organisations should review barriers faced by doctors outside training who want to enter a formal training program or access credentialed programs"

The SoTR further stated in relation to SAS doctors that:

> Para 129 they should also be offered opportunities to enter or return to training throughout their careers. They should also be given access to credentialed training.
>
> Para 130 Credentialing will give opportunities to SAS doctors to further develop in their specialty or move into other practice areas.
>
> Para 131 there will continue to be a need for an equivalence route onto the appropriate registers.

4. In response to the report UK Ministers convened a steering group (UK Shape of Training Steering Group UKSTSG) tasked to consider the implications of implementing the recommendations and to provide appropriate policy advice. The key function of the UKSTSG is to maintain a UK consensus where that is necessary in areas such as curricula development.

5. In the first instance, the UKSTSG initiated a number of workshops of which one was devoted to exploring the training requirements of SAS doctors. It concluded that measures were required to better develop and utilise the skills of SAS doctors. The UKSTSG asked the Welsh and Scottish Implementation groups to take this work forward as follows:

> "measures to be scoped out, based on evidence collected through pilots, how to further develop the careers of doctors who are outside formal post graduate training and who are not consultants such as SAS doctors".

**SAS Doctors**

6. Approximately 20% of doctors are not in training or on the GP or specialist Register. These doctors make an important contribution to health care across the UK.

7. The scope and complexity of care delivered by these doctors varies. Some with specific competencies currently deliver care equivalent to that of Consultants.

8. It is of note that current and future trainees are seeking flexible, part time working with the opportunity to take career breaks. In this context, non-Consultant career posts may become increasingly attractive especially if they are developed.

9. The NHS requires to ensure that all staff can contribute "to the top of their competence". In relation to SAS doctors this means ensuring that they can fully use the skills that they already have and to support them developing new skills. The SoTR specifically recommended that SAS doctors should be able to access credentialed training.

**Purpose of this paper**

10. The purpose of this paper is to describe the work to date and to outline the results of a survey that has been undertaken of SAS doctors in Scotland about how best to recognise skills and enhance career development opportunities.

11. In the first instance officials from the Welsh and Scottish Governments met with a representative from the GMC to discuss the specific recommendation that SAS doctors should have access to credentialing training. It was concluded that given the anticipated length of time that it will take to implement credentialing it would be reasonable for the Medical Education & Training bodies in each country to develop an interim recognition/accreditation process.

12. There is a willingness by both Governments to consider measures that would enhance the training and careers of SAS doctors. In the context of the Shape of Training Review, two specific measures have been proposed. The first would involve the development of a process to recognise specific skills that SAS doctors already process. Such recognition should be "portable" and allow the doctor to deploy the expertise/skill in independent practice.

13. The second proposal involves the development of training modules for SAS doctors based upon local and National Service needs. As in the first initiative, a method should be developed to recognise any additional skill.

14. In order to test whether there would be an appetite among SAS doctors for these proposals, a questionnaire-based survey was undertaken of the approximately 1000 SAS doctors in Scotland (SAS Dentists were excluded). Participants were identified from the databases held by NHS Education for Scotland (NES) SAS Educational Advisers. The response rate was approximately 25% (246 respondents). The results are presented in embedded document at the end of this document.

15. In brief, the survey shows that approximately 60% of the 246 respondents believe that they currently process a specific skill that could be formally recognised. Overall, 83% of respondents would be interested in undertaking a workplace-based training programme, and 87% would value an accreditation process in Scotland that formally recognises enhanced skills. Approximately three quarters of respondents remained interested if the process involved an end of training assessment.

16. These results suggest that, as a minimum, over 200 SAS doctors in Scotland would be interested in a process that recognised their current skills/competencies or allowed them to develop skills that would be formally recognised. On this basis, it is concluded that the development of these measures could make a substantial additional contribution to patient care in Scotland.

17. In considering options it has been assumed that the current process that allows SAS doctors to gain access to the specialist register via CCT/CESR will remain.

18. The UKSTSG are invited to note the results of the questionnaire and to consider the implications.

**Scottish Government Health Workforce Directorate**
**June 2016**

**Scottish Government SAS Survey Report – March 2016**

The purpose of the questionnaire was to determine whether there was appetite from amongst Scotland's SAS Doctors for recognition of skills acquired through funded workplace based training.

The questionnaire was sent out to approx 1000 SAS Doctors (1300 SAS grades minus SAS Dentists) through the databases held by our SAS Educational Advisers. The response rate was 246, which is approx 25% of SAS Doctors in NHS Scotland.

Responses were received proportionately from all grades of SAS Doctors, in all specialties (except laboratory specialties) and all Health Boards areas (except NHS Orkney, Shetland and Western Isles, which may reflect that currently there is no SAS Educational Adviser in post covering these areas).

**Survey Question Responses**

While Scotland has already recognised that more needs to be done to recognise and improve the training and development opportunities for SAS doctors, as evidenced through sustained Scottish Government funding of the SAS Doctors Training and Development Fund, the Shape of Training review has provided further impetus on how best to address barriers to medical training.

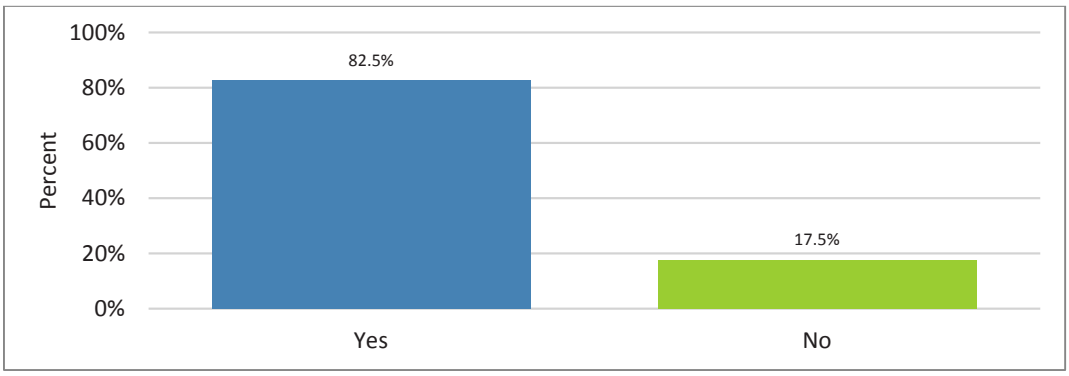
As you will be aware, the Shape of Training Review made the following recommendation.

Recommendation 17:*"Appropriate organisations should review barriers faced by doctors outside of training who want to enter a formal training programme or access credentialed programmes"*

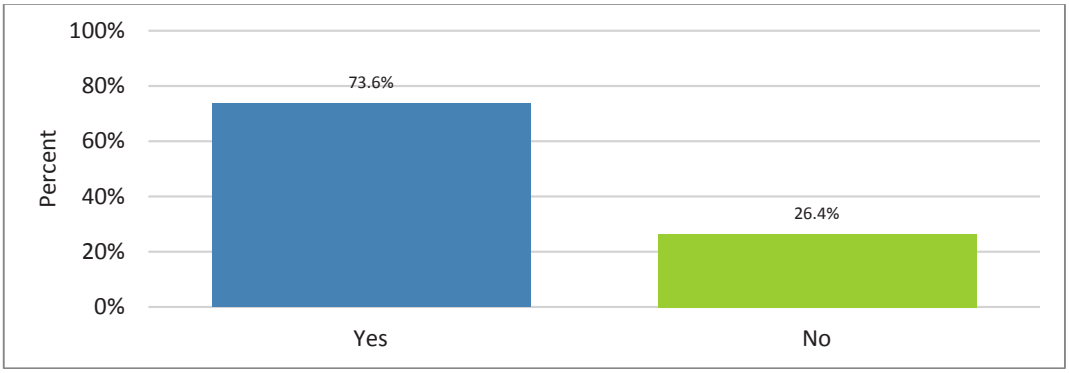
In taking forward consideration of the review's 19 recommendations, this recommendation has been widened to include a consideration of measures to enhance the careers of SAS doctors in general.

It has been proposed that workplace-based training programmes could be developed for SAS doctors allowing them to develop specific enhanced skills that they do not currently have and which would improve delivery of patient-centred NHS Board services. A process for the recognition of these skills would be developed that would allow the doctor to work independently within that skill set.

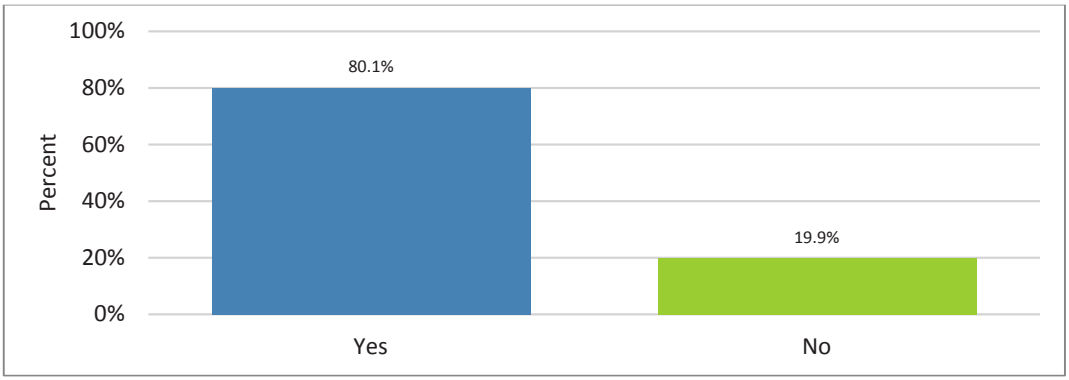
**Q1) In principle, would you be interested in undertaking such a workplace-based training programme?**



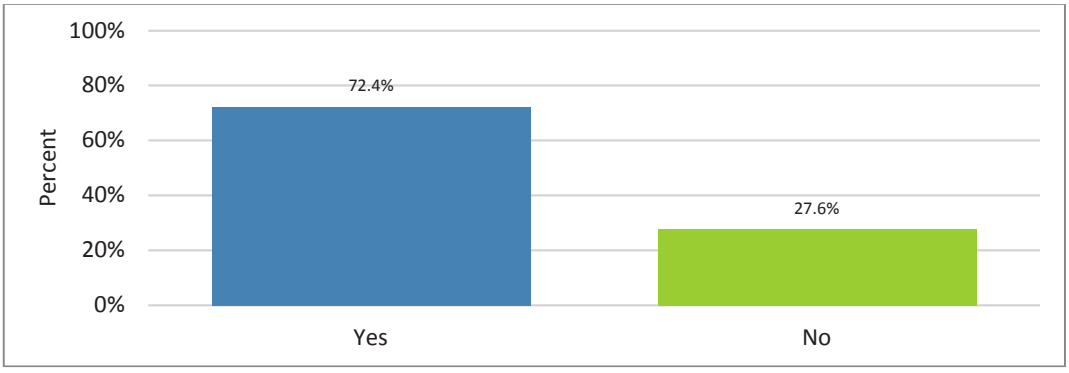
**Q2. Would you be interested in undertaking such a programme if it involved training out with your current workplace assuming reasonable financial support?**




**Q3. Would you be interested in undertaking such a programme if it involved an assessment by log book review or other continuous assessment?**




**Q4. Would you be interested in undertaking such a programme if it involved a formal end of training assessment?**



**Q5. Can you identify an area of training that you would wish to undertake? If so what?**

There were a large variety of suggestions here some of which we have quoted below.

*"Enhanced surgical skills"*

*"Leadership and management training"*

*"Teaching training, rather than specialty/sub-specialty training"*

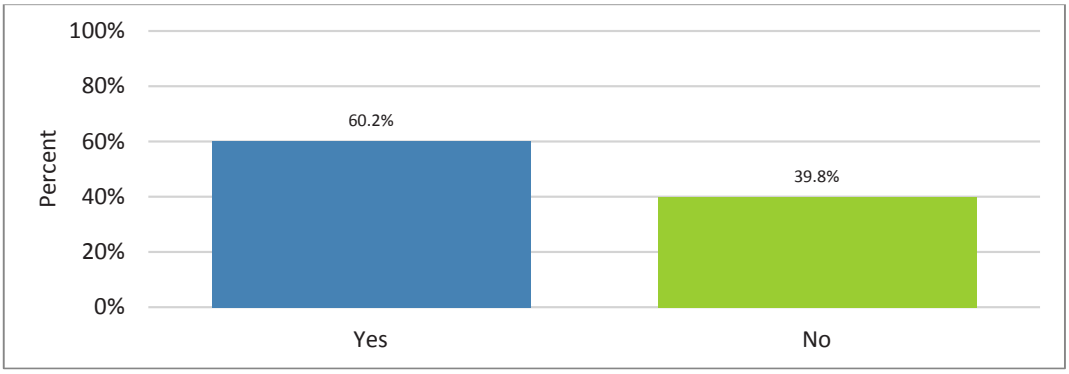
*"Ultrasound and laparoscopy"*

*"Oncology and oncoplastic procedures"*

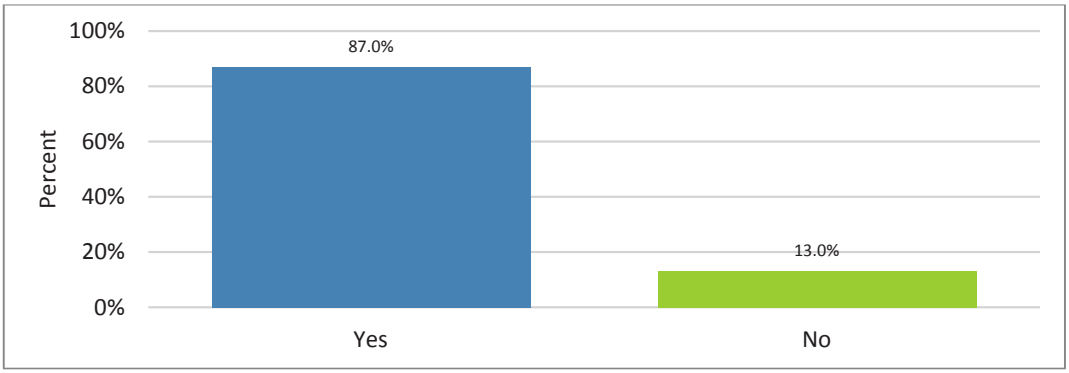
*"Regional anaesthesia"*

**Q6. A number of SAS doctors already have specific enhanced skills that at present are not formally recognised or are transferable to another employer. It may be that these skills at present are not being fully utilised. It has been proposed that a process should be developed to formally recognise such skills i.e. via an accreditation-type process.**

**a) Do you have skills or an area of practice that could be formally recognised?**




**b) In principle, would you value an accreditation-type process in Scotland that formally recognises enhanced skills?**



**c) If not an accreditation-type process in Scotland, what alternative model(s) would you find acceptable? Please briefly describe.**

*"It would be good if there was a provision for SAS Doctors to be recognised based on the experience, rather than their qualifications/exams".*

*"The Associate Specialist grade should be re-opened with the same criteria as before, to allow career development, improve recruitment and retention and make NHS Scotland an attractive place for SAS Doctors to work".*

*"Recognition of experience and use of Appraisal in assessment".*

*"Any potential accreditation process in Scotland, should be the same as the one in the rest of the UK".*

The results of this survey show that this group of SAS Doctors are keen to develop their skills and competencies and interested in any Scottish Level Accreditation of skills that might be developed.

It is clear on discussion within the board areas that many SAS Doctors are unfamiliar with "Shape of Training" and were unaware about proposals within that document. They felt that it did not relate to them as SAS grades and have not attempted to find out more information.

We added the opportunity to provide some free-text comments to the answers which are summarised as above, under the relevant headings.

Of those not interested in a Scottish level accreditation system the themes that emerge are

- Some SAS chose the grade due to other commitments or have developed within the grade without the need for formal accreditation; some of these are already practicing independently within their service or have gained a place on the specialist register through CCT /CESR.
- Those who had concerns about how such accreditation might be viewed in the rest of the UK.
- Some who felt that we should develop Specialty Doctors using a career progression model such as that from Staff Grade to Associate Specialist, with career development relating to the experiential accrual of skills and competencies.
- Concerns around cost and complexity of any such system.
- No mention of any Royal College involvement- would such be recognised by the colleges?
- Might this be a parallel but less creditable route to career development than CESR?

This survey has shown evidence of support for development opportunities within Scotland for SAS doctors. Both those who expressed an interest in these proposals and those with misgivings were keen to find out more about the detail of them.

The SAS project, with the existing network of SAS peer advisers placed within all the boards, would be keen to be involved in any further development or consultation work in this area.

# Annex 10
# SAS Doctor Development Guide England

## SAS doctor development

### Summary of resources and further work

February 2017

Academy of Medical Royal Colleges

BMA

NHS Health Education England

NHS Employers

# Contents

# Introduction

Sustaining good quality services to patients requires doctors to be up to date and fit to practice. The personal development needs of doctors are a vital part of that.

The British Medical Association (BMA), Health Education England (HEE), the Academy of Medical Royal Colleges (The Academy) and NHS Employers (NHSE) have worked together to produce this guidance on the development of specialty and associate specialist (SAS) doctors in the NHS in England, to help ensure that this important group of doctors are helped to remain fit to practice and develop in their careers.

This guide describes actions that can be taken to ensure that best practice is applied in the development of SAS doctors and dentists, and how different groups can work together to ensure best practice is consistently applied.

It is useful and appropriate to anyone involved in the development of SAS doctors, such as employers, medical royal colleges, HEE's local team and SAS doctors themselves. Specific sections are targeted at:

- NHS boards
- medical directors
- medical staffing teams
- SAS doctors.

The principles set out can also be applied to dentists working in the SAS grades and other doctors who are not in training and whose appointment does not require them to be on the General Medical Council's (GMC) specialist register, eg trust grade doctors. In applying the principles to a broader group of doctors, appropriate funding arrangements will need to be made.

## BACKGROUND

SAS doctors and dentists are a diverse group with a wide range of skills, experience, and specialties. They work as staff grade doctors, associate specialists, specialty doctors, hospital practitioners, clinical assistants, senior clinical medical officers and clinical medical officers.

Ensuring that SAS doctors receive effective development will benefit patient safety and employers, as well as the individual doctor. Good patient experience is strongly associated with a motivated and engaged workforce where every individual has the opportunity to work at their full potential. Investing in development is a step to achieving that which will inevitably better equip these doctors to meet the needs of the service and improve patient care.

For SAS doctor development to succeed, it is important that they receive effective annual appraisals, revalidation every five years, study leave, and mutually agreed job plans including agreeing appropriate supporting professional activity (SPA) time.

To assist this, NHS Employers has produced guidance for employers on Improving SAS appraisal.

This includes practical advice based on feedback, ideas and experience from SAS doctors themselves. It also sets out the steps that employers can take to acknowledge and develop SAS doctors' skills.

## CHARTERS

To demonstrate a shared commitment to supporting and developing the role of the SAS doctor as a valued and vital part of the medical workforce, each nation has developed a charter for SAS doctor development. The charters, according to nation, set out what SAS doctors can expect from their employer and what the employer can expect from them.

Looking forward, the NHS Five Year Forward View describes a number of new care models for the NHS in England that aim to break down the traditional divides between primary, secondary and community care, mental health and possibly social care. In the context of these changes to the current ways of working, the development of SAS doctors becomes even more pertinent.

## SURVEY AND WORKSHOPS

The BMA, HEE, the Academy and NHS Employers worked in partnership in early 2015 to run a survey about SAS doctor development and deliver four regional workshops. The survey and the workshops focused on the professional development aspirations of SAS doctors. Our key aims were:

- identification of SAS doctor development and career progression aspirations
- identification of what SAS doctors need to achieve these aspirations
- full and shared understanding of perceived barriers to development
- to produce a list of suggested facilitators to overcome barriers to development
- to develop top key messages to support improvements in SAS doctor development
- to identify potential local actions that can be implemented to improve development
- to showcase best practice
- publication of SAS doctor development tools to spread good practice
- clarification of the role of SAS tutor
- engagement with medical managers.

A total of 403 SAS doctors completed the survey. The findings show many positive aspects of SAS development, for example:

- 82 per cent said they work at a level appropriate to their competences/ experience
- 67 per cent said they receive due recognition of their competences/ experience
- 93 per cent said they receive a good, regular appraisal
- 74 per cent said they have an agreed job plan.

However, the survey also flagged some challenges:

- 10 per cent said they do not have any SPA time in job plans – and, in some cases, where SPA time had been agreed, it is blocked or cancelled for service reasons and not re-scheduled
- although 94 per cent get funded study leave, only 56 per cent utilise their full allowance
- only 60 per cent said they get appropriate time for revalidation and appraisal evidence gathering.

During the workshops, people spoke about good practice, but also raised the issue of a lack of consistency in how SAS doctors have been developed and supported across the country. Workshop participants, many of whom were SAS doctors, suggested areas where improvements could be made, reflecting the issues from the survey.

## AUTONOMY

Many SAS doctors already work as autonomous practitioners. There are a number of benefits to encouraging and enabling autonomous practice, where it is appropriate. These can include:

- recognition of the high level of clinical skills and professionalism in the SAS doctor/dentist grade
- provision of personal and professional development opportunities for SAS doctors/dentists within the trust/organisation
- the opportunity to have greater medical engagement of SAS grades
- support for the recruitment, retention and motivation of highly skilled clinicians
- improved governance and accountability.

In the interest of patient safety, all NHS staff are subject to some form of supervision, but there is no contractual requirement for SAS doctors to be supervised by consultants.

In practice, the level of supervision, if any is required, will depend on a number of factors, including personal competence and agreed accountability arrangements for all aspects of the role. The Academy's Guidance for taking responsibility points to areas where senior SAS doctors have the expertise and ability to be the responsible clinician for patients. Trusts' clinical governance arrangements should reflect this guidance.

The BMA has produced a guide on autonomous working.

## CERTIFICATE OF ELIGIBILITY FOR SPECIALIST REGISTRATION (CESR)

Many SAS doctors are keen to progress their careers by obtaining a certificate of eligibility for specialist registration (CESR) or GP registration (CEGPR) and qualifying for the GMC's specialist register. To do this, SAS doctors will need to demonstrate that they have the same level of skills as a certificate of completion of training (CCT) holder.

E-portfolios are available for SAS doctors applying for CESR/CEGPR, and are a good way to log all evidence of experience, however further work is required to develop these.

Currently the following e-portfolios can be used by SAS doctors:

- Royal College of Emergency Medicine
- The Intercollegiate surgical curriculum portfolio
- Royal College of Obstetrics and Gynaecology
- Royal College of Ophthalmologists
- Royal College of Paediatrics and Child Health
- Joint Royal Colleges of Physicians Training Board
- Royal College of Psychiatrists
- Royal College of Radiologists (on request)

### Routes to CESR

There are routes by which a SAS doctor can apply for a CESR/CEGPR. Details of these are available on the GMC's website:

General information on applications

Specialty specific guidance

It is expected that employers will assist SAS doctors in meeting the requirements of a CESR/CEGPR application, whether this be through offering secondment opportunities, support when sitting exams or releasing the applicant from their post for a period of time to undertake top-up training.

Further work to simplify and streamline the CESR/CEGPR route is being carried out by the GMC.

## DEVELOPMENT OPPORTUNITY IDEAS

Career advancement and progression is of key importance to SAS doctors and it is often necessary for them to gather evidence of continuing professional development to use as evidence in a CESR/CEGPR application.

There are successful local training programmes that are currently active for SAS doctors commissioned by HEE. Through its local teams, HEE will be considering innovative ways to progress training for SAS doctors. Engagement with associate deans, SAS tutors, SAS doctors and local service providers will be important here. HEE will also aim to address obstacles to training which directly affect SAS doctors.

## EXTENDED ROLES

### Educational supervision

The GMC's guidance is clear that the educational supervisor has to be an appropriately trained doctor, as only they can supervise other doctors, but they do not need to be on the specialist register to fulfil this role. There are already many SAS doctors successfully working in these roles.

### Management roles

It is important to recognise the ability of SAS doctors to work in medical manager roles in the trust, for example as medical director, clinical director, or to attend trust clinical management meetings. SAS doctors should be eligible to apply for these opportunities.

### Appraisal roles

SAS doctors should be able to put forward to carry out roles as appraisers of other doctors and be given training to do so.

### Coding/tariffs for clinical activity

Accurate patient coding is important for a number of reasons:

- it is good medical practice for patients and their families to know the name of the senior doctor in charge of caring for a patient
- a reliable record of activity is important for revalidation
- for appraisal and pay progression to accurately audit who has undertaken what work
- for staff morale and job satisfaction.

The NHS e-Referral Service has a patient coding functionality which enables the coding of named clinicians, including SAS doctors. In some hospitals, where patients are under the care of a SAS doctor, this is accurately reflected in the local records, however this can be sporadic. Further work is needed to ensure this becomes common practice across the UK.

The BMA has published guidance on coding and the NHS e-Referral Service.

NHS Digital has confirmed that it is possible to code work to SAS doctors.

## CONTRACT/PROGRESSION

NHS Employers and the BMA will continue to maintain the terms and conditions arrangements, including the effectiveness of progression through the specialty doctor grade, through the joint negotiating committee (SAS). Any re-negotiation of the terms and conditions arrangements will take place through formal negotiations.

NHS Employers and the BMA are committed to considering the best way to ensure that pay progression thresholds properly reflect progression within the specialty doctor grade.

## CREDENTIALING

The GMC's plans for a system of credentialing are about the formal accreditation of attainment of competences in a defined area of practice, while not overlapping or competing with existing specialty or sub-specialty training programmes. This will help SAS doctors to obtain accreditation for specific skills and expertise.

The GMC has produced further information on credentialing.

## DEFINING THE SAS GRADE

At workplace level, the capabilities of SAS doctors must not be based on outdated ideas and prejudices or be unnecessarily restricted in hierarchical ways, or there is a risk that there is a detrimental effect on the recognition of SAS doctors and the value of the skills and expertise that they offer.

Outdated ideas and prejudices should be challenged, and a more concerted effort made to recognise SAS doctors, for example, it may be possible to make appropriate consultant roles available to experienced SAS doctors.

The partners are working together to better understand the number and characteristics of SAS doctors nationally, which will further illustrate the extensive important roles of SAS doctors in the NHS.

## CONCLUSION

The national partners will continue to promote measures to improve the development of SAS doctors with improved access to development resources and opportunities.

## NATIONAL RESOURCES

**Information on SAS charters:**

BMA NHS Employers

**Information on job planning:**

BMA NHS Employers

**Guidance for employers on improving SAS appraisal:**

NHS Employers

# SAS doctor development – actions

## ISSUE

SAS doctors are a diverse group with a range of skills and abilities. SAS doctors make up about 20 per cent of the secondary care workforce (there are almost 20,000 doctors in the UK who are not on the GMC's specialist register or in training but fulfill the criteria of being SAS doctors), but there are fewer opportunities for SAS career progression compared with other senior doctors, and the development of SAS doctors is not always afforded the same attention.

## WHY IT MATTERS

Effective SAS doctor development leads to a more motivated and engaged workforce where every individual has the opportunity to work to their full potential. This inevitably equips these doctors to better meet the needs of the service and improve patient care. Investment in the development of the SAS workforce should always be considered as a possible route to support local workforce plans and resolve skills shortage issues alongside output from national medical training programmes.

# Actions for boards

## WHAT BOARDS SHOULD DO

Board members should consult regularly with SAS doctors to understand the work they deliver and any necessary support they need.

Boards can ask their medical directors to report on a range of measures to gain assurance that the trust is optimising the use of the skills and abilities of their SAS doctor workforce. These include the proportion of SAS doctors who:

- receive an annual appraisal
- are trained and acting as appraisers
- have personal development plans which are supported and monitored
- have a mutually agreed job plan
- have a minimum of one supporting professional activity in their job plans
- make use of their agreed study leave
- received an induction on appointment
- were offered mentoring on appointment.

In addition to collecting this data, boards must ensure that the data is analysed to identify any issues of concern. Plans should be developed and implemented to address any issues of concern.

Additionally, as a part of their standard processes, boards should ensure that:

- clinical activity is coded to the individual who performed that work
- there is a system in place to identify SAS doctors
- trust documentation has a tick box for SAS doctors (not just 'other' category).

Beyond this, we recommend that:

- SAS doctors are actively encouraged to apply for management roles and appropriate consultant posts or roles
- derogatory terminology such as 'middle grade' is not used across the trust
- the SAS Charter is implemented across the trust
- where SAS doctors are successful in appointment to management roles and appropriate consultant posts, they are supported to carry out these roles
- there is appropriate representation of SAS doctors on relevant medical committees
- a SAS tutor is appointed
- SAS doctors receive clinical supervision where appropriate
- SAS doctors work autonomously where appropriate, in line with the Academy's Guidance for taking responsibility.
- SAS doctors have agreed supporting professional activities (SPA) time in their job plans appropriate to their needs.

## RESOURCES

**Information on SAS charters:**

BMA NHS Employers

**Information on job planning:**

BMA NHS Employers

# Actions for medical directors

## WHAT MEDICAL DIRECTORS SHOULD DO

### Appraisals

Ensure that SAS doctors have up-to-date appraisals each year. This can help provide evidence of a SAS doctor's current level of practice, and is an essential basis for medical revalidation.

### Autonomy

Recognise that, where appropriate, SAS doctors can work autonomously in line with the Academy's Guidance for taking responsibility and ensure that local policies take account of this guidance.

### Charter

Pro-actively support implementation of the principles set out in the SAS charter.

### Certificate of Eligibility for Specialist Registration (CESR)

Support SAS doctors in CESR applications where there is a service need that can only be met through increasing the consultant workforce. This could be by supporting progressive development within the post, by considering job swaps or opportunities in other departments, or by helping doctors to gather the necessary evidence to apply.

### Other development opportunities

Identify new ways of working that can help to bridge workforce and skills gaps without the need to grow the consultant workforce. Medical directors may wish to consider how their existing SAS workforce may be able to fulfil that need alongside any development needs that may be required to enable them to fulfil new or enhanced roles, including educational supervisor and appraiser.

### Coding/tariffs for clinical activity

Ensure that clinical activity is coded accurately to the individual who performed the clinical activity. This is important for patient safety and clinical governance. Revalidation systems should include the ability to view a doctor's full scope of work, as per the revalidation support team's Information management for medical revalidation in England.

### Hierarchy

Challenge ideas about the capability and characteristics of SAS doctors that are based on outdated prejudices. Make appropriate consultant posts open to applications from experienced SAS doctors. This could be substantive consultant posts for SAS doctors on the specialist register, or locum consultant posts which do not require post-holders to be on the specialist register.

## Management opportunities

Ensure that eligible SAS doctors are encouraged to apply for management, leadership, training and research roles such as: appraiser, educational supervisor, SAS tutor, clinical director, medical director, and governance lead. Doctors will benefit from taking advantage of these opportunities and employers will benefit from a greater proportion of the workforce supporting wider organisational objectives. It is good practice to support eligible SAS doctors to apply for such roles.

Ensure effective representation of SAS doctors on committees, for example: clinical advisory, clinical governance, audit, morbidity & mortality, serious untoward incident panels, interview panels, directorate meetings, and the local negotiating committee (LNC).

## Support

Encourage the appointment of a SAS tutor who acts as a voice for SAS doctors and promotes their professional development.

Ensure that SAS doctors are supported by mechanisms for adequate clinical supervision where appropriate and required. This is especially important for SAS doctors below threshold one of the specialty doctor pay scales to support their ongoing development needs. Examples would be case-based discussions and supervisor sessions.

## RESOURCES

**Information on SAS charters:**

BMA NHS Employers

**Information on job planning:**

BMA NHS Employers

# Actions for doctors

## WHAT DOCTORS SHOULD DO

### Charter

Pro-actively support implementation of the SAS charter and to formally present it to the appropriate committee, eg the local negotiating committee (LNC) or clinical advisory committee.

### Appraisal

Take personal responsibility for their annual appraisal, supported by a portfolio of evidence, including patient and colleague feedback, and resulting in clear achievable objectives and a personal development plan (PDP).

Contribute to an effective appraisal process across their organisation and consider how they can be supported to become trained medical appraisers.

Encourage appraisals and motivate other SAS doctors to take part in appraisal.

### Autonomy

Be confident in expressing their ability for autonomous working, or for requesting clinical supervision if required. The Academy's Guidance on taking responsibility, asserts that senior SAS doctors have the expertise and ability to take responsibility for patients without consultant supervision.

### Characteristics of SAS doctors

Be assertive in taking advantage of the opportunities that are available and challenging colleagues when opportunities are not open to them.

Take personal responsibility to take the initiative, for example attending their trust induction, finding out about new service developments and offering their services, being informed about their contracts and the SAS Charter and holding managers accountable. They should take every opportunity to get on email distribution lists for job vacancies and opportunities for additional responsibilities and make the most of their SAS tutor.

### Certificate of eligibility for specialist registration (CESR)

Make use of specialty training curricula when applying for CESR, as these processes are based on the knowledge and competences covered by the specialty curricula.

### Development funding

Make use of available development funding to stay up-to-date with skills and expertise.

### Engagement with seniors

Engage with senior colleagues, for example the medical director, chief executive and manager. They might find it helpful to copy in the medical director on organised SAS activities and invite him/her to attend SAS meetings. SAS doctors will also benefit from forging relationships with tomorrow's consultants.

### Extended roles

Seek to take advantage of extended roles such as management opportunities, educational supervisor and appraiser roles, and challenge colleagues where these are not available.

### Hierarchy

Challenge ideas about the capability of SAS doctors where these are based on outdated prejudices

### Networking with other SAS doctors

Create a strong network of SAS doctors which shares information, raises awareness of opportunities and offers peer support.

### Service provider role/time

Challenge the belief that SAS equals no more than service provision through the pursuit of responsibilities that support wider organisational objectives such as clinical management, appraiser, educational supervisor etc.

## RESOURCES

**Information on SAS charters:**

BMA NHS Employers

**Information on job planning:**

BMA NHS Employers

# Actions for medical staffing/ human resources

## WHAT MEDICAL STAFFING COLLEAGUES SHOULD DO

### Charter

- Encouraged to support implementation of the SAS charter.

### Appraisal

- Ensure all SAS doctors have an effective annual appraisal, supported by a portfolio of evidence, including patient and colleague feedback, and resulting in clear achievable objectives and a personal development plan (PDP).
- In line with the medical appraisal guide, appraisals should be carried out by trained medical appraisers rather than by the doctor's immediate line manager. After three successive appraisals by a single appraiser, a new appraiser should be allocated to that doctor.
- Consider how SAS doctors can contribute to the effective appraisal process across their organisation and how they can be supported to become trained medical appraisers themselves.

### Definition of grade/terminology/ identification

- Recognise the SAS grades as grades in their own right and as positive career choices. Ensure that derogatory terminology such as middle grade, non-training grade, non-training doctor, non-consultant career grade (NCCG), are not used on rotas and other communication.
- Trust documentation such as drug charts, X-ray forms and operation booking cards should have tick boxes for SAS doctors and not include SAS doctors in an 'other' category.
- Put in place a system to identify new and existing SAS doctors so medical staffing departments are aware who their SAS doctors are.

### Development opportunities

- Everyone benefits from SAS doctors receiving appropriate supporting professional activity time and study leave for revalidation preparation and continuing professional development (CPD).
- Work closely with local education and training boards (LETBs) to address training needs locally and to offer formal training pathways where appropriate. Employers might consider organising cross cover or rotating attendance at training days to ensure that all SAS doctors have the opportunity to attend.
- It is good practice to support and monitor progression against personal development plans.

### Facilities

- It is helpful to provide appropriate facilities and supporting resources as per the SAS job planning guide.

### Hierarchy

- Challenge ideas about the capability of SAS doctors that are based on outdated prejudices. Open up appropriate consultant posts to experienced SAS doctors. This could be substantive consultant posts for SAS doctors on the specialist register, or locum consultant posts which do not require post-holders to be on the specialist register.

### Induction

- It is good practice to ensure that all new doctors, including SAS doctors, take part in an induction programme and are offered mentoring.

### Job planning

- As per the terms and conditions, SAS doctors should have a mutually agreed, adhered to, job plan which is logged with HR. Those doctors who do not have a job plan will benefit from support to achieve this. Boundaries around supporting professional activities (SPAs) need to be recognised. It is good practice to use the time available in job plan reviews to ensure effective career discussions take place.

### Recruitment

- SAS doctors should be involved in the recruitment of other SAS doctors.

### Service provider role/time

- Employers and doctors are encouraged to challenge the belief that SAS equals no more than service provision. It is good practice to support SAS doctors to take their agreed study leave. In addition, SAS doctors should have one SPA minimum in their job plan and should be able to use their SPA time for the activities set out in the terms and conditions.
  See the SAS job planning guide for more information.

### Support

- SAS doctors should be included on trust email lists for job vacancies and opportunities for additional responsibilities that have traditionally been shared only with the consultant workforce in some trusts.
- The job plan review should identify and agree the supporting resources that are necessary if the objectives are to be met. For more information on supporting resources see Chapter 4 of the SAS job planning guide.

## RESOURCES

**Information on SAS charters:**

BMA NHS Employers

**Information on job planning:**

BMA NHS Employers

# Case Study 1: Associate dean for SAS doctors

## BACKGROUND

Dr Peter Khin Tun, associate postgraduate dean for SAS doctors, Health Education England, is responsible for SAS tutors and doctors across the Thames Valley region.

His duty is to act as a champion for the SAS doctors in the region and lead on developing a strategy for educational development and provision of support and encouragement for SAS doctors to achieve their desired professional goals to become:

- highly skilled senior clinicians
- leaders
- specialists
- educators
- researchers for improved quality and safety of patient care.

## ACHIEVEMENTS IN THE ROLE

- Annual budget planning in liaison with the HEE finance and business manager over the last three years, with new challenges in the last six months due to NHS/HEE financial restraints and a review of cost effectiveness of the SAS doctors development project, which started in 2008/9 with an annual budget of £250,000.
- Understanding the needs of the SAS doctors and tutors in the region.
- Annual appraisals of SAS tutors (eight in the region).
- Quarterly SAS tutors and SAS representatives meetings.
- Communications and sharing information among SAS tutors and on to all SAS doctors in each trust.
- Organisation of biannual Oxford deanery SAS doctors development days.
- Production of guidelines on the use of SAS doctors' development funds and agreement with the career development/ professional support unit for coaching of SAS doctors in difficulty.
- Attending and actively participating in national meetings for SAS doctors.
- Safety and quality – undertaken educational and clinical supervisor training and equality and diversity training.

## SUPPORT AND OBSTACLES TO THE ROLE

Advice from the dean and associate deans, directors of medical education, trauma and emergency care managers, and head of schools as well as coaching was of great help in the role.

A lack of combined study/professional leave (to 10 days a year) limit deanery activities and special leave was negotiated.

A frequent change of management and financial restraints, lack of meaningful engagement of HEE leads and continuing professional development opportunities of SAS doctors remain challenges in finding new ways to develop the 493 SAS doctors in the Thames Valley region.

# Case Study 2: Night rota competent (NRC) night safe

## BACKGROUND

In order to address challenges that hospitals in the Wessex deanery area faced around achieving safe staffing levels and implementing safe rotas, the Wessex deanery provided extra training for SAS doctors to enable them to become senior decision makers during the night ie become night competent.

## AIMS

- Focused training to develop skills required on a night rota.
- Improve patient safety.
- Provide training without depleting departments of their staff.

## PROGRAMME DETAILS

- Funded by Wessex deanery.
- 12 SAS doctors per programme.
- Content focused on Royal College of Emergency Medicine curriculum.
- Two programmed activities per fortnight over four months.
- Training covered pathways for the treatment of the top 10 medical presentations.
- Eight sessions in total:
    - interactive session 1
    - sim session 1
    - interactive session 2
    - sim session 2
    - sim session 3
    - patient safety
    - interactive session 3
    - leadership day.

## OUTCOME OF PROGRAMME

- Hospitals in the area function with safe rotas during out of hours.
- Provided effective professional and personal development for SAS doctors.
- Currently in its third cohort.

# Case Study 3: Health Education England training programme

## BACKGROUND

Health Education England working across the Thames Valley has gained a national reputation for its support programme for SAS doctors and dentists. The system in place is well organised and transparent. There is a strong tradition of providing practical pastoral care for SAS doctors: mentoring schemes, career guidance, help for doctors in difficulty, through professional support unit (PSU).

Delivering emergency care (EC) in the UK is challenging on many fronts, particularly with regards to recruitment and retention. A multi professional, interdisciplinary emergency care task force was formed to develop educational solutions to support the sustainable delivery of quality emergency medicine care.

## THE TRAINING PROGRAMME

The aim is to provide a programme of protected training to support completion of fellowship of the college of emergency medicine (FCEM) and certificate of eligibility for specialist registration CESR. The programme started in October 2014 and 16 doctors have been recruited so far.

- Funding: one professional activity per week paid, in recognition that the doctor will attend 12 training days per year, and an additional 14 days to consolidate their learning and undertake various management, research and training opportunities.
- Duration: three to five years, depending on needs to obtain competency in uncovered area like intensive therapy unit (ITU), anesthetics.
- The formal training programme will consist of 12 days ayear.
- Cover important aspects of the FCEM and the management portfolio.
- Develop the doctor's skills in clinical topic review (CTR), management projects, appraisal skills, leadership and service improvement methodology.
- A formal annual review of progress and quarterly informal progress reviews with educational supervisor and project lead.
- This training includes the equivalent of £2,000 study leave budget.

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# Annex 11
# Process for ensuring that curricula in the future meet the principles of the Shape of Training Review

**Proposal for the process whereby curricula changes for postgraduate medical training will be reviewed to ensure change fulfils the principles and benefits envisaged from adoption of the recommendations within the Shape of Training Review (SoTR).**

**Purpose of this paper**

1. The purpose of this paper is to outline the process whereby future proposals to amend medical training pathways and curricula are reviewed to ensure that they accord with the key principles and benefits envisaged to accrue from implementation of the SoTR.

**Background**

2. The SoTR was established by UK Ministers to consider how medical training could better meet the present and future needs of patients. The review group reported their findings in October 2013 making 19 recommendations. (http://www.shapeoftraining.co.uk/reviewsofar/1788.asp). In response to the report, UK Health Ministers approved the establishment of a UK-wide Shape of Training Steering group (UKSTSG) to assess the report's findings, and make recommendations on how best to proceed. A key task was working with the Academy of Medical Royal Colleges and the General Medical Council (GMC) to bring forward proposals on how to revise training curricula to meet the requirements envisaged by the SoTR. This is an ongoing process, with some proposals being assessed as more advanced than others.

3. The UKSTSG have now considered in detail two specific proposals relating to new training pathways: for general surgery and general medicine. In determining whether a proposal fulfils the principles and benefits envisaged from the SoTR, the UKSTSG requires to be reassured that the training pathway will equip doctors with the skills and experiences necessary to provide the high quality patient centred care that both patients and service providers will require. Where appropriate, this must include the maintenance of generic skills and the flexibility to enable doctors to move between training pathways.

4. The UKSTSG has confirmed that the proposal for general surgery has fulfilled these requirements. The proposal for a new training pathway for internal medicine is currently being considered by the Group. While the UKSTSG has considered these two submissions, its members recognise it is a short life working group, and that it is necessary therefore to develop a process outwith its core business that enables future submissions to be reviewed to ensure that they accord with the principles and benefits envisaged from the SoTR.

5. It is the General Medical Council (GMC) which has ultimate responsibility for setting the educational standards for undergraduate and postgraduate education and training for all doctors in the UK. This includes providing approval for all training posts and programs as well as approving all postgraduate curricula and their associated assessment systems. All proposals therefore for new or revised postgraduate curricula and training pathways must ultimately be submitted to and approved by the GMC. The GMC have an established process for this, which includes seeking views from NHS employers, and representatives of the Postgraduate Deans across the UK. Currently, all curricula submitted to the GMC for approval originate from UK Medical Royal Colleges and Faculties, but it should be noted that the GMC can consider curricula submitted by any competent body.

6. The SoTR also identified areas of patient need beyond educational considerations that relate to the provision of sustainable clinical services within increasingly integrated care models and the reality of a more constrained financial climate. These elements that impact on the type of doctor that the service needs will not be addressed by only using an educational/professional/regulatory process. In recognising these wider strategic factors, and not least the desire to maintain the continuity of UK-wide medical education, it is therefore proposed that future submissions for curricular change should be reviewed in a two-stage process to help ensure that these broader strategic aspects have been considered before a submission progresses for consideration by the GMC.

**The proposed process for new curricula submissions**

7. At present, all proposals for the recognition of curricula that relate to the development of new clinical disciplines are considered in the first instance by the UK Medical Education Reference Group (Reference group), which operates under the auspices of UK Health Ministers. This is to ensure that such developments are necessary, affordable and consistent with the strategic planning and priorities of the UK Health Departments.

8. Given that this process currently exists, and works well, it is proposed that a similar process be used for the consideration of curricula submitted as a result of developments arising from consideration of the SoTR, and for subsequent iterations where the body responsible for the curriculum puts forward proposals for major curricular change Submissions would require to include a brief accompanying document that describes how the new curriculum fulfils the principles and benefits envisaged from the SoTR. A template will be developed for this purpose. The UK Reference group would convene a small panel (or sub-group) to consider each submission and to make recommendations to the Reference group. The remit of this small panel or sub-group would permit the engagement with relevant Royal College representatives, and to require additional information and amended submissions in order to make a recommendation to the Reference group.

9. This prior consideration process is intended to enable the Reference group to expedite a decision that confirms that individual submissions fulfil the principles and benefits envisaged from the SoTR and has the support of all four Countries of the UK. (the GMC will not approve a curriculum that does not have 4 Nation support although recognises that such a curriculum may not be delivered across the UK ) The Reference group reserves the right to seek further views on any submission prior to giving its confirmation. As at present, all submissions would then be submitted to the GMC for regulatory approval against their established standards for curricula and assessments.[5]

**Recommendation**

10. The UKSTSG are invited to consider this paper at their meeting of the 22nd September 2016.

5 It is noted that the GMC is currently undertaking a review of curricula as assessment standards.






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