



Response to Shape of Training Review

The RCP Trainees Committee has read the Shape of Training Review published by the GMC with interest. We support that training should only take place in high-quality training environments, with an emphasis on service delivery providing meaningful learning and training experiences, rather than just filling rota gaps. It is vital that this is effectively supported with protected time for trainers to train, which happens rarely with current consultant contracts.

It is vital that the Certificate of Specialist Training (CST) is internationally recognised as a benchmark of a fully trained doctor. We support the report's statement that the CST should represent competence to practise independently, and its recognition that 'there is no appetite for a sub-consultant grade'. The suggestion of CST holders working under limited clinical supervision contained within one version of the Shape of Training report that was circulated (this is not present in the version published on the GMC website) should be abandoned to provide clarity and reassurance to future trainees. The public regards consultants as being experts in their field and capable of practising independently, and this primary goal of training must remain.

We appreciate the need for broad-based physicianly training, and are aware of the tension between training doctors who are able to provide safe and effective care within broad specialties versus the increasing need for specialists to provide increasingly complex care within single organ diseases. This tension appears to lie at the heart of the Shape of Training review. The concept of credentialing is an appealing one, allowing trainees to gain particular skills that they are then able to use throughout their career. However, general medicine is a huge specialty to start with; within general medicine all specialties are also extremely large, with many sub-specialties of their own. This adds a level of complexity to credentialing which must be properly thought through prior to any implementation. It is clear that what works for one specialty (such as psychiatry), may not be appropriate for another (such as general medicine).

The concept of flexibility within training, and the ability to transfer competencies between curricula is welcomed. The development of opportunities to follow patients throughout their entire care pathway is to be encouraged as a positive experience for both patient care and training. In order to permit the proposed flexibility with regard to time taken to train, assessment of training should be reviewed to dispel the impression of a paper exercise that currently exists. Competencies must be reviewed rather than merely forms counted. An increasing role for patients in the training of doctors is to be welcomed. Longer placements during training are welcomed, with the proviso that those placements must provide good training.

Training must be rigorously quality assured, with genuine sanctions available to ensure the required quality standard. The time and effort that this will require must not be underestimated. Without careful thought and implementation on both national and local levels as to who will train, and the provision of dedicated time to train for physicianly trainers, the time in training cannot be reduced as indicated in the Shape of Training recommendations. Currently consultants often do not have protected time to train; training is all too often piecemeal and dependent on the goodwill of consultants. A key recommendation is that 'Training should be limited to places that provide high-quality training and supervision, and that are approved and quality assured by the GMC' (Recommendation 9). We feel that the Shape of Training review should state in the strongest possible terms that a key outcome within this recommendation should be the provision of

dedicated training time. There should be an explicit emphasis that trusts with trainees have a responsibility to ensure that such training is provided.

However, training a specialist is more than credentialing a general physician in defined skills, and we feel that specialist training remains important. In the diagram outlining the proposed Shape of Training, there is no indication of when specialist training may occur; instead only credentialing is indicated following the award of the Certificate of Specialist Training. There is little detail in the report as to how specialists will be trained. This important aspect of medical training must not be neglected. Even with an increase in training generalists, specialists will still be required. A clear majority of specialties are already operating beyond capacity, and while training increasing numbers of generalists would reduce some of this pressure there is still a clear need for specialist physicians.

There needs to be clarity with regard to workforce planning such that trainees are clear at the start of their career as to the roles that will be required. We strongly support Recommendation 3: 'Appropriate organisations must provide clear advice to potential and current medical students about what they should expect from a medical career'. Training for physicianly trainees to provide community-based care is welcomed, as this service is currently provided in a patchy manner and is predominantly consultant-delivered, with little or no training provided. In addition, the time taken to train must be clarified.

There is an implication in the Shape of Training Review that 4-6 years post-Foundation training is sufficient to train; it is not clear whether this would be pure generalist training or whether specialty training would additionally be included in this timeframe. This is a reduction in time compared to current training schemes, which are currently 7 years for the majority of specialties. Given that some trainees, especially those in more procedural-based specialties, report struggling to train in the time currently provided, with many trainees taking time out of programme to gain competencies, we cannot currently support a reduction in the duration of training without clarity regarding the nature of training that would be anticipated to be completed in this time. The current approach of parallel dual accreditation is not sustainable in the proposed 4-6 year timeframe. Physician leaders will have to decide whether they want to continue with dual accreditation without reducing anticipated years of training, or define what a CST in Internal Medicine, will include and what it will not. Recommendation 11, that curricula need to be reviewed, is required as part of this decision.

We are concerned with the statement that doctors with a 'Certificate of Specialist Training' will be 'able to practise with no or limited clinical supervision within multiprofessional teams and networks. They are able to make safe and competent judgements in broad specialty areas'. We note that this statement has been removed from the version of the report published on the GMC website, while it was present in the version circulated at the time of release. We would not support the idea contained within this statement that those who have completed a training scheme still require 'limited clinical supervision'. It is essential to ensure that doctors at the end of their training scheme are fully trained to practice independently and without supervision, and that this is recognised not only nationally but also internationally.

The report refers to 'a service delivered by consultants'; this carries with it a potential risk to training. More senior doctors taking on the roles that have up until now been met by trainees might mean that trainees take no or few clinical decisions and end up doing only paperwork. This is already happening to some extent. Trainees learn by experience to a significant degree, and they must continue to gain skills in decision-making and implementation during training in order to practice independently with confidence on the award of CST.

We are also concerned that opportunities for out-of-programme experience will be significantly limited for those not on the academic programme. The Shape of Training review states that ‘during postgraduate training, doctors should be given opportunities to spend up to a year working in a related specialty or undertaking education, leadership or management work’. We would support this, but cannot support the removal of longer periods of out-of-programme experience for those trainees wishing to pursue interests such as research, education and/or management. A significant number of trainees undertaking dedicated periods of research leading to higher qualification are not ‘academic trainees’. In order to gain good-quality research experience a period of more than a year is required. We feel that all trainees should have the opportunity to apply for such experience, and that this should not be limited to a minority of trainees.

Training according to local needs, while in some ways an attractive proposition, should be treated with caution. We support the statement that all training must be within a UK regulatory framework to maintain standards, and would highlight the value of trainees working with different employers in order to share examples of good practice and benchmark their practice against the national, not local, standards.

We welcome the initial statement that ‘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’. Previous changes have been brought in rapidly, with negative consequences. The full implication of changes to training must be considered prior to the implementation of change, and lessons learnt from previous overhauls of medical training. Care must be taken to ensure that current trainees are not disadvantaged during the implementation of changes, and in the longer term. Shorter-term solutions to the current crisis in medical care should be considered to enable for a more controlled implementation of more radical changes.

Key messages (as identified by the GMC)

1. 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 comorbidities, an ageing population, health inequalities and increasing patient expectations.
2. We will continue to need doctors who are trained in more specialised areas to meet local patient and workforce needs.
3. Postgraduate training needs to adapt to prepare medical graduates to deliver safe and effective general care in broad specialties.
4. Medicine has to be a sustainable career with opportunities for doctors to change roles and specialties throughout their careers.
5. Local workforce and patient needs should drive opportunities to train in new specialties or to credential in specific areas.
6. 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.
7. Full registration should move to the point of graduation from medical school, provided there are measures in place to demonstrate graduates are fit to practise at the end of medical school.
1. 6. Patients' interests must be considered first and foremost as part of this change.
8. 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.
9. A UK-wide Delivery Group should be formed immediately to oversee the implementation of the recommendations.