SHAPE OF TRAINING

Report from the UK Shape of Training Steering Group (UKSTSG)

29 March 2017

Table of Contents

Preface 2

Narrative summary 4

1. Introduction 12

2. The Shape of Training Review Report 13

3 The UK Shape of Training Steering Group (UKSTSG) 15

4. The work of the UKSTSG 16

5. The UKSTSG interpretation of key aspects of the report 18

6. The structure of medical education and training 21

7. The Academy of Medical Royal Colleges Curricula Mapping Exercise 22

8. Anticipated benefits 26

9. Certificates of Completion of Training (CCT) and Certificate of Specialist Training (CST) 27

10. Mentoring 28

11. Progress towards implementation of the 19 recommendations 29

12. Summary and recommendations 37

Appendix 1 – Royal College responses 39

1. The Joint Royal College of Physicians Training Board (JRCPTB) 39
2. The Royal College of Surgeons England (RCSEng) 41
3. The Royal College of Obstetricians and Gynaecologists (RCOG) 43
4. The Royal College of General Practitioners (RCGP) 44
5. The Royal College of Paediatrics and Child Health (RCPCH) 45
6. The Royal College of Anaesthetists (RCoA) 47
7. The Royal College of Ophthalmologists (RCOphth) 48

Appendix 2 – Membership of the UK Shape of Training Steering Group 51

Annexes 52

Glossary of terms 53

Works cited 54

Preface

The needs of patients and their expectations of healthcare services and those who deliver them are changing. The nature of these changes is well known and includes the fact that people are living longer and with multiple long-term conditions. Other drivers for change include rapid developments in medical science, pharmaceuticals, information technology and patient-centred legislation. Meanwhile, as in other workplaces, the medical workforce has changing career aspirations, expectations and requirements.

Across the UK, Governments have responded by publishing strategic plans that differ in detail but with the common theme that more care requires to be delivered by integrated teams in the community. There is a transformational agenda that is well underway. It is timely therefore to review whether medical education and training is producing the type of doctor that patients and service providers need, and to ensure that the training of the doctors of tomorrow remains relevant and fit for purpose.

The Shape of Training review (SoTR), led by Professor Sir David Greenaway, was undertaken for this purpose. His report recognises that the way UK medical education and training is designed and functions is complex; it exists and functions within multi-layered structures, with many representative groups, operating in a multi-professional environment and competing for financial resources. Professor Greenway's report offered ideas and solutions in the form of a broad framework as to how the education and training of medical professionals must adapt if it is to remain relevant and fit for purpose.

His report concluded that there is a clear need for change and made 19 recommendations. In response, UK Health Ministers convened the UK Shape of Training Steering Group (UKSTSG) to consider the review and its recommendations and to bring forward policy proposals as to how it could be implemented. This report describes the work of the UKSTSG and makes a number of recommendations.

The challenge for the UKSTSG was that the SoTR report described a broad framework for change. It did not consider the practical implications of implementing the recommendations within the complex structures of medical training and clinical service delivery that exist across the UK. Consequently, the challenge was to interpret many aspects of the SoTR recommendations, ideas and concepts and to reach consensus on what was reasonable, logical and practical to implement. Further, we were required to ensure that any recommendations made could be implemented with the minimum of service disruption and would be facilitative of the strategic plans of the four UK Health Departments to transform healthcare delivery. This report seeks to give the reader an understanding of the approach adopted by the UKSTSG, and the extent of the work that has been undertaken to fulfil its task. This report also seeks to explain how we worked collaboratively to reach our conclusions.

In all our considerations we were guided by the principles that we set for ourselves. First and foremost was that medical education and training must be configured to meet the needs of patients. The second was that medical education operates within a UK-wide regulatory framework and that any recommendations must ensure that it is delivered to a common high standard across the UK.

We were also mindful of the need to ensure that medical careers remain sustainable and fulfilling, and that central to the delivery of high quality care are those who work and aspire to work in our healthcare services. There are many hard-working, compassionate and dedicated professionals, training, learning and delivering high quality care day in, day out in order to ensure that those who need care and support receive it. What doctors, and all health

professionals, do in support of patients is highly valued and we would be remiss if we did not say so in a report of this significance.

Also of relevance is that our work has taken place against a background of increasing anxiety and dissatisfaction amongst trainee doctors. While this has many facets, it is right that we acknowledge that in part this relates to how current medical training is organised and delivered, and that trainees have sought improvements not only in the quality of training provided, but that their career ambitions and choices should be considered in planning how we deliver training programmes. Policy makers across the UK have recognised that there is a need for improvements and action has already commenced.

On the basis of the work we have undertaken, we have reached the point where we are able to describe and recommend a pragmatic, proportionate and practical way to implement the key elements of the SOTR with the minimum of service disruption, while maintaining UK agreed standards and curricula and delivering tangible benefits for patients. This approach also allows for elements of medical education and training to respond to local strategic plans and patient needs across the UK. It is widely accepted that more flexibility is required to current training pathways. It is of note that in this respect our proposals closely align with those outlined in the GMC's review of "flexibility in training".

We are living in an age of unprecedented demand, change and innovation. This especially impacts on the delivery of health care, and requires us to respond. It is important therefore that medical education and training adapts to meet these challenges, and this report describes how that can be achieved. We are able to recommend that the curricula changes that we have set in train with the Medical Royal Colleges on a UK basis should be developed and submitted to the GMC for approval with an indicative start date of August 2018. Thereafter it will be for each of the 4 UK nations to oversee the detailed aspects of implementation that fit local needs and strategic priorities.

Overall, we believe that the approach we have described will be incremental, requiring "evolution" rather than "revolution" but, given the length of medical training programmes, if we are to meet the future needs of patients in transformed services it is important that this process of change starts now.

Narrative summary

Background

The Shape of Medical Training Review (SoTR) was established to consider how medical training could better meet the needs of patients and service providers over the next 30 years.

The resulting report made 19 recommendations and was received by UK Ministers in November 2013. Although the report was accepted in principle it described a broad framework for change that was open to interpretation and did not consider the practical implications of implementation. In response, Ministers convened a UK Group (UK Shape of Training Steering Group) to consider the report and to provide policy advice.

This report outlines the work that has been undertaken by the UK Shape of Training Steering Group (UKSTSG). It offers policy advice and describes a structure and process for the implementation of the key recommendations arising from the SoTR that is practical, proportionate and will cause a minimum of service disruption.

Why was a review of medical education and training necessary?

A review was necessary because the needs of patients and service providers are changing. Life expectancy is increasing. Whilst this is welcome it will lead to more patients with multiple comorbidities and dementia. It has been estimated that the number of over 75's will increase by 60% by 2033 requiring a 70% increase in health spending if current approaches to the provision of healthcare remain unchanged.

Other factors driving change include the rapid development of new technologies (such as gene therapy), new pharmaceuticals and sophisticated IT systems. These have the potential to lead to new treatments making current therapies (and potentially some medical careers) redundant. Indeed such is the rate of change that elements of the information gained during undergraduate training have been superseded by the time doctors commence work.

In the future doctors must be able to adapt to this rate of change by having the flexibility to acquire new skills, change careers and participate in career long learning. Medical training must also respond to the changing aspirations of doctors for part-time working, portfolio careers and to have the opportunity to take career breaks. Current training regulations and pathways are too inflexible to respond to these challenges.

There have also been changes to the configuration of medical services and working practices that have inadvertently had adverse implications for patients. These include a focus on care in hospital arguably at the expense of care in the community. Within hospitals there has been a focus on the specialist at the expense of the generalist. As a consequence service providers report that it is challenging to deliver the emergency service and that the continuity of patient care has been diminished. This is aptly characterised in the Royal College of Physicians of London Future Hospital Report as follows:

> "All too often our most vulnerable patients – those who are old, who are frail or who have dementia – are failed by a system ill-equipped and seemingly unwilling to meet their needs"
>
> "Older patients with an ill-defined acute illness and multiple comorbidities are much more commonly encountered on the acute medical take. There is increasing evidence of substandard care provided to many older patients with care poorly coordinated and reports of patients being moved round the system like parcels".

What did the SoTR say requires to be done?

The SoTR report recommended that first and foremost the type of doctor that is trained in the future must reflect the needs of patients and service providers, taking into account the changing demographic of the population and the fact that more care will require to be delivered in the community. This means that more doctors will be required who have general rather than specialist skills. The report was clear that the need for specialists will remain but the number and type of specialists should be determined by patient need and sub-specialist training should be dealt with as a post-CCT credential.

The report also stated that in the future most trained doctors will require to contribute to the acute unselected take within their broad clinical discipline.

The review also dealt with the practical aspects of the delivery of teaching and training advocating a return to a more apprenticeship style based on the attainment of competencies and generic capabilities rather than being time based. Current medical training was also noted to be inflexible with limited capacity for doctors to change careers or to take career breaks. Measures are required to increase flexibility within and between training pathways.

Finally the SoTR recommended that action was required to develop and support the delivery of more patient care in community settings. One such action was to blur the current distinct “interface between primary and secondary” care.

The 19 recommendations are available in full in annex 1 of this report.

The Review stated:

> “in order to ensure that the doctors of tomorrow have the appropriate skills, competencies and aptitudes to meet changing needs requires a rethink of the current arrangements for post graduate education and training”.

The chair of the SoTR, Professor Sir David Greenaway, summarised the findings of the review as follows:

> “in undertaking this review I discovered a wide recognition of the need for change” and a “clear consensus about what change should deliver: greater flexibility, better preparation for working in multi-professional teams and more generalists”

The UK Shape of Training Steering Group (UKSTSG)

The UKSTSG was convened by Ministers to review the SoTR report and to provide policy advice. The purpose of the Group (see terms of reference annex 2) was to oversee implementation activities arising from the SoTR, providing policy advice and recommendations to UK Ministers as necessary. The group was chaired by Professor Ian G Finlay and had administrative support from both the Scottish Governments Health Workforce Directorate and the General Medical Council. In considering the report the UKSTSG was also required to work within the following parameters:

- To ensure that any recommendations that are made apply to all four Countries of the UK and are consistent with and facilitative to the strategic priorities in any individual Country.
- To ensure that any change will be proportionate and capable of implementation while minimising service disruption.

A further challenge to the work of the UKSTSG was that the service delivery landscape has changed since the publication of the SoTR because the UK Health Departments have published their strategic plans. These differ in detail but share the common theme that more health care

requires to be delivered by integrated multi-disciplinary teams in the community. Other key partners have also published or are progressing work that is relevant to the implementation of the Shape of Training Review. These are as outlined in the main report.

Work of the UKSTSG

The SoTR report described a broad framework for change. The challenge for the UKSTSG was to determine how these broad concepts could be applied in practice given the complexity of medical education and training and the parameters within which it was required to work. It was also necessary to interpret and define fundamental components of the recommendations such as the meaning of the terms “generalist and specialist”.

This was progressed by sponsoring 6 workshops involving a range of stakeholders who were tasked to consider the practical implications and anticipated tangible benefits of implementing the recommendations. Informed by this work the UKSTSG developed guiding principles. These included a commitment by the 4 Health Department to work collaboratively to develop implementation actions based on the principles of the SoTR but to retain those elements of medical training that are currently fit for purpose.

The UKSTSG interpretation of key aspects of the report

It was necessary for the UKSTSG to interpret and develop a practical meaning for several of the broad concepts outlined in the SoTR. For example, the review emphasised the need for more generalists. This was expressed as follows:

> “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”
>
> “Postgraduate training needs to adapt to prepare medical graduates to deliver safe and effective general care in broad specialties”

The report also recognised that the requirement for specialists to work within narrow competencies would continue. The UKSTSG identified that understanding the correct balance between the generalist and the specialist in each area of medicine as determined by patient and service need would be the key to implementing the Review’s recommendations.

For the purpose of progressing their work the UKSTSG identified the following three areas where there is a clear patient need for more generalists.

- To provide care for unscheduled patients in hospitals; particularly those with multiple co-morbidities.
- To provide continuity of clinical care in hospitals.
- The development of more doctors who can work at the boundary between primary and secondary care and doctors who can support more care in the community

The practical definition of “generalist” adopted by the UKSTSG when considering whether a College proposal fulfilled the SoTR recommendation for “more generalists” was whether it met those three areas of patient need. The report also stated that;

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

The challenge for the UKSTSG was to identify areas where patients would benefit from specialisation without diluting the proposal that most doctors in the future must retain sufficient breadth of practice to provide unscheduled care. This was an important aspect of the engagement exercise that was undertaken with the Medical Royal Colleges.

Credentialing was another area where further clarity was required. This is a new concept that could be interpreted in a number of ways. For the purpose of undertaking the mapping exercise the Colleges were asked to assume that they would develop credentials, the GMC would approve and regulate them and the UK statutory postgraduate medical education bodies would deliver and quality manage the credentialed training in the same way that they deliver pre-CCT training.

The Academy of Medical Royal Colleges Curriculum Mapping Exercise

The UKSTSG identified that the route to implementing many of the SoTR's recommendations would be to revise the current postgraduate curricula and training pathways. Consequently the Academy of Medical Royal Colleges was asked to coordinate a review of current curricula and to describe how these could be amended to incorporate the key principles of the SoTR. The output from this exercise was compiled by the GMC and submitted to the UKSTSG. A series of meetings followed involving representatives of individual Colleges and a sub group (Panel) of the UKSTSG who were tasked to ensure that the submissions embraced the principles of the SoTR. The Panel considered whether a submission was "shape compliant" on the basis of the following 5 broad principles.

- Whether the proposal had taken account of the type of doctor that patients and service providers across the UK will need in the future.
- Whether the proposal was broad enough to ensure that most doctors within that discipline will have and maintain the skills to manage acutely ill patients including those admitted via the acute unselected take and to be able to provide continuity of care thereafter. This included an assessment of the relative requirement of generalists and specialists within the discipline.
- Whether the proposal demonstrated a commitment to make training more flexible by recognising a doctor's previous learning, by facilitating transfer between disciplines or to permit out of programme learning such as the pursuit of research.
- Whether the proposal will better facilitate and support the delivery of more care in the community.
- Whether the proposal included a description of the components of the current curricula that may be suitable for credentialing.

The UKSTSG accepted that the extent to which current curricula and training pathways required to change varied between clinical disciplines. The Panel was also mindful of the need to ensure that medical careers remain sustainable, attractive, fulfilling and consider the needs of an increasingly diverse workforce.

Proposals resulting from the Academy Curriculum mapping exercise

All Colleges submitted proposals. At the time of writing, the UKSTSG had engaged in detail with 11 Medical Royal Colleges and (subject to further discussion with regard to aspects of detail) has agreed that their proposals broadly fulfil (or could be amended to fulfil) the principles of the SoTR. These submissions are described in appendix 1 of this report. Work is on-going to review the submitted proposals from the other Colleges.

Although the submissions differ regarding the extent to which change was required they all include common elements. They are all based on the anticipated needs of patients and service providers. They all commit to the principle that in the future learning will be competency rather than time based. They all include the GMC's "generic professional capabilities" which will explicitly describe for the first time the common skills and aptitudes required from doctors in all disciplines. Turning to the key criteria:

Balance between generalists and specialists based upon patient/service needs
All proposals ensure that, where appropriate, doctors will be equipped with the skills to participate in the acute unselected take for their discipline and to provide continuity of care thereafter. It is expected that this will be reflected in the type of posts that are advertised in the future. The opportunity to develop a "specialty interest" will remain in several of the current proposals.

Flexibility within and between training pathways
All submissions include a commitment to increase flexibility for trainees who wish to move between disciplines predominantly based on the GMC's generic professional capabilities. All Colleges have committed to support trainees to gain experience "out of programme", to undertake research or a higher degree and to provide training experience for doctors from other disciplines. The UKSTSG welcomes these commitments but believes that more flexibility can be achieved beyond this.

Current regulation dictates that previous learning can only be recognised for CCT purposes if it has taken place in a formal regulated training post. Increasingly doctors are choosing not to progress directly from Foundation to a specialty training post, or from core into a higher specialist training post but are gaining experience in non-recognised posts. At present this learning cannot easily be recognised for CCT purposes unnecessarily prolonging the training pathway.

Supporting the delivery of care in the community
All submissions included proposals to support the delivery of more care in the community. Several Colleges proposed links with the RCGP to offer post CCT modules or fellowships and to better support GPs in community settings. General practitioners have a key role in the delivery of care in the community by leading multidisciplinary teams. The UKSTSG agrees that there is a requirement to enhance the training of general practitioners to support this. This could be achieved in a number of ways such as the development of the current model of post-CCT fellowships that are being delivered in some parts of the UK.

Credentialing
The Colleges were asked to describe components of their current curricula that would be suitable for credentialing. This assumed that Colleges would develop these credentials. Areas within current curricula such as the optional specialty and sub-specialty components that are not undertaken by all trainees have been identified as suitable for credentialing. The UKSTSG believes that developing credentialing as described in this report will allow the training and deployment of specialists to be more responsive to patient and service needs. They may also provide opportunities for lifelong learning.

UKSTSG response to the 19 recommendations arising from the SoTR

In addition to undertaking the curricula mapping exercise the UKSTSG has carefully considered and responded to each of the SoTR's 19 recommendations. These are outlined in section 11 of this report.

The Group also considered the benefits that it is anticipated would accrue for patients, service providers and doctors if the SoTR's recommendations were implemented. Indeed achieving these benefits will serve as the test of success of this work. These are listed in full in annex 6 and summarised below.

Anticipated benefits

For patients:

- Will improve patient care in hospitals and in the community
- Will improve the continuity of patient care which would allow for the implementation of the proposal for a named clinician for patients
- Will support the delivery of more care in the community
- Will allow patients to influence medical education and training
- Will better equip doctors with the skills to meet the needs of the population
- Will allow patients access to specialist doctors when that is appropriate

For service providers:

- Will support the sustainability of acute hospital services by equipping more doctors with the skills to manage and provide continuity of care for unscheduled admissions
- Will support and enhance the delivery of more care in the community in integrated multi-disciplinary teams emphasizing the provision of care closer to the patient's home
- Will allow future service providers to influence the design and number of training opportunities
- Will develop the workforce to support the transformation of services as described in the strategic plans of the UK Departments of Health
- Will provide for the appropriate specialisation of doctors to meet patient need

For doctors:

- Will improve the quality of training
- Will increase the flexibility for doctors to change career pathways and take career breaks
- Will support the recognition of previous learning
- Will make training competency rather than time based
- Will build upon the concept of life long support and learning
- Will enhance the training and careers of general practitioners
- Will improve the provision of mentoring support for doctors and safeguard patients at transition points such as when consultants are appointed

Other benefits:

- Will support the development of academic careers and give doctors the flexibility to undertake research

Summary and UKSTSG recommendations

In summary the UKSTSG was tasked to consider the recommendations arising from the SoTR and to make policy proposals to UK Ministers. For the past 2 years the Group has worked collaboratively with stakeholders to understand and interpret the recommendations and to develop a strategy for implementation.

During that time the 4 UK Health departments described their strategic plans for the future configuration and delivery of clinical services. It became evident that these plans and the recommendations outlined in the SoTR were complementary and should be taken forward in tandem.

The UKSTSG recommends that the principles of the SoTR as interpreted in this report should underpin future developments in medical education and training to meet the current and future needs of patients within an evolving service landscape.

The UKSTSG considers that the following recommendations are a proportionate and practical response to the SoTR and will not disrupt services. It is also anticipated that successful implementation of these recommendations would deliver clear and tangible benefits for patients, doctors and service providers.

UKSTSG Recommendations

The UKSTSG recommends that the following activity should commence.

In relation to curricula and training pathways:

- The curricula and training pathways outlined in this document should be further developed by the appropriate Medical Royal Colleges in collaboration with educational commissioners and other stakeholders and submitted to the GMC for approval.
- The Panel of the UKSTSG should consider the submissions from the remaining Colleges to ensure that they fulfil the principles of the SoTR aiming to complete this element of the work by July 2017.
- The 4 UK statutory post-graduate medical education bodies should continue work to prepare for implementation of the new curricula and training pathways described in this document.

In relation to credentialing:

- The UKSTSG identified the development of regulated credentialing as described in this report as an important element of the strategy to ensure that medical education and training responds to the needs of patients and the service and provides flexibility for doctor’s career developments.
- The UKSTSG has identified a simple method whereby the process of developing post CCT credentials could begin. Namely; Medical Royal Colleges develop the educational content based on the sub-specialty components of their current curricula, the GMC as the regulator approve and quality assure them (subject to any legislative change that may be required), and the four UK statuary post-graduate medical education bodies implement and quality manage them in the same way that they deliver pre-CCT training.
- On this basis the GMC should bring forward proposals to further develop credentialing as soon as it is reasonable to do so.
- The UK Medical Royal Colleges and others should work collaboratively with the GMC to agree the components of their curricula that will be credentialed.
- The determination of the number and type of credentials should be informed by local patient and service needs.

In relation to responding to patient and service needs:

- Any other implementation activity should be undertaken by the Implementation Steering Groups or other appropriate organisations in each Country taking account of local strategic plans and patient needs but based on UK agreed standards and curricula.

Other:

- Medical Royal Colleges and employers should work collaboratively with others to deliver a more formalised system of supportive mentoring for doctors at the transition points of their careers and particularly for newly appointed consultants.

In relation to future curricula submissions and oversight:

The UK Medical Education Reference Group (UKMERG) is currently the forum for the discussion and approval of matters relating to medical education and training with representation from the four UK health departments and the four statutory post graduate medical education bodies. At present applications for the recognition of new specialties are considered by this group in the first instance. Since in the future it will be necessary to ensure that curricula fulfil the principles of the SoTR the UKSTSG recommends that the following protocol be adopted.

- Submissions of new curricula or major revisions of existing curricula will be submitted to the UKMERG in the first instance and thereafter to the GMC for Regulatory approval. It is anticipated that in the future given the rapidly changing healthcare landscape it will be necessary to refresh curricula more frequently than has happened in the past.
- Submissions will be assessed to ensure that they fulfil the following 5 key principles of the SoTR:
  - (i) Take account of and describe how the proposal will better support the needs of patients and service providers.
  - (ii) Ensures that the proposed curriculum to CCT equips doctors with the generic skills to participate in the acute unselected take and to provide continuity of care thereafter.
  - (iii) Where appropriate describes how the proposal would better support the delivery of care in the community.
  - (iv) Describes how the proposal will support a more flexible approach to training.
  - (v) Describes the role that credentialing will play in delivering the specialist and sub-specialist components of the curriculum.
- The UKMERG should engage with and seek regular reports from Colleges and others as necessary to monitor progress in implementing any agreed changes.

1. Introduction

1.1 The Shape of Medical Training Review (SoTR) led by Professor Sir David Greenaway was established to consider how medical training could better meet the needs of patients over the next 30 years.

1.2 Doctors are trained primarily for the purpose of providing care to patients. The review was necessary because the current and anticipated future needs of patients across the UK are changing rapidly (Department of Health, 2014). The increase in patients with multiple co-morbidities and a requirement for more care to be delivered in the community necessitates a different approach to medical training and variations to the type and the skill mix of doctors it produces.

1.3 The SoTR group was convened to consider how medical training could better meet the current and future needs of patients. It was given clear terms of reference by the Sponsoring Board with a requirement to focus on post-graduate medical education and training across the UK and to include the learning from previous reviews; in particular to consider the conclusions of Sir John Tooke's report entitled "Aspiring to Excellence" (Tooke, 2008). This called for a more flexible approach to training and the better integration of training and service planning. The terms of reference also required that the following aspects be covered: patient needs, workforce needs, service needs, flexibility of training and the breadth and scope of training.

1.4 The review group published their findings in October 2013 and made 19 recommendations (Greenaway D., 2013) See annex 1.

2. The Shape of Training Review Report

2.1 The Shape of Training Review Report described in detail how the review was undertaken and emphasized the fact that wide engagement took place with key stakeholders. The rationale for undertaking the review was that patient and service needs are rapidly changing. Average life expectancy is increasing leading to more patients with co-morbidities and in particular dementia. It has been estimated that the population aged over 75 in Scotland will increase by 60% by 2033 requiring a 70% increase in health and social care spending (NHS Scotland, 2011). There is broad agreement that an important component of the response will be to deliver more care for patients with multiple chronic conditions in the community.

2.2 Other factors that will drive change include new medical technology, new pharmaceuticals and developments in information technology and medical science that will lead to new treatment options and make current treatments (and potentially medical careers) obsolete. In order to meet this challenge it will be necessary for the doctors of the future to have the flexibility to acquire new skills, change careers, participate in career long learning and to be able to adapt to changing patient and service needs.

2.3 These factors led the review group to conclude that "to ensure that the doctors of tomorrow have the appropriate skills, competencies and aptitudes to meet the changing needs, we have to rethink current arrangements for post graduate education and training".

2.4 The Terms of Reference for the Review defined 5 key themes that were to be explored and form the basis for the recommendations that arise from the Report. These are:

Theme one: Patient needs drive how we must train doctors in the future
Under this theme it was concluded that the type of doctor we train in the future must first and foremost be responsive to patient needs, reflect the changing patient population demographics and anticipate that more care will be delivered in the community. Training should facilitate blurring of the current distinct interface between primary and secondary care. Training must also recognize that patients are better informed than ever before and expect to be fully involved in the decision making about their care.

Theme two: Changing the balance between specialists and generalists
This theme considered the impact of increasing sub-specialisation in hospitals on career choices and the ability of service providers to deliver emergency care. The SoTR concluded that more doctors require to be trained who have generalist rather than specialist skills. The status of the generalist also requires to be raised. The review emphasised that training doctors with generalist clinical and professional capabilities that can be adapted and enhanced will respond to the demand from service provider organisations for doctors who can provide care in different settings depending on local service needs.

Theme three: A broader approach to post graduate training
This theme dealt with the practical aspects of the delivery of teaching and training. It advocated a return to a more apprentice style of training based on the attainment of competencies and generic capabilities rather than solely time based. This will need longer clinical placements and more focused supervision and support. The Review also recommended that "postgraduate training must recognise and value doctors who are well grounded in the broad areas of their specialty" with the important caveat that this should not lead to a sub-consultant. Any specialisation beyond this should be determined by patient and service needs. Finally there is recognition that doctors require more support at the transition points during their careers when they are new to carrying a higher level of responsibility such as when they first take up a post in the consultant grade.

Theme four: Tension between service and training
Under this theme delivering the emergency service is highlighted as one of the major challenges currently facing service providers. The report recognised that doctors in training will continue to make an important contribution to emergency and acute care but should be better supported by trainers and supervisors. Importantly it also recommended that most trained doctors in the future must continue to deliver general emergency care in their broad clinical area throughout their careers.

Theme five: More flexibility in training
The SoTR noted that current training structures are unnecessarily rigid. There is limited recognition of previous learning making it difficult for doctors to change careers or to take career breaks. Increased flexibility in training is also required to allow service providers to plan for and to deliver medical innovation and other services for patients in the future. Finally it was recommended that this flexibility should allow doctors to pursue an academic career or to undertake research.

The SoTR concluded by making 19 recommendations that are available in full in appendix 1. A summary of the key messages is as follows:

- Patients and the public need more doctors who can provide general care in broad specialties across a range of different settings.
- Local workforce and patient needs should drive opportunities to train in new specialties or to credential in specific areas that would still be approved, regulated and quality assured by the GMC.
- We will continue to need doctors who are trained in more specialized areas to meet local patient and workforce needs.
- Medicine must be a sustainable career with opportunities for doctors to change roles and specialties throughout their careers.
- 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.
- Full registration should move to the point of graduation from medical school, provided there are measures in place to demonstrate graduates are fit to practice at the end of medical school. Patients' interests must be considered first and foremost as part of this change.
- 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.

Professor Greenaway summarised the report's findings as follows:

> "in undertaking this review I discovered a wide recognition of the need for change" and a "clear consensus about what change should deliver: greater flexibility, better preparation for working in multi-professional teams and more generalists"

3. The UK Shape of Training Steering Group (UKSTSG)

3.1 UK Ministers received and considered the Shape of Training Report in November 2013. Although the Report was accepted in principle it was recognised to be a broad framework for change that was open to interpretation. It also did not consider or describe the practical implications of implementation. In response Ministers convened the UK Shape of Training Steering Group (UKSTSG) to consider the report and to provide policy advice. Implementation groups were also convened in the devolved administrations. In England, the Department of Health mandated Health Education England (HEE) to lead this work.

3.2 The Terms of Reference for the UKSTSG (see annex 2) stated that the purpose of the Group was to oversee implementation activities arising from the Shape of Training Review (Greenaway D. , 2013) on the future structure of UK Medical Training, providing advice and recommendations to UK Ministers as necessary.

3.3 The UKSTSG was required to maintain a UK consensus on medical training while recognising that strategic objectives differ across the UK. The Group was also required to develop a policy and structure to guide implementation of the recommendations within the report, to provide oversight, coordination & direction to any Policy for implementation, to identify work to be undertaken to deliver any agreed policy and commission relevant bodies to take these forward where appropriate.

Membership of the UKSTSG

Professor Ian Finlay, Senior Medical Officer, Scottish Government, administratively supported by the Scottish Government's Health Workforce Directorate and the GMC, chaired the Group. The Membership included representatives from the following stakeholders:

- The 4 UK Departments of Heath
- Health Education England (HEE)
- NHS Education for Scotland (NES)
- Wales Deanery
- Northern Ireland Medical and Dental Training Agency (NIMDT)
- The Academy of Medical Royal Colleges (AOMRC)
- The Academy of Medical Royal Colleges Trainee group
- The British Medical Association UK (BMA UK)
- The General Medical Council (GMC)
- The Medical Schools Council (MSC)
- Chair of the UK Conference of Postgraduate Medical Deans (COPMeD)
- NHS Employers (England)
- Patient Forum

The members of the UKSTSG are listed in appendix 2.

4. The work of the UKSTSG

4.1 In considering a strategy for implementing the 19 recommendations the UKSTSG was required to work within the following parameters:

- To ensure that any recommendations could apply to all four Countries of the UK while being consistent with and facilitative of the strategic priorities in any individual Country.
- To ensure that any change would be proportionate and capable of implementation while minimising service disruption.

4.2 A further challenge to the work of the UKSTSG is the fact that the service delivery landscape has changed since the publication of the SoTR report. In particular, the UK Health Departments have published their strategic plans for health. They differ with regard to detail but share the common theme that in the future more health care will require to be delivered by integrated multi-disciplinary teams in the community.

4.2.1 In England in 2014 the *NHS Five Year Forward View* was published. It proposed that "more care will be delivered locally" but that some services will be provided in specialist centres. The need to break down the barriers between family doctors and hospitals with out-of-hospital care delivered by multispecialty community provider units was emphasised (NHS in England, 2014). Sustainability and transformation plans (5 year plans for the future of health and care services in local areas) have also been published (NHS England, 2015).

4.2.2 In Scotland the National Clinical Strategy, published in February 2016, described a framework for future services that envisages more care will be delivered in the community. This will be planned around 'community hubs' underpinned by social care integration, the availability of multidisciplinary teams and extended roles for general practitioners in dealing with more complex cases. In secondary care it proposed that specialist interventions will be focused on fewer sites. Scotland also faces the challenge of delivering care to remote and rural communities (Scottish Government, 2016).

4.2.3 In Wales in 2015 a 5 year plan was launched entitled, "Together for Health: A five year vision for the NHS in Wales". It described a path towards a sustainable service that ensures better health for everyone, better patient access and experience, the provision of more local services and better health outcomes by improving safety and quality of services (Welsh Government, 2011). The Welsh NHS then published core principles that committed to putting patients first while creating a sustainable workforce (Welsh Government 2016). At the time of publication of this report there was an on-going review of health in Wales (Welsh Government, 2017).

4.2.4 In the North of Ireland, the Health Minister recently launched a 10-year vision to transform the health and social care system; "Health and Wellbeing 2026: Delivering Together". This outlines the immediate challenges to the delivery of health care arising from demographic change and the need to reduce health inequalities. It focuses both on disease prevention and the provision of high quality clinical services. It was also envisaged that an element of service reconfiguration might be required to provide the best possible outcomes for patients (Department of Health – Northern Ireland, 2016).

4.3 Other key partners have either published or are progressing work that is relevant to the implementation of the Shape of Training Review. The GMC is undertaking a consultation exercise regarding the development of a Medical Licensing Assessment (MLA) and has published work describing generic professional capabilities and quality standards for curricula (GMC, 2016) (GMC, 2016). The GMC are also undertaking work to review the flexibility of training. The UK reference group in collaboration with HEE has undertaken work relating to moving the point of registration. This remains under consideration but is out with the remit of the UKSTSG. In England, HEE has taken forward initiatives that address some of the SoTR Report recommendations including the introduction of a Quality Framework for England, a review of the

ARCP process and are committed to review the length of training placements (Health Education England, 2016) (Health Education England, 2016).

The consultation and interpretation process

4.4 The UKSTSG began the program of work by sponsoring 6 workshops that included a wide range of stakeholders and considered the following key recommendations arising from the SoTR report: the requirement for more generalists, the role of credentialing, the role of patients and employers in influencing the content of medical training, measures to blur the interface between primary and secondary care and to support the delivery of more care in the community, the academic pathway and measures to support the careers of SAS doctors.

4.5 These workshops were important because the SoTR had described a framework for change. The challenge for the UKSTSG was to determine how these broad concepts should be interpreted and applied in practice given the complexity of medical education and training and the parameters within which it was required to work.

For example, although the report stated that there is a requirement for more doctors with general skills it did not indicate the extent to which this should occur or how these doctors should be deployed to meet the needs of patients in each discipline. Similarly, the SoTR stated that there would continue to be a need for specialist doctors but it did not state which specialists and where they should be deployed in the context of on-going transformational change to the delivery of health services.

Attendees were also asked to identify the tangible benefits that might be anticipated to accrue for patients and service providers and the practical implications if each of the recommendations was implemented.

Principles adopted by the UKSTSG

4.6 The UKSTSG developed Principles to guide their further work based on their interpretation of the recommendations. These were informed by the output of the workshops and are shown in full in annex 3. In summary, the 4 Health Departments committed to working collaboratively to develop implementation actions arising from the Shape of Training review. These were required to take into account national strategies, policies and structures. Specifically, in relation to Medical Education and training the following principles were agreed.

- to train doctors to deliver safe, high quality and patient-centred medical care.
- to train doctors to meet the anticipated needs of patients and the service, including the capacity to deliver more broad-based care which addresses the needs of an ageing population and those with multiple co-morbidities.
- to ensure that medical education and training is flexible enough to adapt to the changing needs of the service and of patients, and to scientific innovation. This will include but not be limited to the recognition that previous learning, education and training should be based on the demonstration of capabilities and not simply upon time.
- to ensure that all doctors have the capabilities to pass on their skills and knowledge as mentors and trainers, and to undertake and analyse research as appropriate.
- to ensure that the outcomes of medical training must provide transparency for patients, their carer’s, the public and the service about the level of capability doctors have attained.
- to instil in doctors a sense of professionalism and compassion.
- to embed and promote a career-long culture of continuous professional development.
- to ensure medical education and training is subject to robust governance and quality assurance arrangements.
- to deliver these objectives with the minimum structural change and service disruption.

5. The UKSTSG interpretation of key aspects of the report

5.1 In order to provide guidance as to the extent and nature of change that would constitute “Shape compliance”, the UKSTSG needed to develop clear and practical definitions. The most important was the practical interpretation of the terms “generalist” and “specialist”. The UKSTSG interpreted these as follows:

Generalists

5.2 The report strongly emphasized (in recommendations 10, 11, 12 and 18) that medical training must become structured to deliver a more generic, competency based training and that doctors in the future must be able to manage acutely ill patients within their broad specialty area and to maintain these skills throughout their future careers. These were expressed in the report as follows:

> “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”
>
> “Postgraduate training needs to adapt to prepare medical graduates to deliver safe and effective general care in broad specialties”

5.3 The report also recognized that there would be a continuing requirement for specialist doctors to work within narrow competencies. The UKSTSG identified that understanding the correct balance between the generalist and the specialist in each area of medicine as determined by patient and service need would be fundamental in implementing the Review’s recommendations.

5.4 On this basis, the UKSTSG identified three areas where there is a clear requirement for more “generalists”. These are:

- **The provision of care for unscheduled patients in hospitals**

  Over the past 25 years, hospital doctors have become increasingly specialised and sub-specialised. The Shape of Training review recognised that this has weakened the provision of generic/holistic care to patients and challenged the sustainability of services for unselected, unscheduled admissions to hospitals because fewer doctors contribute to the “unselected take” or contribute appropriate specialist skills to the initial assessment of patients.

  Since more than 50% of hospital admissions in some clinical disciplines are unscheduled this is an important area of patient need that requires to be addressed (Comptroller and Auditor General, 2013). In this context, the UKSTSG has interpreted the SoTR recommendation that patients need more “generalists” to mean that doctors must have and maintain the skills to provide emergency care to acutely ill patients. Further that there is an expectation that most doctors in the future will have and maintain the skills to be able to contribute to the emergency unselected “take” within their broad area of clinical practice.

- **The provision of continuity of clinical care in Acute Hospitals**
  The Group were told that specialisation in hospitals has contributed to a loss of continuity of care for patients. This occurs because if "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 patients having several responsible doctors over a short time period. This practice was described in the Royal College of Physicians London Future Hospital document as follows:

  > "older patients with an ill-defined acute illness and multiple comorbidities is much more commonly encountered on the acute medical take. There is increasing evidence of substandard care provided to many older patients with care poorly coordinated and reports of patients being moved between wards and within wards like parcels".
  >
  > (Royal College of Physicians London, 2013)

  Independent reviews of poorly performing hospitals have also identified this is an important contributory factor in the delivery of poor patient care that requires urgent action (Francis, 2013). In response, it has been recommended that all hospital patients should have a single named consultant who is responsible for their care throughout their hospital admission (Royal College of Physicians London, 2013).

  In considering the role of the generalist the UKSTSG concluded that in the future doctors should have the breadth of training that ensures that they can provide continuity of patient care within their broad area of clinical practice and can meet the needs of the increasing number of patients with multiple chronic conditions.

- **The development of more doctors who can work at the boundary between primary and secondary care and doctors who can support more care in the community**
  There has been rapid growth in the numbers of patients admitted to hospital. For the past decade, unscheduled hospital admissions have been rising at 5-6% per annum (Purdy, 2010) with an increase of 124% in short stay admissions between 1998 and 2013 (Comptroller and Auditor General, 2013). Further, approximately one-fifth of hospital admissions involve conditions that could have been managed as well or better in the community (Health Foundation, 2013). In response all UK Governments have policies/strategic plans to transform health and social care delivery and to provide more care in the community. It will be necessary to ensure that doctors are equipped with the skills to deliver this.

5.5 General practitioners already undertake "general training" and treat patients with all conditions at all ages. To facilitate more care in community-based settings, GPs will require appropriate support and resource, and to have the opportunities to enhance their skills in a range of areas including the management of patients with complex co-morbidities. This was described in the Shape of Training Workshops as a "community physician" or an enhanced "expert medical generalist" GP role. Other suggestions included the training of a new kind of doctor to work at the "interface" with commitments in both primary and secondary care.

There is also a requirement for disciplines that are currently predominantly hospital based to consider how they might support the delivery of more care in the community.

Specialists and sub-specialists

The report also stated that:

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

5.6 It has been reported that specialisation in specific clinical areas improves patient outcome. As such, the UKSTSG wishes to identify and support specialisation (and sub-specialisation) where that is consistent with patient need. In doing so, the UKSTSG is mindful that no study, of which they are aware, has been published that was designed to measure any detrimental consequences of specialisation. These may include the failure to recognise and treat clinical conditions out with the narrow expertise of the specialist or the fragmentation of care that occurs from multiple handovers when expert specialist input is seen as the sole approach.

The UKSTSG Panel identified a further potential unintended consequence of the ad-hoc development of sub-specialisation over the past two decades. In several instances the academic and experiential requirements expected from a sub-specialist have not been described, do not form part of current assessment processes and lack governance. Consequently, there is the potential for variability in the quality and standards of the delivery of these services. The recommendation within the SoTR for the development of credentials to deal with specialisation offers a solution.

The UKSTSG also noted that there are more specialties and sub-specialties in the UK than in comparable western Countries (GMC, 2017). The challenge for the UKSTSG was to identify areas where patients would benefit from specialisation without diluting the importance of the proposal that most doctors in future must retain sufficient breadth of practice to provide unscheduled care. This was an important aspect of the engagement exercise that was undertaken with the Medical Royal Colleges.

6. The structure of medical education and training

6.1 The current training pathway for doctors typically begins with 5 years of undergraduate study at medical school followed by two years working predominantly in hospitals (the foundation programme). Doctors become fully "registered" with the GMC at the end of the first foundation year having obtained provisional registration on graduation from medical school. On completion of the second foundation year a doctor can pursue a range of career options by competitive entry to post-graduate training programmes that vary in length from 3 to 10 years.

6.2 Post graduate medical education and training has been has been subject to statutory regulation since the inception of the Post Graduate Medical Education and Training Board in 2005. These functions were taken over by the GMC in 2010. During nationally approved and regulated post graduate training doctors are employed and supervised, and follow a pre-determined curriculum that is developed and regularly updated normally by the relevant Medical Royal College or Faculty. Curricula must be approved by the General Medical Council (GMC) who as the UK Regulator is responsible for setting the standards that govern both undergraduate and post-graduate medical education and training. The 4 UK statutory post-graduate medical education bodies manage training and are responsible for the end of training assessment. Successful trainees are awarded a certificate of completion of training (CCT) and are recommended by the relevant College for inclusion on the GP or Specialist register of the GMC.

6.3 The UKSTSG identified that the key to implementing the SoTR's recommendations was to revise postgraduate curricula and training pathways. Although Colleges currently design post-graduate medical curricula the GMC can consider curricula submissions from other bodies. The UKSTSG considered approaching alternative organisations but decided that, due to their experience in undertaking this work, the Medical Royal Colleges should in the first instance be given the opportunity to amend their current curricula to fulfil the SoTR's recommendations. This was progressed by undertaking the curriculum mapping exercise, detailed in section 7.1.

7. The Academy of Medical Royal Colleges Curricula Mapping Exercise

7.1 The UK Academy of Medical Royal Colleges supported by the GMC coordinated the curriculum mapping exercise. The Academy's constituent bodies (Colleges and Faculties, hereafter referred to as Colleges for simplicity) were asked to describe how their current curricula and training pathways could be modified to incorporate the following key recommendations arising from the SoTR:

- To describe how the College's current curriculum and training pathway could be amended to take account of, and meet, the current and anticipated needs of patients and service providers
- To describe how the College would ensure that the training within their discipline was sufficiently broad to fulfil the SoTR recommendation that patients and service providers require more generalists
- To describe how the College would make training more flexible
- To describe how training in appropriate areas would develop doctors who are better able to work at the interface between primary and secondary care and in the community
- To identify the components of the current curriculum that would be suitable for credentialing

7.2 In undertaking this exercise, the UKSTSG recognised that the extent to which current curricula and training pathways require to change varies within and between clinical disciplines. It was also stated in the guiding principles that the UKSTSG would not seek to change a current curriculum if it already meets the current and anticipated needs of patients.

7.3 The responses from individual Colleges were compiled by the GMC and presented to the UKSTSG in December 2015. That document is available in full in annex 5. While the UKSTSG welcomed these proposals, further work was required to ensure that the amended curricula adequately embraced the key recommendations of the SoTR. Follow up meetings involving a sub-group (Panel) of the UKSTSG and representatives from individual Colleges were arranged for this purpose.

7.4 The Panel discussions principally considered the extent to which the proposals fulfilled the key principles of the SoTR (were "Shape compliant"). Other factors discussed included the extent to which the proposal was aligned with the strategic objectives of the 4 UK Departments of Health and the practicality of implementing the proposed change. The Panel was also mindful of the need to ensure that medical careers remain sustainable, attractive, fulfilling and consider the needs of an increasingly diverse workforce.

7.5 The Panel considered whether a submission was "Shape compliant" based on the following 5 mandatory components.

- Whether the proposed curriculum/training pathway had taken account of the type of doctor that patients and service providers across the UK will need in the future
- Whether the proposed curriculum/training pathway was broad enough to ensure that most doctors within that discipline will be able to treat acutely ill patients and to provide continuity of care thereafter. It was important that the proposal ensured that "generalists" and "sub-specialists" within that discipline will have equal status and that in the future most doctors will have and maintain the skills to manage the acute unselected take where that is appropriate. This included a discussion as to the relative proportions of generalists and specialists that will be required for each discipline based on patient and service need

- Whether the proposal demonstrated a commitment to make training more flexible by recognising a doctor's previous learning and facilitating transfer between disciplines or to facilitate out of programme learning such as the pursuit of research
- How the proposal within the scope of the discipline will facilitate and support the delivery of more care in the community
- A description of the components of the current curricula that will be suitable for credentialing. For the purpose of undertaking this exercise the Colleges were asked to assume that they would develop and assess credentials, the GMC would approve them and the UK statutory post-graduate medical education bodies would implement and deliver the credentialed training.

7.6 All Colleges participated in the mapping exercise and submitted responses. To date the UKSTSG has reviewed in detail the submissions from the following 11 Colleges (two are joint College submissions) and considers that these are broadly consistent with the principles of the SoTR. (Work is on-going with regard to aspects of detail and also to consider the submissions from the other Colleges).

- Royal Colleges of Physicians (UK JRCPTB)
- Royal College of Surgeons (JCST)
- Royal College of Obstetrics and Gynaecology
- Royal College of General Practitioners
- Royal College of Paediatrics and Child Health
- Royal College of Anaesthetists
- Royal College of Ophthalmologists

7.7 Although the submissions differed regarding the extent to which they propose change they all include common elements. They all take account of the needs of patients and service providers. They all commit to the principle that in the future learning will be competency rather than time based. Importantly all the curricula will include the GMC's "generic professional capabilities". This will explicitly describe for the first time the common skills and aptitudes required from doctors in all disciplines.

For an outline of the proposals from these Colleges see appendix 1. An overview of compliance with the key recommendations is given below.

7.8 Balance between generalists and specialists based upon patient/service needs
This question was particularly applicable to the disciplines of general medicine and general surgery because they have an important role in managing unscheduled admissions and have been subject to considerable specialisation. Both have described proposals to address this by increasing the "general" content in their curricula and by increasing the breadth of clinical experience for trainees. In both proposals doctors will have the opportunity to develop a "specialist interest" but in the future the expectation is that most doctors in both disciplines will require to have and maintain the skills to participate in the "acute take" and to deliver continuity of care thereafter. It is expected that this will be reflected in the type of posts that are advertised in the future.

A feature of the proposal for general surgery is that it will include mandatory simulation based training and protected training time for trainers and trainees. It is anticipated that this will accelerate the development of craft skills particularly in the early years. The UKSTSG are especially supportive of this proposal because it fulfils the principles of the SoTR and has the potential to improve general surgical training in the UK.

In contrast, doctors in anaesthetics and obstetrics & gynaecology already undergo broad based training. Further, most of these doctors contribute to the acute take. Consequently, the UKSTSG accepted that in this respect these curricula were largely fit for purpose.

The situation for paediatrics is more complex. The current pathway allows for both general and sub-specialist training within the CCT programme. This is contrary to the principles of the SoTR that stated that specialist elements of training may be better undertaken as credentials. The UKSTSG has accepted that a specialist approach to training is appropriate for some of the 17 sub-specialties within paediatrics based on patient need but has not accepted that this approach should necessarily apply to all 17 sub-specialties. It has recommended that further work be undertaken to determine the correct proportion of generalists and specialists that are required to meet patient needs in this discipline.

The UKSTSG was particularly supportive of proposals that had considered the future needs of patients. For example, the Royal College of Ophthalmologists has identified a rapidly rising demand based on demographic change for the care of patients with age related diabetes and macular degeneration. The College has proposed that a new CCT should be created with a more “medical focus”. The UKSTSG broadly supports this proposal and has suggested that the College make the appropriate submission to the UK reference group.

7.9 Flexibility within and between training pathways

All submissions included a commitment to increasing flexibility for trainees within and between disciplines and in this respect were broadly “Shape compliant”. This will be predominantly based on the incorporation of the GMC’s generic professional capabilities that will allow the recognition of prior learning. All Colleges are committed to supporting trainees to gain experience out of programme, to undertake research or a higher degree and to provide training experience for doctors from other disciplines.

Several Colleges during the Panel engagement exercise highlighted that the principle impediment to extending the recognition of previous learning is the inflexibility of the current Regulations. These mandate that only learning obtained in a regulated training post is eligible for this purpose. Many current trainees however are choosing not to enter a formal higher training programme immediately after foundation training (The Foundation Programme, 2016).

The UKSTSG welcomes these commitments but believes that further flexibility needs to be achieved beyond simply recognising generic professional capabilities.

7.10 Supporting the delivery of care in the community

All submissions to a varying degree included proposals to support the delivery of more care in the community. Some are particularly innovative. The UKSTSG heard of projects using telemedicine to support care to rural communities. Other examples included the published proposal from the RCoA to undertake pre-operative assessments in the community.

Several Colleges proposed links with the RCGP to offer post CCT modules or fellowships and to better support GPs in community settings. These included aspects of general medicine and care of the elderly, obstetrics & gynaecology and paediatric services. The UKSTSG was also told that pilot initiatives are taking place across the UK to develop and /or to support multi-discipline community hubs and/or practice clusters.

General practitioners have a key role in the delivery of care in the community by leading multidisciplinary teams. The RCGP believes that there is a requirement to enhance the training of general practitioners to support the delivery of more care in the community. The College proposed that the current 3-year programme to CCT be extended to four years with the fourth

year taking place within general practice. The UKSTSG supports the proposal to enhance the training of GPs but believes that there are alternative ways to achieve this that would more closely fulfil the principles of the SoTR such as building on the current model of post CCT fellowships that are now being delivered in some parts of the UK. This is explained in appendix 1 under the proposal from RCGP. Further work is required to identify the best way to achieve this end.

7.11 Credentialing

The Colleges were asked to describe areas within their current curricula that would be suitable for credentialing in the future. This assumed that Colleges would develop and assess these credentials and that the GMC would approve and regulate them. RCOG and RCoA have identified areas that are not undertaken by all trainees and are currently considered to be "sub-specialties". The UKSTSG identified these as potential areas for credentialing in the future.

The proposals from the Royal Colleges of Physicians and Surgeons include the opportunity for doctors to pursue a "specialist interest" alongside general training. Any further optional specialisation in these disciplines should be dealt with by credentialing. Work is on-going to identify the components within the RCPCH curriculum that would be suitable for credentialing.

The development of credentialing is considered by the UKSTSG to be an important element in the delivery of the recommendations arising from the SoTR. It will allow the training of specialists to be more responsive to patient and service needs and will provide quality and governance to the delivery of these services. When credentialing has been fully developed, it will be necessary to review both curricula and training pathways.

8. Anticipated benefits

8.1 It is important that implementation of the SoTR recommendations leads to tangible benefits for patients, doctors and service providers. Further, these benefits must justify embarking on the process of change. The UKSTSG has undertaken an analysis of the benefits that are likely to accrue for patients if the key principles of the SoTR are implemented. These are explained in annex 6 and outlined for each College proposals in appendix 1. Achieving these benefits will serve as the test of success of this work.

In summary, the anticipated benefits are:

For patients

- Will improve patient care in hospitals and in the community
- Will improve the continuity of patient care which would allow for the implementation of the proposal for a named clinician for patients
- Will support the delivery of more care in the community
- Will allow patients to influence medical education and training
- Will better equip doctors with the skills to meet the needs of the population
- Will allow patients access to specialist doctors when that is appropriate

For service providers

- Will support the sustainability of acute hospital services by equipping more doctors with the skills to manage and provide continuity of care for unscheduled admissions
- Will support and enhance the delivery of more care in the community in integrated multi-disciplinary teams emphasizing the provision of care closer to the patient's home
- Will allow future service providers to influence the design and number of training opportunities
- Will develop the workforce to support the transformation of services as described in the strategic plans of the UK Departments of Health
- Will provide for the appropriate specialisation of doctors to meet patient need

For doctors

- Will improve the quality of training
- Will increase the flexibility for doctors to change career pathways and take career breaks
- Will support the recognition of previous learning
- Will make training more competency rather than time based
- Will build upon the concept of life long support and learning
- Will enhance the training and careers of general practitioners
- Will improve the provision of mentoring support for doctors and safeguard patients at transition points such as when consultants are appointed

Other benefits

- Will support the development of academic careers and give doctors the flexibility to undertake research

9. Certificates of Completion of Training (CCT) and Certificate of Specialist Training (CST)

9.1 Although not included as one of the 19 recommendations in the SoTR, it was suggested in paragraph 88 of the report that consideration be given to changing the current terminology of awarding a CCT (Certificate of Completion of Training) to indicate the end of formal training to the term CST (Certificate of Specialist Training). The rationale for this change was that it would indicate that learning was "not complete" at this point but is a career long process.

9.2 During our consultation doctors in training expressed concern that, if implemented, the term CST would imply that their training was inferior to doctors who had been awarded a CCT. While understanding the rationale for proposing the introduction of the CST the UKSTSG believe that changes that occur because of the SoTR must enhance training and not diminish it. Consequently, the UKSTSG has recommended that to avoid any misunderstanding the term CCT should continue to be used.

10. Mentoring

10.1 The SoTR identified a need to support doctors at the "transition phases" of their careers. The first appointment to the consultant grade is recognised to be particularly challenging. The concept of introducing mandatory or formalised "mentoring" was proposed by attendees at a UKSTSG workshop as a potential solution. Mentoring is already considered to be good practice and is offered to many appointees.

10.2 Although the SoTR did not recommend mentorship the UKSTSG suggested that further work should be undertaken to understand the implications of instituting a period of formal and mandatory mentorship. This has been progressed by the Academy of Medical Royal Colleges who organized a consensus meeting that included key stakeholders and led to the development of principles for the introduction of formal mentoring (see annex 8). These recognise that the nature of the mentoring process may differ between disciplines.

11. Progress towards implementation of the 19 recommendations

This section describes the UKSTSG's recommended response to the SoTR's 19 recommendations.

Recommendation 1
Appropriate organisations must make sure post-graduate medical education and training enhances its response to changing demographic and patient needs.

The UKSTSG noted that published evidence shows that the UK population is ageing leading to more patients with multiple chronic conditions who would be better and more appropriately treated in the community (Edwards, 2014). It also noted that the strategic aim in all four Countries is to deliver more care in multi-disciplinary teams in a community setting.

In response, as described above, the UKSTSG has worked with individual Colleges to develop their proposals for curricula change to meet this challenge; namely train doctors with more general skills and train doctors who can work better at the interface between primary and secondary care. Measures have also been proposed to enhance the training of general practitioners to meet the needs of patients with complex comorbidities. In addition to GPs, many more doctors will be equipped with the skills to work beyond the traditional hospital setting.

Recommendation 2
Appropriate organisations should identify more ways of involving patients in educating and training doctors.

In considering this recommendation the UKSTSG noted that at present most medical undergraduates undertake a component of their training in clinical settings that involves interaction with patients. Post-graduate trainees have an important role in the delivery of clinical services interacting with patients daily. Further many components of the assessments and examinations that trainees must complete either directly involve patients or are based upon specific clinical case discussions.

The UKSTSG included patient representatives in all 6 workshops and has included their views in responding to this recommendation. It was also noted that there are patient representatives on various groups at the GMC and the four UK statutory post-graduate medical education bodies. Individual Medical Royal Colleges also have to a varying extent patient representatives on their committees.

Nevertheless these groups will be encouraged to review membership to ensure that there is appropriate patient representation.

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

The Terms of Reference for the SoTR focused on postgraduate medical education. Two of the 19 recommendations however relate to aspects of undergraduate education. These are principally the responsibility of the university Medical Schools Council (MSC) and the GMC with support from the UK statutory post-graduate medical education bodies.

A recent review has been undertaken by HEE and the MSC of the experience of medical students in making career choices, in particular why they chose primary or secondary care. The reasons were varied and included overall perceptions of the various disciplines within medicine, the site of student placements and morale of the current workforce. In response, recommendations have been made that are designed to inform career choice (Medical Schools Council and Health Education England, 2016).

Based on the changes that we are proposing to curricula it will be important that medical students understand the values and attitudes that will be expected of a doctor. This will include an understanding that a generalist and a specialist will have equal status and that most doctors will require to have and to maintain the skills to treat acutely ill patients in the emergency setting. There is also an expectation that general practitioners and hospital doctors will have equal status. A specific initiative to support this has been the proposal to combine the GP Register and Specialist Register. This now has GMC support.

This has been discussed at the Council meeting of the Medical Schools Council (MSC). Medical Schools already undertake work with schools and in the community to explain the implications of choosing a medical career. This advice will be adapted to reflect the principles of the SOTR.

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.

The overall responsibility for the regulation of the standards and quality of undergraduate education lies with the GMC. It is essential that doctors can work safely at a pre-determined level of competence at the point of Registration. The GMC are currently taking to public and stakeholder consultation a proposal for a Medical Licensing Assessment (MLA) that aims to ensure that all undergraduates across the UK have achieved a common standard at the point of graduation.

Recommendation 5
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.

The regulation of Health Professionals is a matter largely reserved to Westminster. There have been discussions between DH, HEE and GMC about the possibility of moving the point of registration but no conclusion has yet been reached. Any recommendation will be discussed at the UK Medical Education Reference Group. Consequently this has not been included in the work programme of the UKSTSG.

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.

Since the SoTR was published the GMC has published proposals for the development of generic professional capabilities that include communication, leadership and quality improvement (GMC, 2016). These will become common components of all training programmes permitting objective recognition of learning between programmes allowing trainees the flexibility to move between disciplines. This responds to the following statement within the SoTR:

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

Colleges have been asked to describe how they will ensure that their training pathways recognise previous learning and can accommodate trainees who wish to transfer between disciplines without the necessity for these trainees to complete the entirety of the new training pathway. This may involve the development of bespoke "bridging" components to current curricula.

Recommendation 7
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.

The UKSTSG is especially supportive of the recommendation that training should be competency rather than time based. This will be an important component of the assessment of trainees pursing all the proposed new curricula described above and will be implemented by the 4 UK statutory post graduate medical education bodies. As an example, it is anticipated that the measures that are proposed to support the new general surgery curriculum including high quality clinical placements, protected training time and simulation based training may allow some trainees to achieve the required competencies more quickly than at present.

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.

Based on the proposed changes to curricula it will be the responsibility of the 4 UK statutory post graduate medical education bodies in conjunction with employers (who are represented on the UKSTSG through the NHS Employers organisation) to structure training to permit longer placements that are more apprenticeship based. In England HEE are already working to achieve this.

In the context of apprenticeships, the UKSTSG was told during the workshops that there is a requirement to support doctors at the points of transition in their careers and in particular when they are first appointed as consultants. It was proposed that this could be achieved by introducing more formalised mentoring. This is discussed in section 10 of this report.

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.

This recommendation has been implemented in that the GMC carries out annual surveys of training making recommendations for improvement where necessary and has the power to remove the recognition of training places. The quality of training is also currently assessed and quality managed by the four UK statutory postgraduate medical education bodies via their Deaneries and associated structures.

The new curricula proposals such as those for general surgery include a commitment to improving the quality of training by protecting training time and developing simulation based training (see proposals for General Surgery appendix 1).

It will be the responsibility of the 4 UK statutory postgraduate medical education bodies to ensure that trainees are placed in units that provide training that meets GMC quality standards.

> **Recommendation 10**
> Postgraduate training must be structured within broad specialty areas based on patient care themes and defined by common clinical objectives.

This recommendation was considered in the workshops. Concern was expressed by several stakeholders as to the practical implications of implementing this given that it would require a “root and branch” restructuring of medical education. The UKSTSG was required to ensure that the implementation of any of the 19 recommendations could be achieved with the minimum of disruption. It was concluded that this was unlikely for this recommendation and that the anticipated benefits would be met by implementing the other recommendations.

The UKSTSG however wishes to add caveats to this decision. The SoTR stated that the Foundation programme as currently configured was fit for purpose. In the event of the point of registration being moved to graduation, with the required changes made to the structure of undergraduate medical education to enable such a change, it may be appropriate to review the foundation programme. This would provide an opportunity to align undergraduate and postgraduate education to meet strategic priorities, especially in terms of creating more doctors with generalist skills.

An alternative proposal that the UKSTSG supports was to develop “clusters” or “families” of related clinical disciplines such as “surgical” or “medical” based specialties. It may be easier to develop apprentice based training with cross-recognition of skills within and across such clusters.

> **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.

A review of postgraduate curricula has been undertaken as described above. These reflect the anticipated needs of patients and the Service. NHS Employers are represented on the UKSTSG and have been involved in developing the response to the SoTR recommendations. Employers in the NHS have requested that they be given notice of curricula and training changes in a timely fashion in order that they can co-ordinate these with their plans for transformation of local services.

The GMC has described and are implementing transferable generic professional capabilities that are expected to improve identification of transferable elements of curricula (GMC, 2016). It is envisaged that detailed implementation of the proposals will be undertaken by implementation groups across the UK who will liaise with and involve local service providers and employers. The GMC are also committed to removing barriers to, and encouraging greater use of, existing opportunities for recognising transferable competences in existing curricula.

> **Recommendation 12**
> 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.

The SoTR also stated that:

> "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".

and that:

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

This is similar to recommendation one. All Colleges have been asked to review their curricula to ensure that they are more generic and will equip doctors with the skills to treat acutely ill patients in the emergency setting and patients with multiple co-morbidities. This will provide the doctors who have the requisite skills to meet this need.

Employers recognise that if this recommendation is to be fulfilled in the future it will be necessary to configure jobs to ensure that doctors are able to utilise these skills. This means that more consultant posts will require to be advertised as general with a special interest (rather than a free-standing specialist post) with a clear requirement that the doctor contributes to the unselected unscheduled "take".

> **Recommendation 13**
> Appropriate organisations, including employers, must consider how training arrangements will be coordinated to meet local needs while maintaining UK-wide standards.

The UKSTSG undertook a workshop to understand the needs of employers. In addition to meeting the local needs of patients, employers are required to configure their services to meet the strategic aims of the four UK Health Departments. It is inevitable that this will lead to a difference in emphasis regarding service provision across the UK.

Arguably the most important aspect of the UKSTSG's work therefore has been to maintain a UK consensus on the key aspects of medical education and training while recognising these regional differences. The proposals that are outlined in this document have been agreed in principle on a UK wide basis.

Standards however are determined and assured by the GMC on a UK wide basis. The 4 UK statutory post-graduate education bodies implement and oversee training programmes that accord with these standards. The planning and coordination to meet local needs and strategic aims will be led in the first instance by the Shape of Training Implementation Boards in the devolved nations and by Health Education England (HEE) in England.

Recommendation 14
Appropriate organisations, including postgraduate research and funding bodies, must support a flexible approach to clinical academic training.

It is important for patients that medical training equips doctors with the skills to teach and to undertake clinical and scientific research. The current training pathways are considered not to be flexible enough to permit the acquisition of both clinical and research skills or to allow trainees to undertake a period of research without jeopardising their clinical training.

The UKSTSG support the recommendation that a more flexible approach would better support clinical academic training. In the first instance a workshop was initiated to consider how this could be achieved. A challenge that was identified is to ensure that academic trainees attain both the required clinical and research competencies. This will be more readily facilitated by competency rather than time based training and the inclusion of specific generic professional capabilities in curricula. Further, Colleges in their proposals to amend current training curricula and pathways to meet the principles of the SOTR have committed to the adoption of a more flexible approach to academic training.

The UKSTSG received a document from key stakeholders proposing the adoption of principles to underpin the future development of medical academic careers (see annex 7). These were broadly supported by the Group with the caveat that it was out with the remit of the UKSTSG to comment on the terms and conditions of employment of doctors.

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.

The UKSTSG agree that career long learning will be important in ensuring that doctors remain up to date, fit to practice and able to respond to changes that arise from innovation. Job plans for employed doctors should therefore include provision for CPD.

The UKSTSG has identified the appraisal and revalidation process as an appropriate vehicle for the governance of CPD. Appraisal identifies individual development needs and reviews the extent to which they are addressed on an annual basis. It also itemises the extent to which CPD and other learning has occurred. It will continue to be necessary in the future for employers to ensure that time is included in job plans to facilitate this and that doctors are able to use this time as intended. The failure to do so should be raised by doctors through their local workplace structures and will then be highlighted on an individual basis at appraisal and on an institutional basis by the local governance of appraisal and revalidation.

The UKSTSG also suggest that organisations such as the statutory education Bodies, Universities and/or Medical Royal Colleges consider developing career long CPD packages and learning programmes.

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.

The UKSTSG identified the development of credentials to be an important recommendation that will make medical training more responsive to patient needs. In response, the Medical Royal Colleges were asked to identify components of their current curricula that would be better undertaken within credentialed programmes. For this purpose, Colleges were asked to assume that they would develop curricula and assessment systems for credentials, the GMC would approve them and the 4 UK Post graduate statutory bodies would deliver them. It is of note that the GMC are piloting their approach to credentialing with the Royal College of Surgeons of England in relation to the accreditation of cosmetic surgeons. The further development of credentialing may require an amendment to the Medical Act.

The UKSTSG has identified in discussion with Colleges that components of their current curricula could be transferred to post CCT credentialed programmes without compromising the core components of training to CCT. These are principally the “optional components” that at present are undertaken by a relatively small proportion of trainees *en-route* to a CCT. It was also noted that at present many trainees undertake post CCT Fellowships that are similar in concept to credentials.

Although the development of credentialing had the potential to be complex the UKSTSG has identified a straightforward, pragmatic and incremental way to implement it. This involves transferring the components of current curricula that have been identified in this report as suitable for this purpose to post CCT credentials. The pre-CCT curriculum may then require to be reviewed. The GMC would approve the credential and the 4 UK postgraduate statuary bodies would deliver the post CCT credentialed training in the same way that they currently deliver pre CCT training.

The UK Shape of Training Implementation groups or other appropriate organisations working with the 4 UK statutory post-graduate medical education bodies will require to work with local service providers to identify the number and type of credentialed doctors that they will require in the future.

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.

The recommendation that SAS doctors should have access to credentialed programmes will be fulfilled when credentialing has been developed by the GMC. It has also been assumed that the current process that allows SAS doctors to gain access to the specialist register via Certificate of Eligibility for Specialist Registration (CESR) or Certificate of Eligibility or GP registration (CEGPR) will remain. The UKSTSG welcomes the expectation that this process should become simpler and less bureaucratic once the GMC implements its new standards requiring curricula to become “outcomes-based”.

The UKSTSG undertook work to consider whether other measures could be developed to support SAS doctors in the interim. Under the auspices of the UKSTSG work was undertaken in Wales and Scotland to explore how the current skills of SAS doctors could be more formally recognised and how new skills could be developed.

It is clear that SAS doctors across the UK wish to develop their skills to better serve their patients. The UKSTSG was told that regarding the acquisition of new skills the current SAS doctor development programmes, where they exist, were working well and there was a desire for these to continue. The group was also told that there was demand from SAS doctors in areas where such programmes do not currently exist to be able to access this type of training.

In Scotland, a survey of SAS doctors was undertaken to determine their appetite for the development of an interim process to recognise their current extended skills. The results of this are shown in annex 9. In brief, approximately 75% of responders expressed support in principle for the development of a process to identify their extended skills and competencies particularly if these could subsequently be included in applications to gain access to the specialist register. In Wales a similar listening exercise was undertaken. In England, the BMA, Health Education England, the Academy of Medical Royal Colleges and NHS Employers have undertaken joint work to promote development opportunities for SAS doctors by extending their skills and competencies culminating in the publication of an SAS doctor development guide (see annex 10)

The UKSTSG also noted and commended the fact that SAS doctor "charters" had been published across the UK that embrace several key aspects of this recommendation.

In conclusion until and alongside the development of credentialing by the GMC the UKSTSG recommends that initiatives to support SAS doctors should be developed and progressed by appropriate bodies in the devolved nations and by HEE in England.

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

The UKSTSG has responded to this recommendation by asking the Colleges to consider how their curricula can be more generic in content. Broad based training programmes have been developed to a varying degree across the UK and are popular with trainees who have not made a definitive career choice. The UKSTSG response is explained above at recommendation 10.

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.

Convening the UKSTSG fulfilled this recommendation.

12. Summary and recommendations

12.1 In summary the UKSTSG was tasked to consider the recommendations arising from the SoTR and to make policy proposals to UK Ministers. For the past 3 years the Group has worked collaboratively with stakeholders to understand and interpret the recommendations and to develop a strategy for implementation.

12.2 During that time the 4 UK Health departments described their strategic plans for the future configuration and delivery of clinical services. It became evident that these plans and the recommendations outlined in the SoTR were complementary and should be taken forward in tandem.

12.3 The UKSTSG recommends that the principles of the SoTR as interpreted in this report should underpin future developments in medical education and training to meet the current and future needs of patients within an evolving service landscape.

12.4 The UKSTSG considers that the following recommendations are a proportionate and practical response to the SoTR and will not disrupt services. It is also anticipated that successful implementation of these recommendations would deliver clear and tangible benefits for patients, doctors and service providers.

UKSTSG Recommendations

The UKSTSG recommends that the following activity should commence.

In relation to curricula and training pathways:

- The curricula and training pathways outlined in this document should be further developed by the appropriate Medical Royal Colleges in collaboration with educational commissioners and other stakeholders and submitted to the GMC for approval.
- The Panel of the UKSTSG should consider the submissions from the remaining Colleges to ensure that they fulfil the principles of the SoTR aiming to complete this element of the work by July 2017.
- The 4 UK statutory post-graduate medical education bodies should continue work to prepare for implementation of the new curricula and training pathways described in this document.

In relation to credentialing:

- The UKSTSG identified the development of credentialing as described in this report an important element of the strategy to ensure that medical education and training responds to the needs of patients and service providers.
- The UKSTSG has identified a simple method whereby the process of developing post CCT credentials could begin. Namely; Medical Royal Colleges develop the educational content based on the specialty components of their current curricula, the GMC as the regulator approve and quality assure them (subject to any legislative change that may be required), and the four UK statuary post-graduate medical education bodies implement them in the same way that they deliver pre-CCT training.
- On this basis the GMC should bring forward proposals to further develop credentialing as soon as it is reasonable to do so.
- The UK Medical Royal Colleges and others should work collaboratively with the GMC to agree the components of their curricula that will be credentialed.
- The determination of the number and type of credentials should be informed by local patient and service needs.

In relation to responding to patient and service needs:

- Any other implementation activity should be undertaken by the Implementation Steering Groups or other appropriate organisations in each Country taking account of local strategic plans and patient needs but based on UK agreed standards and curricula.

Other:

- Medical Royal Colleges and employers should work collaboratively with others to deliver a more formalised system of supportive mentoring for doctors at the transition points of their careers and particularly for newly appointed consultants.

In relation to future curricula submissions and oversight:

The UK Medical Education Reference Group (UKMERG) is currently the forum for the discussion and approval of matters relating the medical education and training with representation from the four UK health departments and the four statutory post graduate medical education bodies. At present proposals for new training curricula and applications for the recognition of new specialties are considered by this group in the first instance. Since in the future it will be necessary to ensure that curricula fulfil the principles of the SoTR the UKSTSG recommends that the following protocol be adopted.

- Submissions (as at present) to be submitted to the UKMERG in the first instance and thereafter to the GMC for Regulatory approval.
- Submissions to be assessed to ensure that they fulfil the following 5 key principles of the SoTR:
  - (i) Take account of and describe how the proposal will better support the needs of patients and service providers.
  - (ii) Ensures that the proposed curriculum to CCT equips doctors with the generic skills to participate in the acute unselected take and to provide continuity of care thereafter.
  - (iii) Where appropriate describes how the proposal would better support the delivery of care in the community.
  - (iv) Describes how the proposal will support a more flexible approach to training.
  - (v) Describes the role that credentialing will play in delivering the specialist and sub-specialist components of a curriculum.
- The UKMERG should engage with and seek regular reports from Colleges and others as necessary to monitor progress in implementing any agreed changes.

Appendix 1
Royal College responses

1. The Joint Royal College of Physicians Training Board (JRCPTB)

The clinical service requirement
Service providers have reported that the single most important unmet patient need relating to this clinical discipline is the supply of doctors who can support the unselected unscheduled "take" and can provide continuity of care. This often involves the management of elderly patients with multiple chronic conditions. The challenge was characterised in a Royal College of Physicians, London report as follows:

> "All too often our most vulnerable patients – those who are old, who are frail or who have dementia – are failed by a system ill-equipped and seemingly unwilling to meet their needs".
>
> (Royal College of Physicians London, 2013)

and

> "older patients with an ill-defined acute illness and multiple comorbidities are much more commonly encountered on the acute medical take. There is increasing evidence of substandard care provided to many older patients with care poorly coordinated and reports of patients being moved between wards and within wards 'like parcels'".
>
> (Royal College of Physicians London, 2013)

The Current training pathway

- The training pathway for most physicians is 7 years comprising an initial 2-year of general medical training leading to the award of the MRCP.
- Trainees can then choose to continue in general internal medicine or to enter one of 27 sub-specialties by competitive entry and undertake a further 4-6 years of training. At the end, a certificate of completion of specialty training (CCT) is awarded.
- Some specialties do not contribute to the "general medical take"; those trainees are awarded a single CCT. Those that do can 'dual' CCT in internal medicine and the specialty. The general component however is held in relatively low regard and most physicians prize their specialty or "ology".

The SoTR recommended that patients need doctors with more general skills that can be delivered in a variety of clinical situations. The UKSTSG has agreed that in the context of secondary care this means that doctors will require to retain sufficient breadth in their practice to contribute to the "acute take" and to provide continuity of care.

The current pathway fails to meet these requirements because the general component of training stops for many trainees after year 2. Thereafter, and throughout a physician's career, the emphasis is on specialism.

The proposed training pathway
The "Joint Colleges" have proposed the following staged pathway in response to the SoTR:

Stage 1 – a three-year training program in internal (general) medicine leading to the award subject to examination of the MRCP. During this period doctors in training, as at present, would contribute to the "acute take".

Stage 2 – a period of specialty training (indicative time 4 years) that includes an element of training in internal (general) medicine with an expectation that trainees will contribute to the "acute unselected take" during the entire training pathway.

Further discussion is taking place with regard to the proposed training pathway for medical oncology, palliative medicine, dermatology and neurology to ensure that these training pathways fulfil the principles of the SoTR.

At the end a dual certificate of completion of training (CCT) will be awarded. This will indicate that the doctor has the skills of a general physician with an interest in a specific specialty. In order to fulfil the needs of patients in the future, service provider organisations will require to employee physicians who will contribute to the acute unselected take and provide continuity of care thereafter. It is proposed that a small number of the 27 specialties, due to the configuration of their work, will not participate in the acute unselected take as consultants. These trainees would obtain a single CCT in their specialty.

The proposal also includes a commitment to more flexibility in recognizing previous learning based on the GMC's generic professional capabilities.

General medicine is an important discipline providing skills that are applicable and transferable to other areas of clinical practice such as general practice and child health, The Physician Colleges will have an important role in developing doctors with the skills to work at the interface between primary and secondary care and in the community. The UKSTSG are especially supportive of an initiative being undertaken by a College to develop modular training jointly with the RCGP.

The UKSTSG response

The UKSTSG welcomes this proposal and recognizes that it fulfils many of the principles outlined in the SoTR. The Colleges are committed to increasing flexibility in training and are actively involved in developing measures to support the delivery of more care in the community. In particular, more doctors will have and retain the skills to contribute to the acute unselected take both during training and as consultants. The concern is that the expectation they will make such a contribution is translated into reality and it will be for employers to ensure that job descriptions include this and the delivery of continuity of care thereafter. At the same time it is proposed that the option of the single CCT in general (internal) medicine is retained to help meet predicted future service needs.

The proposal that most physicians will retain an element of specialist training within the CCT pathway could be viewed as contrary to the recommendation within the SoTR that specialist training should be undertaken as a credential. In the current absence of detailed plans to support credentialing however, the UKSTSG considers that this proposal makes significant progress towards achieving the principles of the SoTR. In the meantime as per our recommendation the development of credentialing should be progressed as a priority. There is also a requirement to "model" these proposals in order to determine the financial implications of proceeding to implementation.

Subject to these caveats around costs and ensuring greater contribution to the acute unselected take, and a satisfactory conclusion to the on-going discussions, the UKSTSG supports the proposal in principal as an interim measure until credentialing becomes available. At that time a further review of the training pathway will be required. The UKSTSG recommends that consideration should then be given to developing specialty components of the current curricula as post CCT credentials.

Anticipated Benefits
It is anticipated that this proposal would bring the following tangible benefits for patients, doctors and service providers.

- Improve patient care
- Improve the continuity of patient care
- Allow service providers to proceed with plans for more integrated care models
- Increase the number of experienced trainees who contribute to the "acute unselected take".
- Increase the number of consultants who will contribute to the acute unselected take sharing the burden more evenly
- Provide greater support to trainees performing the role of medical registrar. (Trainees report that the requirement to undertake this role is a principle reason for not choosing a career in a medical specialty that has a general internal medicine component).
- Will increase the profile and status of general/internal medicine
- Will increase flexibility with the training pathways of other disciplines
- Will improve training in key areas such as geriatric medicine and High Dependency and Intensive care

2. The Royal College of Surgeons England (RCSEng)

The UKSTSG has endorsed a proposal for a new curriculum and training pathway to improve training in general surgery (improving surgery training initiative or IST). The historical context was that Health Education England (HEE) in conjunction with the Royal College of Surgeons of England was undertaking work independently of the UKSTSG to review training in general surgery.

What is general surgery and why should we change the training pathway?
General surgeons (GS) have a key role within the hospital service delivering elective and emergency surgery. They treat patients with abdominal conditions such as gallbladder disease and cancer. They also treat breast & endocrine disease. In the emergency setting (which involves> 50% of their work) general surgeons (GS) treat patients with conditions such as bowel obstruction, appendicitis and abdominal trauma. Traditionally GS have undergone a broad training to allow them to deal with this range of clinical conditions.

Over the past 20 years GS have become increasingly sub-specialised in their elective work. As a consequence they are losing the range of skills required to deliver emergency care. This is challenging the sustainability of emergency general surgery services particularly in district and rural hospitals and has adversely affected the continuity of patient care.

The UKSTSG are aware however that sub-specialism within general surgery in areas such as oesophageal and pancreatic surgery has been reported to improve patient outcomes. General surgery is a key clinical discipline where it is important to train the correct proportion of generalist and specialist surgeons to meet the future needs of patients and service providers.

The proposed general surgery curriculum and training pathway
A curriculum has been proposed that will equip trainees with the competencies to deliver elective and emergency general surgery in a district general hospital setting under the improving surgical training initiative. The recognised requirement for a proportion of general surgeons to become sub specialists will remain. At present sub-specialist surgeons have usually undertaken post CCT Fellowships. In the future it is envisaged that this need will be met by credentialing with the number and scope of credentials met by local patient and service need.

The Improving Surgery Training Initiative

With the endorsement of the UKSTSG, the Royal College of Surgeons of England (RCS) is working with HEE to take forward the Improving Surgical Training (IST) initiative that will pilot a new competence-based training programme in general surgery from August 2018. The pilot is being undertaken in association with the Joint Committee on Surgical Training (JCST), which works on behalf of the four Surgical Royal Colleges of the UK and Ireland for all matters related to surgical training. Further details on the project are available on the College's website.

The IST pilot aims to create an improved surgical training system that produces competent, confident, self-motivated professionals who are able to provide the highest quality of care to patients in the NHS. It aims to do this by:

- providing them with an appropriate balance between service and training;
- professionalising their trainers;
- introducing a curriculum (subject to regulatory approval) that is truly competence-based within a learning environment that embeds and enhances simulation; and
- ensuring that the existing end-of-training product continues to meet current and future patient needs

The IST pilot also represents an opportunity for trusts to develop an alternative workforce model, maximising productive training time and making use of the focused specialisms of members of the extended surgical team.

The IST pilot will offer the following benefits:

For patients

- Training of consultants better-suited to provide the highest quality of patient care, to meet current and future patient needs.
    - Retains the capacity for patients to access sub-specialists when appropriate
    - Will improve the continuity of patient care

For the service

- Opportunity to develop an alternative, more sustainable model of service delivery as described in the strategic aims of the four health departments.
- Support for workforce transformation in relation to non-medical roles.
- Support for rota redesign.
- Reduced reliance on locum staff.
    - Develops surgeons better able to work in remote and rural locations

For training providers

- Ability to influence new educational delivery models.
- Opportunity to improve trainee and trainer morale.
- Focused support throughout the duration of the pilot.

For trainees

- Greater quality of training, provided by professional trainers.
- Greater quantity of training, with improved balance between training and service.
- Enhanced trainer/trainee relationship through an apprenticeship training model
- Competence-based training
- Reduction in duties of low educational value, through reduced administrative responsibilities and support from the extended surgical team.

For trainers

- Greater recognition of training role with dedicated training time in job plans.
- Enhanced training for trainers.
- Enhanced trainer/trainee relationship through an apprenticeship training model.

Such is the interest and enthusiasm for the project, urology and vascular surgery also now wish to be included. HEE has recently endorsed their inclusion with a view to introducing pilots in these specialties in August 2019.

3. The Royal College of Obstetricians and Gynaecologists (RCOG)

The RCOG proposal is based on the premise that the current and anticipated service requirements and duties of a consultant in obstetrics and gynaecology will not change in the foreseeable future. As such consultants will require to have the skills to provide the full range of elective and emergency obstetric care and emergency gynaecological care in the district hospital setting. Evidence was presented that currently approximately 80% of O & G consultants across the UK participate in general on call.

On this basis the RCOG has proposed that the current training pathway, which has an indicative duration of 7 years beyond foundation, is broadly fit for purpose and fulfils the principle of the SoT Review that doctors should be sufficiently general to allow them to participate in the emergency care of acutely ill patients.

At present, years 6 and 7 of the pathway are considered by the College to be optional advanced training and are designed to accommodate trainee preference. The College has identified at least four of these areas of advanced training that would be suitable for recognition by credentialing. The UKSTSG has suggested that this should now be discussed with the GMC. When credentialing has been developed the residual curriculum would then require to be reviewed.

The College has also agreed to adopt a more flexible approach to recognising competencies obtained in other disciplines and will consider this further when the GMC formally publishes guidance with regard to generic professional capabilities.

O and G consultants currently provide a range of services in the community and are working with the RCGP to develop training modules for this purpose. This aligns with the strategic aims of the UK Health Departments to deliver more care in the community. The UKSTSG strongly supports these initiatives and encouraged the College to prioritise further work in this area.

Benefits

- Provides a general training program as recommended by the SoTR
- Supports the clinical service for patients.
- Supports strategic plans for more care to be delivered in the community
- In due course transfers optional specialist components of training to credentials

4. The Royal College of General Practitioners (RCGP)

Current training pathway and proposal

The current training pathway for general practice is a three-year programme leading to CCT. Thereafter some GPs have the opportunity to undertake a post CCT fellowship in order to develop their skills in a specific area. The RCGP proposed that the initial 3-year programme should increase to four years with the additional training occurring within general practice. The rationale for this change is that the current structure and length of training fails to equip trainees with a sufficient level of skill and confidence in several areas including mental health, paediatrics, dermatology and the assessment & management of frailty and complex multiple co-morbidity. The College also believes that the role of the GP will change in the future with more emphasis on the leadership and management of multidisciplinary teams in the community. This will require new skills.

UKSTSG response

The UKSTSG broadly accepted that there is a requirement to enhance the skills of general practitioners to allow them to fulfil the new roles that are envisaged in integrated health systems. The Group were of the view however that the proposal as it was presented to them did not embrace the recommendations of the SoTR in a number of ways.

The UKSTSG also noted that alternative models for enhancing skills such as one-year post CCT Fellowships had been developed across the UK and these were generally proving to be popular with trainees. This can be described as a "3 plus 1" model of training.

Panel members considered that the 3+1 model better aligns with the principles of the SoTR. It allows flexibility since the "plus 1 year" can be undertaken during the formal structured training programme, immediately after training or flexibly during a doctor's career. The content of such an additional year would add skills beyond those that are required for CCT and would be responsive to local provider and patient needs. It also closely follows the Shape of Training vision for credentialing and would support Government strategies for delivering more complex care in the community. Most importantly the Panel believes that this model would help meet the demands of current trainees for portfolio and flexible careers.

The UKSTSG agrees that the core content of the GP training programme leading to CCT must continue to cover the elements required of an independently practicing GP in the NHS.

An important consideration is the impact that any change to the training programme will have on the recruitment and retention of doctors in general practice. The UKSTSG was told that the current four-year continuum training programs, where they exist, are proving to be unpopular with trainees despite many having a high quality educational content.

Conclusion

In conclusion the UKSTSG agree with the RCGP that there is a sound educational case for reviewing the way in which GPs are trained but was not convinced that an extension of the core element of CCT training as it was proposed to them is the most suitable way to achieve this. For the reasons outlined above the UKSTSG has written to the RCGP indicating that in considering the two options it prefers where appropriate a "3 plus one model" because it more closely fulfils the key Principles of the Shape of Training Review.

The RCGP has also been encouraged to look at different ways of enhancing GP training to meet the needs of the workforce by reviewing what can be achieved by a Fellowship year, what could be achieved by an integrated 3 year training plus 12 months post CCT and the impact of Transferable Competencies on trainee competence and confidence.

Benefits
- Enhances the skills and status of general practitioners
- Contributes to flexibility in the training pathway to meet the demands from trainees for flexible and portfolio careers
- Allows training to better respond to local provider and population needs
- Supports the delivery of more complex care in the community within integrated health systems.

5. The Royal College of Paediatrics and Child Health (RCPCH)

The service requirements
It was agreed that the predominant service and patient requirement in district general and rural hospitals is for general paediatricians who can contribute to the emergency service. In large city hospitals there is a requirement for both general and sub-specialist paediatricians. The Shape of Training Review (SoTR) stated that a requirement for specialists will remain in the future but suggested that sub-specialty training may best be met by the development of credentials. The challenge for the Panel was to understand the relative requirement of the paediatric service for sub-specialist and generalist paediatricians in the context of the sustainability of services. The Panel was told that Health Education England (HEE) is undertaking work to identify this for England and that data would be available during 2017.

It was also noted that the paediatric service faces challenges with regard to recruitment and retention of medical staff.

The current training pathway
- Level 1 2-3 years training (ST1-3) in basic general paediatrics and neonatology. At the end of this program trainees undertake the membership examination.
- Level 2 Intermediate level training for 2 years (ST4-5) including 6 months exposure to each of general paediatrics, neonatology and community child health.
- Level 3 a further 2-3 years (ST 6-8) in either general paediatrics or a sub-specialty of paediatrics by competitive entry. This culminates in a CCT in paediatrics; those who undertake a sub specialty have this recognised by the GMC in brackets after the entry CCT paediatrics.
- Most trainees take approximately 8 years to complete training (50% of trainees take more than 8 years on a WTE basis). It is estimated that approximately 28% of the current trainees are awarded a CCT with a sub-specialty component. There is a perception that the specialty CCT is prized over a general CCT.

The proposed training programme
The RCPCH has convened a shape of training group and has proposed the following training program. The previous three-tier program will be amended to constitute 2 levels;

- New Level 1 – Training in paediatrics in general. The indicative length will be 2.5-4 years but successful completion will be capability rather than time based. Trainees will be expected to complete membership during this period.
- New Level 2 – The indicative length will be 2.5-4 years – The first year will be common to all in general paediatrics followed by either (a) three years in general paediatrics or (b) a sub-specialty of paediatrics. The balance between the number of training posts in general paediatrics and the range of sub-specialties would be determined by service need and workforce planning decisions. It should be noted that all paediatric trainees, including

sub-specialty trainees will continue training in generic paediatrics and thus contribute to the acute unscheduled care.

- It was suggested that many trainees will be able to by-pass the first year of level 2 by demonstrating appropriate capability. This will be further facilitated by the fact that the proposed curriculum review will remove some repetitive elements. As at present, trainees will continue to obtain either a CCT paediatrics or a CCT paediatrics subspecialty.

Other proposed changes include:

- Increased flexibility for trainees by permitting periods of training out of program in other disciplines and by facilitating trainees from other disciplines, such as general practice to train in paediatrics.

The College is broadly supportive of the recommendation to deliver more care in the community. This includes a willingness to develop a post CCT Fellowships in paediatrics for general practitioners and to encourage secondary care doctors to support paediatric care in the community.

The UKSTSG response

Flexibility of training

The College is committed to increasing flexibility for trainees within the training pathway. This will include the adoption within the curriculum of the generic professional capabilities work described by the GMC allowing the recognition of previous learning. The College is also committed to accommodating the needs of trainees who wish to undertake a period of academic research or work towards a higher degree. The discipline of paediatrics is also popular with trainees in other training pathways such as general practice. The College is committed to providing opportunities for trainees from other disciplines to undertake periods of training in paediatrics.

Measures to facilitate blurring of the interface between primary and secondary care

The College is supportive of measures to deliver more care to children in the community. There are already numerous examples across the UK where this is occurring. In the context of the SOTR the College would support measures such as the development of post CCT fellowships in paediatrics for GPs.

Training more generalists and identification of aspects of the current curriculum that would be suitable for credentialing.

In considering the overall structure of the training pathway, the UKSTSG welcomes the proposed more “efficient” 2-tier model with progression based on capability rather than time. The Group also supports the proposed training pathway for general paediatrics leading to the award of a CCT Paediatrics. In all these aspects the RCPCH proposal fulfils the principles of the SoTR. The Group accepts however that further discussion will be required with the further development of credentialing to consider the future balance between sub-specialty training and credentialing.

Overall the UKSTSG welcomes the proposals from the RCPCH and recognises that for the most part it fulfils the principles of the SoTR. Further discussion is planned between the UKSTSG panel and representatives of the College to identify the correct proportions of specialists and generalist that are required to meet patient need in this specialty and to discuss further the place of credentialing within the proposed structure.

Benefits arising from implementation of these proposals:

- Promotes the status of the general paediatrician
- Ensures that the proportion of training posts in general versus sub-specialist paediatrics meets the needs of patients
- Allows more flexibility in training within paediatrics and between paediatrics and other clinical disciplines.
- Will support the delivery of more paediatric care in the community.
- Stream lines the current training pathway for trainees and should make paediatrics an even more attractive career option.

6. The Royal College of Anaesthetists (RCoA)

The clinical service requirement

There are currently 10 million procedures performed per annum in the UK that involve the administration of an anaesthetic. Of these, 250 thousand are considered to be high-risk often occurring in an emergency setting. Further, in the course of routine elective work anaesthetists are required to deal with patients who have a wide range of clinical conditions and co-morbidities. It is essential therefore those anaesthetists are equipped with the broad skills to deal with this diverse workload.

The Current training pathway

The College submission suggested that the current training pathway is broadly fit for purpose since it produces doctors with the skills that patients across the UK require. It is a broad based training program configured in 2 stages as follows:

Stage 1 – Core Anaesthetic training (indicative duration 2 years)

or

– ACCS (Acute Care Common Stem) with an indicative training time of 3 years. This includes a minimum of 6 months training experience in each of the acute specialties of emergency medicine, intensive care medicine and acute medicine.

Stage 2 – a 5-year program of higher training in anaesthesia. Trainees have the opportunity to undertake up to one year in a sub-specialty of anaesthetics such as cardiac or neuro-anaesthesia, pain management or obstetric anaesthesia. This is normally undertaken in year 4 or 5. There is no formal recognition of this period of sub-specialty training but anaesthetists who subsequently work in a district general hospital (DGH) often “major” in that area. Doctors who wish to be sub-specialist anaesthetists normally undertake a post CCT fellowship.

UKSTSG response

Flexibility of training

The College proposed that this would be achieved by the adoption of the generic professional capabilities work described by the GMC. The College is also committed to flexibility with regard to accommodating trainees who wish to undertake a period of academic research or work towards a higher degree. The College indicated that any further flexibility in recognising previous training is at present limited by the current Legislative requirements that training can only be recognised if it has taken place in a recognised training program.

Measures to facilitate blurring of the interface between primary and secondary care
The College presented an innovative proposal to undertake all or part of pre-operative assessment in the community thereby avoiding the need for patients to attend hospital or to use hospital beds for this purpose. The College also suggested that there would be opportunities for anaesthetists with an interest in clinical areas such as chronic pain management to undertake more work in the community. It is not envisaged however that anaesthetics will be routinely administered in a community setting in the future.

Training more generalists
The UKSTSG accepted the College position that most anaesthetists undergo broad general training and utilise these skills in both their elective and emergency work thereafter. Most contribute to emergency on-call rotas. In this respect the current training pathway fulfils this key principle of the SoTR.

Identification of areas of specialist training within current curricula that are suitable for credentialing
There are specialty components of the current training program that are not undertaken by all trainees and are not formally recognised. These would appear to be suitable for credentialing.

Although the meeting was not convened to consider the training pathways for intensive care medicine the Panel identified this as a potential area for credentialing in the future for trainees who have a CCT in anaesthetics.

Conclusions
The UKSTSG broadly accepted that the current training pathway fulfils the principles of the SoTR with regard to producing generalists, including flexibility and seeking to deliver more care in the community. The UKSTSG recommends that the College should work collaboratively with the GMC to identify those areas of the current curriculum that may be suitable for credentialing.

7. The Royal College of Ophthalmologists (RCOphth)

The clinical service requirement
At present most ophthalmologists in both district general and large city hospitals participate in the appropriate emergency on call rota and undertake clinics that deal with general ophthalmology. They can do this because the current curriculum provides the broad range of skills that are required. A particular feature of ophthalmology training is the requirement for trainees to develop the technical skills to perform accurate and intricate work.

The current large volume patient and service needs are for the treatment of cataracts, macular degeneration and glaucoma. The College has also identified that there is a rapidly rising demand based upon demographic change for the care of patients with age related diabetes and macular degeneration. There is a requirement to take this into account in a review of training.

In addition to providing the general service many ophthalmologists also undertake more focused work as a “special interest”. At present there is no formal training pathway or recognition for these “specialty skills” although in many cases the doctors who perform this work have undertaken additional ad-hoc post-CCT fellowship training.

The current training programme
At present training is of seven years duration. This was considered necessary because trainees enter the specialty with few pre-existing skills that are relevant to ophthalmology. There are opportunities for sub-specialty "tasters" in years 6 and 7 but there is no formal academic recognition for these sub-specialties. The College submission also recognised that some registrars lose generalist skills before the time of CCT because they are concentrating on a specific sub-specialty area.

The proposed training programme
The College proposal designed to meet changing patient needs is innovative. The current training pathway is focused towards the surgical aspects of ophthalmology and the acquisition of practical skills. In the future there will be a requirement for ophthalmologists who have a more medically based focus to their work. On the basis of current knowledge it is estimated that the future requirement will be for approximately 70% of staff to have a surgery focus and 30% to have a medical focus.

It is proposed that this will be achieved by having a common stem to ophthalmology training for two years and will include an enhanced component of simulation-based training. Thereafter trainees will enter one of two higher training programs that will be capability rather than time based but will have an indicative length of 5 years. These will have a "surgical" or a "medical" emphasis. An advantage of this proposal (which is not available at present) is that there will be the opportunity for trainees pursuing the surgery-focused pathway to transfer to the more medically based pathway.

The College envisages that the current opportunities for trainees to undertake "taster periods" in a sub-specialty in years 6 and 7 would continue.

The UKSTSG response
The UKSTSG broadly welcomes these proposals. In particular, the proposal to have surgical and medical focused pathways provides an innovative solution to the anticipated future needs of patients. The Group also supports the proposal to enhance the simulation component of technical skills training. It was also noted that ophthalmologists had embraced the development of "new working" arrangements with increasing roles for allied health professionals (AHPs) and advanced nurse practitioners.

The proposal was considered against the following four key SoTR principals.

General Training
The current training pathway equips all doctors with the skills to participate in the appropriate general unselected on call rotas. Further, most ophthalmologists currently participate in the emergency service and undertake "general clinics". In this respect the current curriculum fulfils this principle of the SoTR.

Whilst the UKSTSG are broadly supportive of the development of a new medically focused pathway it will be essential that this does not compromise the ability of service providers to deliver emergency care. The UKSTSG require further reassurance that "medically focused" trainees will have the skills to manage conditions that require immediate care such as retinal detachment. Alternatively the UKSTSG would be interested to understand how emergency services in the future might be configured to accommodate this change in training.

Flexibility
The College representatives highlighted the fact that most trainees who enter the specialty have only a rudimentary understanding of the “eye”. As such there is little scope to recognise previous learning with regard to practicing clinical ophthalmology. The College will however recognise previous experience based on generic professional capabilities as described by the GMC. The College is also supportive of flexibility in relation to supporting academic work and for doctors who wish to pursue an academic career. The UKSTSG broadly accepts that there is specificity to training in ophthalmology but recommends that the College review the options for flexibility beyond generic professional capabilities.

Supporting Care in the community
At present ophthalmology has strong links with community care with an important role for optometrists. Indeed many referrals to ophthalmologists currently come from optometrists who are taking an increasing role in patient care. The College representatives did not envisage that more ophthalmology would be undertaken in general practice principally due to the time that it takes to acquire the requisite skills and the costs of setting up ophthalmology suits. Consequently it is not envisaged that this is an area for extended role GPs. The UKSTSG broadly accepts this view.

Credentialing
The College had not considered the role of credentialing in their proposal predominantly because of the lack of clarity as to how it would be configured. The representatives however accepted that components of the current curriculum may be suitable for credentialing; in particular the “taster elements” that are not undertaken by all trainees in years 6 and 7. Credentialing would also provide a solution to the current lack of objective recognition and governance of “sub specialisation” within ophthalmology.

Conclusions
The UKSTSG broadly welcomes this proposal. In the most part it fulfils the principles of the SoTR. The proposal to develop a new training pathway that is “medically focused” appears to address a specific patient need. This will require the development of a new CCT. While being broadly supportive of this aspect reassurance will be required that it will not adversely affect the delivery of emergency services.

The UKSTSG recommends the following actions:

- The College makes a submission to the UK Reference Group seeking support for a new “medically focused” curriculum/CCT.
- The College identifies those components of the current curriculum that will be suitable for credentialing.

Appendix 2
Membership of the UK Shape of Training Steering Group

Chair: Professor Ian G Finlay

Scottish Government (& Secretary to Group)	Mr Dave McLeod
Northern Ireland Government	Dr Paddy Woods
Department of Health	Ms Natalie Cullen
	Ms Emma Rush
	Mr Alan Robson
Welsh Government	Dr Chris Jones
	Ms Elaina Chamberlain
	Ms Geraldine Buckley
Health Education England	Professor Wendy Reid
	Mr Andrew Matthewman
Northern Ireland Medical and Dental Training Agency	Professor Keith Gardiner
NHS Education Scotland	Professor Stewart Irvine
Wales Deanery	Professor Derek Gallen
Academy of Medical Royal Colleges	Mr Alistair Henderson
Academy of Medical Royal Colleges Trainee representative	Dr Gethin Pugh
General Medical Council	Dr Vicky Osgood
	Dr Judith Hulf
	Ms Paula Robblee
British Medical Association	Dr Ian Wilson
	Dr Anthea Mowatt
	Dr Jeeves Wijesuriya
NHS Employers	Mr Daniel Mortimer
	Mr William McMillan
Medical School Council	Professor Paul Stewart
	Professor Peter Kopelman
Conference of Post-Graduate Medical Deans	Professor William Reid

Annexes (will be available online)

Annex 1
The 19 Shape of Training Review recommendations

Annex 2
The terms of reference for the UKSTSG

Annex 3
Principles adopted by the UKSTSG

Annex 4
UKSTSG Interim statement 2015

Annex 5
The Curriculum Mapping Exercise report to the UKSTSG meeting of November 2015

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

Annex 7
Principles for the development of Clinical Academic Training

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

Annex 9
SAS doctor questionnaire in Scotland

Annex 10
SAS Doctor Development Guide England

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

Glossary of terms

SoTR: Shape of Training review, written by Sir David Greenaway, published October 2013

UKSTSG: UK Shape of Training Steering Group

GMC: General Medical Council

MSC: Medical School Council

NES: NHS Education for Scotland

HEE: Health Education England

COPMeD: Conference of Postgraduate Medical Deans

JRCPTB: The Joint Royal College of Physicians Training Board – comprised of the Royal College of Physicians of London, Royal College of Physicians of Edinburgh and the Royal College of Physicians and Surgeons of Glasgow

RCSEng: Royal College of Surgeons of England

RCGP: Royal College of General Practitioners

RCOG: Royal College of Obstetricians and Gynaecologists

RCPCH: The Royal College of Paediatrics and Child Health

RCOphth: The Royal College of Ophthalmologists

RCoA: The Royal College of Anaesthetists

UKMERG: UK Medical Education Reference Group: This encompasses representation from the four UK health departments and the four statutory post -graduate medical education bodies.

MLA: Medical Licensing Assessment

Works cited

Comptroller and Auditor General. (2013). *Emergency admissions to hospital: managing the demand.*

Department of Health. (2014). *Comorbidities: A framework of principles for system-wide action.*

Department of Health – Northern Ireland. (2016). *Health and Wellbeing 2026: Delivering Together.*

Edwards, N. (2014). *Community services: How they can transform care.* The King's Fund.

Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.*

GMC. (2015). *Update on National Licensing Examination.* GMC.

GMC. (2016). *Development of generic professional capabilities*. Retrieved October 18, 2016, from GMC: http://www.gmc-uk.org/education/23581.asp

GMC. (2016). *Generic professional capabilities – outcome of public consultation draft.*

GMC. (2016). *Standards for Postgraduate cirricula and regulated credentials- Draft.*

GMC. (2017). *Approved specialty and sub-specialty training curricula by Royal College*. Retrieved February 16, 2017, from GMC: http://www.gmc-uk.org/education/approved_curricula_systems.asp

Greenaway, D. (2013). *Securing the future of excellent patient care.* GMC.

Greenaway, D. (2013). *Shape of training. Securing the future of excellent patient care.*

Health Education England. (2016). *HEE Quality Framework 2016/17.* HEE.

Health Education England. (2016, November 30). *News and Events*. Retrieved February 13, 2017, from Health Education England: https://hee.nhs.uk/news-events/news/health-education-england-lead-review-increase-support-junior-doctors-career-progression

Health Foundation. (2013). *Improving patient flow: how two trusts focused on how to improve the quality of care and use available capacity effectively.* London.

Medical Schools Council and Health Education England. (2016). *By Choice – Not by Chance.*

NHS England. (2015). *Five year forward view. The Success Regime: A whole systems intervention.*

NHS in England. (2014). *Five Year Forward View.* England.

NHS Scotland. (2011). *A Route Map to the 2020 Vision for Health and Social Care.* Scottish Government.

Purdy, S. (2010). *Avoiding hospital admissions: What does the evidence say?* The King's Fund.

Royal College of Physicians London. (2013). *Future hospital: caring for medical patients.*

Royal College of Physicians London. (2013). *Future hospital: caring for medical patients.*

Scottish Government. (2016). *A National Clinical Strategy for Scotland.*

The Foundation Programme. (2016). *Career destination report 2016 – The Foundation Programme.*

Tooke, J. (2008). *Aspiring to Excellence.*

Welsh Government. (2011). *Together for Health: A five year vision for the NHS in Wales.*

Welsh Government. (2017, February 7). *Health and Social Services*. Retrieved February 15, 2017, from Welsh Government: http://gov.wales/topics/health/nhswales/review/?lang=en

Scottish Government
Riaghaltas na h-Alba
gov.scot

© Crown copyright 2017

OGL

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit **nationalarchives.gov.uk/doc/open-government-licence/version/3** or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: **psi@nationalarchives.gsi.gov.uk**.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

This publication is available at **www.gov.scot**

Any enquiries regarding this publication should be sent to us at
The Scottish Government
St Andrew’s House
Edinburgh
EH1 3DG

ISBN: 978-1-78652-925-1 (web only)

Published by The Scottish Government, August 2017

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS264481 (08/17)