ACADEMY OF
MEDICAL ROYAL
COLLEGES

Academy of Medical Royal Colleges Shape of Training Mapping Exercise

Report of the Mapping Exercise Panel

1. Purpose

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

2. Introduction

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

3. Summary of findings

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

4. Key messages

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

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

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

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

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

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

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

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

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

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

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

5. Next steps

The Panel recommends that the UK Steering Group:

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

24 November 2015

Annex A
Process to Receive Output from the Academy Shape of Training Mapping Exercise.

Background

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

2. The Chair of the UKSTSG then wrote to the Academy inviting them to commence this work.

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

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

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

Remit, Terms of Reference and Membership of the Panel

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

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

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

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

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

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

Membership of the Curricula Mapping Panel

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

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

12. In addition to the Chair, Membership will be drawn from the UKSTSG or the Academy and will include:
Representatives from UK Education and Training:

- Health Education England
- NHS Education Scotland
- Education representative from Wales
- General Medical Council.

UK Academy of Medical Royal Colleges:

- Senior Officer
- Representative of Craft specialties
- Representative of Medical Specialties
- Representative of Primary care.

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

Reporting to the UK Steering group

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

Annex B
Report on Academy Mapping Exercise

Background

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

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

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

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

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

What the panel is considering?

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

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

We have received 11 College and three Faculty submissions.

As part of this exercise, the panel held a seminar for representatives from colleges and faculties to consider the issues identified in their submissions. The seminar focused on

challenging areas within the four Shape of Training themes. More than 40 people participated in the discussions with representation from doctors in training, patients, a wide range of specialties, and the Academy mapping exercise panel.

This report considers the feedback from the College and Faculty submitted responses as well as the discussions at the seminar.

Capable of emergency and acute care

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

Current training

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

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

Concerns with current training

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

Paediatrics and Child Health (RCPCH) warned that their doctors need to maintain exposure to general paediatric and neonatal emergency care.

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

Potential areas for change

A number of Colleges and Faculties, however, identified ways they might further develop emergency and acute care as part of postgraduate training. The Royal College of Pathologists (RCPath) suggested that specialties like clinical pathology could provide support to specialties caring for acutely ill patients through more joint training and working opportunities. Similarly the FSRH suggested their doctors in training could be trained to provide more urgent care in the community, but warned they still would not be able to care for critically ill patients. The Royal College of Psychiatrists (RCPsych) is mapping out cross-specialty psychiatric emergency management in mental health specialties, and intend to make changes to higher specialty training if they find cross-specialty competence has not been attained.

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

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

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

Blurring the boundaries between primary and secondary care

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

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

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

Current approaches

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

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

Concerns about current training in delivery integrated care

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

There was overwhelming support for a much greater role for GPs and multi-disciplinary teams in caring for patients in the community. Specialties such as psychiatry, obstetrics and gynaecology as well as paediatrics and child health recommended a much closer relationship with primary care. There was also strong support for more cross-specialty training between specialists and GPs to improve diagnosis and/or care for people with specific conditions. Indeed the Royal College of Obstetricians and Gynaecologists (RCOG) suggested '*While the service is in transition to greater community/primary care working, RCOG is increasingly working with RCGP to develop training modules. The specialty remains mindful of how other*

specialty training programmes and service requirements develop as cross specialty working (physicians, surgeons) is common practice now.' The Royal College of Anaesthetists (RCoA) suggested '*Increasingly anaesthetists will need to work with GPs to enhance perioperative care at both ends of pathway – shared information, pre-op screening, discharge planning and information*.' Although the RCGP also recognised this same need, it highlighted that the current three-year GP curriculum is already full and this was a significant barrier to development.

However, it is worth noting that few specialties suggested opportunities for specialty doctors in training to train in community settings.

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

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

Potential areas for change

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

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

health care, and primary care for benign gynaecology. Within the hospital setting, complex surgery will require greater cross specialty involvement with colorectal surgery and urology.'

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

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

More flexibility in training and moving between specialties

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

Current approaches

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

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

Feedback from specialties that already have broad based training programmes identified a number of benefits from these arrangements, including better support networks across the specialties. Some of these specialties, such as those associated with the JRCPTB, FICM and

FPH have all recommended expanding these broad based programmes to other specialties, especially where they will help develop better integrated care.

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

Concerns about flexibility in training

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

Potential areas for change

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

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

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

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

- Recognising that one approach to postgraduate training will not fit for all specialties
- Considering the benefits of a more modular approach to training or a more flexible way of developing training. For example, training could be based on a framework of training modules that sets out expected outcomes or time in training but not content. Curricula would determine how many of these modules would be needed to deliver the required outcomes and develop content to meet those requirements, including generic components

- Begin to discuss the possibility of combining specialties in some areas – but must be clear what benefit to training and service this would offer.
- Developing a broader approach to core training so that it includes more cross-specialty integration. It has to be a more radical approach to change. For example, specialties should train together based on patient requirements and cut across colleges and faculties where appropriate or with other professionals
- Considering mechanisms to lessen the reliance on doctors in training to deliver service
- Recognise that generalist training does not necessarily equate to shorter training.

Implications on the length of training

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

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

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

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

Potential areas for change

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

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

Feedback on other areas of training

Academic training

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

Undergraduate and Foundation Programme

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

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

Fostering lifelong learning and Credentialing

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

Current approach

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

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

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

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

Concerns raised about credentialing

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

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

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

A few responses recommended that credentialing should not be developed in isolation from Shape of Training (e.g. RCoA).

Feedback from the seminar was consistent with College and Faculty submissions. Key suggestions included:

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

Maintaining momentum

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

Colleges and Faculties that submitted responses to the mapping exercise

- Royal College of Anaesthetists
- Royal College of Emergency Medicine
- Royal College of General Practitioners
- Royal College of Obstetricians and Gynaecologists
- Royal College of Ophthalmologists
- Royal College of Paediatrics and Child Health
- Royal College of Pathologists
- Royal Colleges of Physicians (London, Edinburgh and Glasgow) – through the Joint Royal College of Physicians Training Board.
- Royal College of Psychiatrists
- Royal College of Radiologists including Faculty of Clinical Oncology and Faculty of Clinical Radiology
- Royal Colleges of Surgeons (England, Edinburgh and Glasgow) – through the Joint Committee on Surgical Training. Their response encompassed specific responses from a number of specialties: ENT, Plastics, Core, Cardiothoracic, Vascular, General, Neurosurgery and OMFS
- Faculty of Public Health
- Faculty of Intensive Care Medicine
- Faculty of Sexual and Reproductive Health.