General Medical Council

Adapting for the future:

a plan for improving the flexibility of UK postgraduate medical training

Working with doctors Working for patients

Contents

Foreword

While carrying out this review, we were struck by how many patients, doctors and employers said that the way we train doctors in the UK has to change.

In this report we identify five problems that create barriers to more flexible training arrangements. These result in training that is rigid, slow to adapt, and fixated with time and tick boxes. We will respond by taking specific actions, together with others, to realise our ambition for more transparency across specialties about outcomes.

We want trainees to have clarity and confidence in what it will mean for them if they switch specialties. Equivalent training between related specialties will be recognised. This will improve efficiency by allowing doctors to transfer their skills more easily and to avoid repeating training. Patients and health services will benefit from having doctors who can care for patients with conditions that cross specialty and subspecialty boundaries.

Delivering changes to training by 2020

Because of our UK-wide remit we have submitted this report to the health ministers of the four UK countries. Much of the report builds on the findings and recommendations made by past reviews of postgraduate training. What makes this review different is not just the context, but a determination to deliver real changes by 2020.

Towards the end of last year, we said the medical profession was in a 'state of unease'.* Every conversation we have with doctors tells us that the pressure on the medical profession has increased. The actions we are committing to in this review can make a meaningful difference to the professional lives of doctors and the choices they make about their careers.

Ultimately, it is patients who will benefit the most from these changes in training. We will require training to have a greater focus on the generic professional capabilities common to all doctors. We will ask medical colleges and faculties to work together to identify aspects of their training that are common across related areas of practice. Combined, these changes will help ensure doctors have a broader understanding of the complex and interconnected conditions of their patients.

* www.gmc-uk.org/news/27482.asp

Working together to drive reforms

The GMC's responsibilities for medical education and training in all four nations of the UK make us ideally placed to drive forward the changes set out in this report. But we cannot deliver more flexibility and choice for doctors – and the benefits which flow from this work for patients – on our own. We must work in partnership with organisations involved in UK medical education and training.

With strong commitment from all these bodies, many of the reforms within this report can be taken forward without legislative change. Blocking part of the way, though, is the *Medical Act 1983* – the legislation from which we draw our responsibilities and powers for medical education across the UK. We will ask the UK Government, which will need to consult closely with the devolved administrations of the UK, to make the legislative framework less restrictive.

Our vision in this report is ambitious. However if postgraduate training in the UK looks the same in five years' time, then we will have failed trainees and we will have failed patients. We owe it to them to make sure this plan succeeds.

We are enormously grateful to the many organisations and individuals that contributed to this review and we look forward to continue to work with them to deliver these changes over the next few years.

Professor Terence Stephenson
Chair

Charlie Massey
Chief Executive

Executive summary

We heard in this review that the current approach to training is out of date and urgently in need of reform. The structure and processes in training have created barriers for trainees who seek to change specialty. The same structures limit the ability of training to adapt to changing population and service needs.

The rigid approach to training is caused, in part, by the complexity of our training structure. Many of the 66 specialties and 32 subspecialties develop their training requirements in isolation. Different specialties focus on particular patient and service needs. We recognise that as aresult of this, there are some inherent differences in training requirements between specialties. But there are also many professional, and to some extent specialty, attributes that could be more commonly recognised across training. These opportunities have not been fully realised in the way training has developed.

In this report we set out actions that will ensure trainees have more clarity and confidence in what it will mean for them if they switch specialties. Equivalent training between related specialties will be recognised, with clear indications about what further training will be necessary in the new specialty. This approach will help doctors transfer their skills more easily. It will be more efficient because they will not need to repeat training or learning already achieved. And a benefit to patients and the service will be doctors capable of caring for patients with medical conditions that reach across specialty and subspecialty boundaries.[1]

This ambitious vision will be achieved, in part, through the introduction of the generic professional capabilities framework and our revised standards for postgraduate curricula. These will make sure all specialties identify aspects of their curricula that support flexibility in training.

It is important that there is strategic oversight of these changes and that the four countries of the UK are engaged with their delivery, to make sure the needs of their healthcare systems and patient populations are balanced with the drive towards greater flexibility.

Working with representatives from the four UK countries, we want to quickly establish whether this oversight can be achieved within existing UK governance arrangements - for example, via the Medical Education UK Reference Group - to make sure the majority of these commitments are delivered by 2020.

[1] The UK Shape of Training Steering Group report on the implementation of the Shape of Training recommendations is addressing the need for better cross-specialty training opportunities. A report about this work will be published in April 2017.

Context

How the review was commissioned

The Secretary of State for Health, Rt Hon Jeremy Hunt, asked us, as the UK regulator of doctors, to review the flexibility of postgraduate training. The review came about during the industrial dispute between trainees and the Government in England. The ACAS agreement between the British Medical Association (BMA), NHS Employers and the Department of Health (England) on 18 May 2016 proposed that:

'Following a discussion with the Secretary of State, the GMC has agreed to lead a review with the medical colleges, representatives of junior doctors and the organisations funding postgraduate medical education in the four countries across the UK to support appropriate recognition of competence where junior doctors change training paths.'[2]

Although this contract agreement was subsequently rejected by trainees, our Chair, Professor Terence Stephenson, recognised:

'The industrial dispute between doctors in training in England and the UK Government has highlighted a series of deep-seated issues beyond the contract which need to be addressed – not just by governments across the UK, but by the profession itself and by those of us who regulate and oversee the profession and its education and training.'[3]

We are well placed to conduct this review because we are the statutory body that sets the educational standards for all UK doctors through undergraduate and postgraduate education and training. We promote high standards and make sure that medical education and training meets our expectations across the UK through our quality assurance processes. Annex A provides information on the structure of postgraduate training in the UK.

[2] See www.acas.org.uk/media/pdf/l/p/ACAS_FINAL_AGREED_NHS_Emp_BMA_DoH_Package_180516.pdf.

[3] See www.gmc-uk.org/news/28613.asp.

Our vision for flexibility

We will make sure trainees have a much clearer view of, and confidence in, what it will mean for them if they switch specialties. Equivalent training between related specialties will be recognised, with clear indications about what further training will be necessary in the new specialty. This approach will help doctors transfer their skills more easily. It will also be more efficient because they will not need to repeat training or learning already achieved. A benefit to patients and the health service will be doctors capable of working and caring for patients with medical conditions that extend beyond their immediate specialty or subspecialty boundaries.

Training like the broad based training programme shows that this approach can work. It gives trainees six months of experience in each of four specialties: core medical training; general practice; paediatrics; and psychiatry. Doctors enter further training with experience from these other specialties. This translates into more rounded care for their patients, and more flexibility for doctors who want to move between these specialties later on in their training. We will learn from this approach to develop the same flexibility across more groups of specialties.

This vision for more flexible training has been informed by, and produced with, our stakeholders. Information about the methodology used in the review is described in Annex B. It is clear that our approach resonates across the healthcare landscape.

- Patients at our patient engagement event supported better flexibility in training. They want doctors who help them manage the complexities of their care across different care contexts, and throughout their care journey.
- The current generation of doctors want more flexibility in the way they are trained. They are deeply committed to providing high quality care to patients, but they want training pathways that can adapt to their needs, enhancing and widening their career choices. They want to train in a way that helps them strike the right balance between their professional and personal lives, including training on a less than full time basis. Alongside this, they also want greater opportunities to learn outside the defined training programme, through out of programme training or work experiences.
- Employers and education providers told us in our evidence days that they want doctors who can work more generically and effectively across specialty areas. They also require ways for the medical workforce to adapt rapidly to meet local pressures and emerging service needs.
- Postgraduate training bodies (including the medical colleges) urged us to introduce ways for curricula and training to adapt more rapidly to meet advances in medicine and service needs.

We have considered varying interpretations of flexibility needed in the system in this report. These were identified by our stakeholders:

- Flexibility to move between specialties.
- Better cross specialty understanding and recognition.
- A more flexible medical workforce. More general training within and across specialties will help in its development. This emphasis is covered by the UK Shape of Training Steering Group.
- Flexibility in training arrangements that consider how and where doctors train, such as less than full time training.
- Flexibility in working practices to adapt to patient and health service needs.
- Flexibility in working arrangements without changing specialty. Many specialties require their doctors to work in complementary contexts or work environments. For example, general practice trainees work in hospital settings.

These themes are not new: they were identified in Professor Sir John Tooke's 2009 review of postgraduate training (*Aspiring to Excellence*) and in Professor David Greenaway's 2013 review (*Securing the future of excellent patient care*). Both proposed that medical training should be structured within broader specialty groupings. Doctors would, consequently, have more varied career pathways. Greenaway's report also suggested that this more flexible approach would help employers manage the immediate workforce crises in emergency and acute care, better manage heavy workloads and make sure patient and population needs are met in the future.

Our reforms to curricular development and our new approvals processes will make sure we deliver on many of the ambitions from these previous reviews, in a pragmatic way that respects existing specialty structures. We will require all specialties to embed the generic professional capabilities framework, and to identify learning that is common across related areas of practice. This is how we will make sure equivalent learning between related specialties is recognised. Curricula will not be approved if they fail to meet these requirements.

The problems

We can be proud of the high quality training experienced by doctors in the UK. Year on year, our quality assurance processes find most training in the UK is good overall, with many examples of excellence and innovation. For example, in our 2016 national training survey, more than 83% of doctors rated the overall quality of their training experience as excellent or good.

And yet there are problems with the way postgraduate training is developed and organised. We heard in this review that the current approach to training is in need of reform. Stakeholders have described it as rigid and inflexible. This is caused, in part, by the complexity of our training structure and the legal framework under which we work. Many of the 66 specialties and 32 subspecialties develop their training requirements in isolation. Different specialties focus on particular patient and service needs. As a result of this, there are some inherent differences in training requirements between specialties. But there are also many professional, and to some extent specialty, attributes that could be shared between curricula. These opportunities have not been fully realised in the way training is developed. The structure and processes in training have created barriers for trainees who seek to change specialty. The same structures limit the ability for training to adapt to changing population and service needs.

We have identified five key barriers to improving flexibility in postgraduate medical training, in consultation with patients, trainees and system-leaders. We will consider how to address these issues in the next section.

Transferring between specialties is difficult

The impact of EU/UK law on flexibility

The legal framework controlling postgraduate training in the UK is complex and leads to inconsistencies in approach for doctors.

Of the 66 specialties, over two thirds are listed in an Annex to the directive that governs the recognition of professional qualifications across the European Economic Area (EEA). These are called 'Annex V' specialties.

The Annex was created to facilitate the mobility of specialist doctors across Europe. It allows doctors with a specialty qualification listed in the Annex to have that qualification automatically recognised in another EEA state that also lists that specialty in the Annex.

This directive is embedded in UK law – through the *Medical Act 1983* and the *Postgraduate Medical Education and Training Order 2010* (the PMET Order), from which we draw our education responsibilities and other regulatory powers. UK law prescribes the minimum duration for each specialty training programme delivered in the UK. Each EU member state is entitled to set its own duration of specialist training as long as this complies with the duration set in the directive. The minimum training durations

prescribed in UK, as Annex C shows, are generally longer than the minimum periods set in Annex V of the directive.

To maintain the minimum training periods set out in the Annex, the directive places some restrictions on doctors wishing to train in another specialty from the one they chose originally.

What does this mean for a UK doctor?

In certain circumstances, the directive (and the *Medical Act 1983*) allows for partial exemptions of training. This means that a doctor with a specialist qualification (for example, a Certificate of Completion of Training (CCT)) can have their training time in a second specialty reduced below the minimum duration set by the GMC. However there are restrictions around this.

- The doctor must have already obtained a qualification in an Annex V specialty.
- The second specialty must be another Annex V specialty.
- And the training duration can be reduced by no more than 50%.

For example, a doctor who has gained a CCT in general surgery could subsequently train in vascular surgery (for which the minimum training duration in the UK is eight years). Because the doctor has a qualification in an Annex V specialty, they are eligible to have their training in vascular surgery (another Annex V specialty) reduced by up to a maximum of four years.

While there is flexibility for 'qualified' doctors, these partial exemptions for Annex V specialties are not available to doctors who are partway through their specialist training. What these doctors experience is a 'snakes and ladders' effect. Instead of having such training recognised, they need to start again from scratch.

This has a real impact on doctors and healthcare systems. It is inefficient for doctors to repeat learning unnecessarily. If we could solve this problem, systems leaders could better manage their resources and the medical workforce in their countries.

'Non-Annex V' specialties

For the remaining 19 UK specialties not covered in the directive but covered in UK legislation, the restrictions on exemptions from minimum training periods do not apply. Doctors can, with the support of medical colleges and postgraduate deans, move between specialties. They still need to secure a post through recruitment and selection processes.

The number of doctors that currently transfer between specialty training programmes is not large. For example between 2013 and 2016 in the first two years of specialty training (ST1 and ST2), 173 doctors in psychiatry and 293 doctors in obstetrics and gynaecology transferred into general practice. In the same period just 51 anaesthetists moved into general practice.[4] Stakeholders have suggested these small numbers could be the result of a complicated and unclear process, which contributes to it being rarely used for trainees.

[4] GMC national training survey data 2012–16.

A trainee told us how important flexibility was to their career: 'I joined the training programme at ST4 level, halfway through the programme due to my previous experience and training in obstetrics and gynaecology, and sexual and reproductive health. This not only shortened the training programme, it was one of the main reasons for me to apply for the programme and secure a training post. If this flexible opportunity was not in place at that time, I might not have considered applying for the training post. I do feel it was a great opportunity at that time for candidates like me with previous many years of experience to apply for the training programme and start the training programme at mid-level.'

Only five specialties use the Academy of Medical Royal Colleges (AoMRC) *Accreditation of Transferable Competences Framework*, which recognises that previous relevant training does not have to be repeated. Of these five, general practice has the highest number of doctors transferring into it, using the framework. The Royal College of General Practitioners estimate that in 2016 more than 380 doctors applied from other specialties into general practice. Of these about 139 were accepted with nearly half originating from medicine. While the numbers are small, there appears to be an appetite for these types of arrangements.

This framework, already limited by the EU and UK legislation, does not seem to be widely used for trainees. This has caused some trainees to unnecessarily start over in new specialties. For example, one trainee told us that when moving from general practice to paediatrics, she repeated part of the training already covered in the GP programme. Neither she, nor her programme managers, realised that a portion of her training could be recognised through the *Accreditation of Transferable Competences Framework.*

Training in other ways is not recognised

Doctors who have worked in non-training jobs or have worked overseas for a period of time before entering training may get none or only a portion of this experience recognised, even if working in the same specialty.

In order to meet patient needs and address rota gaps, employers have created non-training grade jobs in parallel with the training posts. Doctors in these roles sometimes have the same opportunities as trainees, often following the specialty curriculum. When doctors return to their training programmes, their out of training experiences are not counted fully. This is the result of the UK law that requires us to approve training for it to lead to the award of a CCT.

We already have a mechanism that supports doctors who want a more flexible and personalised way to develop their careers. Trainees, who have been in non-approved posts, are able to join an approved training programme, with some learning recognised. They are able to enter training at a later starting point and only need to gain the remaining requirements in the curriculum. This is known as the 'combined programme'. At the end of it, trainees can apply for entry onto the Specialist Register via a Certificate of Eligibility for Specialist Registration (CESR) or to the GP Register via a Certificate of Eligibility for GP Registration (CEGPR). The Royal College of Emergency Medicine suggested that 'some [trainees] are leaving to follow the CESR route as it allows them to train in one centre and choose what they do, in large part due to the inflexibility of training rotations and deanery processes.'

But like the AoMRC *Accreditation of Transferable Competences Framework*, it is poorly understood and perceived as burdensome, with only about 150 doctors using it a year.

There is also an issue of portability of this type of recognition. Within the UK, there's no difference in the status of a CESR/CEGPR and a CCT: both grant entry to the specialist or GP register on exactly the same terms. But if doctors want to work elsewhere in Europe, CESRs and CEGPRs are not recognised in the same way. Instead, the holder must apply for recognition under what the directive calls 'the general system for the recognition of evidence of training'. And this is likely to involve a process of assessment. This might be another reason for trainees opting to 'start again' in a new specialty, rather than use this combined programme route onto the registers.

More career support is needed

Stakeholders, especially organisations responsible for workforce planning and employers, suggested current training arrangements prevent them from deploying the medical workforce quickly into much needed areas of care. It takes years to retrain in a completely new specialty – whereas service revisions arising from changing patient needs are pressing and demand more immediate action.

While there are a large number of fellowships available after doctors complete their training, these are very often defined by academic or professional expectations. These are often not tailored to address gaps in patient care or the medical workforce. Doctors also confirmed that there are limited mechanisms to redirect or refocus their careers in a formal and recognised way, short of retraining in another specialty. The current training structure, then, is not agile enough to respond to patient, service or even professional needs as they change over time.

Doctors are able to apply for more flexible training arrangements for health or caring reasons. These

arrangements rely on the ability of employers to support flexible training arrangements, including potential risks to patient safety due to the impact on rotas. Health Education England (HEE) has identified structural and cultural barriers in England to less than full time training, and inequality in support for doctors who return from time out of training. Less than full time training in England is often organised through 'slot shares' that specify that each doctor does 60% of the full-time workload, and 50% on call.[5] The structure is welcomed by employers and some trainees because it provides assurance around planning. But it also results in rigid rules to support doctors who work on a part-time basis. Doctors are prevented from working up to their capacity because they are unable to work a higher proportion below full-time. And the arrangements often fail to give them certainty around actual working days to enable planning, for example, regarding childcare. HEE is piloting different approaches to less than full time training that will give more flexibility to trainees. It is looking at supporting doctors working less hours than full time, or working less in the standard clinical training environment, with some time on other training.

Postgraduate training is slow to adapt

The provision of medical care is changing rapidly, working at the cutting edge of science and technology. A longstanding criticism of postgraduate training is that it is slow and inflexible. Training cannot adapt quickly to encompass emerging service requirements and areas of practice, or address changes to the workforce and patient care.

We have 66 specialties that each set out their training plans in different ways and with varying levels of detail. This creates barriers which prevent training from reacting rapidly to population or service changes in two ways.

First, doctors, in many cases, only gain general skills in the specialty for one or two years before narrowing their scope of practice. In some run-through programmes, this might be appropriate. But this early specialisation, in many cases, limits the opportunity for curricula to have common components across specialties. As doctors focus down their scope of practice, they are unable to work across the breadth of their specialty or gain skills in related areas of practice. It is these broader skills combined with stronger generic capabilities, however, that allow them to respond to emerging demands. The UK Shape of Training Steering Group has also identified these issues through its work with medical colleges to develop more general training in specialties.[6]

Second, training does not recognise what is common between specialties, making it difficult for doctors to move to new areas of practice outside of their specialty without unnecessarily repeating training already acquired.

Part of the problem rests with us. Our standards for curricula development and our approval processes require submissions that explain in detail the plan for training doctors (the curriculum).[7] It takes a long time to get changes to these plans approved because of their complexity.

[5] Health Education England, *Enhancing Junior Doctors' Working Lives*, March 2017.

[6] The report from the UK Shape of Training Steering Group on the implementation of the recommendations from the Shape of Training report - due to be published in April 2017.

[7] The standards and processes were established by the Postgraduate Medical and Education Training Board (PMETB) in 2006 and incorporated into the GMC in 2009.

Rigid training structures can make rota gaps worse

In the national training survey in 2016, we reported on the concerns raised by trainees about the impact of service pressure resulting from rota gaps.[8] The current training structure results in many doctors narrowing their focus to increasingly specialised areas as they progress. This often limits the capacity of doctors to support rotas outside their specialty, or critically, their subspecialty. Towards the middle to end of their training, many doctors are less able to provide care in broader areas of their specialty. In many cases they have not continued to hone these general skills after the first two years of training. Many training programmes also have fewer connections to other areas of practice to which they might link naturally. This approach reduces the exposure of trainees to caring for patients whose needs cross specialty boundaries.

Our national training survey in 2016 identified lack of staffing/resources as the most significant concern to the quality of training, accounting for 522 out of 838 free text comments. Feedback from our annual specialty returns shows that the impact of rota gaps on training is challenging across most specialties, but most especially in the middle grade years. This is a real source of frustration for trainees and trainers – especially where training opportunities are cancelled in the face of service pressures.

The Royal College of Obstetrics and Gynaecology confirm that their training is structured in a way that trainees' 'service, education and training [is being affected] given that there are not enough doctors to fill the rota gaps'. They very much welcomed more flexibility to train doctors in ways that meet both professional and service demands. Other stakeholders told us that despite an increase in consultant and trainee numbers over the last twenty years, employers are still facing medical workforce supply problems.

[8] Our national training survey 2016 - www.gmc-uk.org/national_training_survey_2016___key_findings_68462938.pdf.

The solutions

We want twenty-first century training to support the aspirations and commitment of twenty-first century medical professionals to meet the needs of patients. To achieve this, postgraduate medical training must change – in structure, provision and approach. Doctors will gain more flexible options throughout their careers. The real benefit will be improved patient care. Doctors will share expertise with the specialties to which they naturally link. This will allow them to work more effectively in their teams and across care contexts. Doctors will also be trained from the outset for the important leadership role they play within healthcare.

We will launch the generic professional capabilities framework and standards for postgraduate curricula in May 2017. Most specialties will revise their curricula in line with the new standards by 2020. From 2020, therefore, the benefits of our new standards for curricula and the generic professional capabilities framework will be realised. Patients, trainees and employers will better understand what to expect from doctors in different specialties – and how these will have to be met.

Some of the changes described here are ready to be introduced or can be enacted quickly. Others, such as the current legal framework which controls postgraduate training, are more challenging and require further work and consideration by the four UK countries.

Training will be organised by outcomes rather than time served

The focus of postgraduate training will shift – away from 'time-based' approaches to ones that help a doctor to achieve high-level learning outcomes. Curricula, in the future, will explain what doctors should know, and be capable of doing, at key points in their training and by the time they complete it.

We will deliver this through our new standards for postgraduate curricula, the generic professional capabilities framework and a refined approvals process that will be launched in May 2017. Medical colleges and faculties will benefit from more flexibility to change the detail that underpins their curricula without oversight from us, enabling them to become responsive to the demands of health services and patients.

Through the generic professional capabilities framework, we will expect all postgraduate curricula to reflect essential generic professional capabilities crucial to safe and effective patient care, such as communication, leadership and patient safety. This framework will strengthen the emphasis on training all doctors to be future leaders and to work well in multidisciplinary teams. All doctors, regardless of their specialty, will have to demonstrate they have achieved these capabilities by the time they complete training.

The majority of 103 curricula will have to meet these standards by 2020.[9] We anticipate, however, that a small number of specialties will submit their new curricula to us during 2017. If these applications are successful, doctors will begin to train in this new way from 2018. By 2020, most curricula will describe the generic and specialty requirements as high-level outcomes and what trainees will need to do to meet these outcomes at different stages in their training. Many of the specialty requirements may only relate to one or a small number of areas of practice. It will be clear to trainees and others what is expected of them at critical points in their training and what learning, if they wish, can be transferred to other specialties where there are natural links from 2020.

The standards for postgraduate curricula are explicit about what postgraduate curricula, which are developed currently by the medical colleges and faculties, will have to cover in order to be approved by us. We expect all specialties to embed the generic professional capabilities framework into curricula. These standards complement our widely respected standards – *Promoting excellence: standards for medical education and training*[10] – which we use to check that training is implemented properly at the local level.

Key commitments and actions

We expect a small number of medical colleges and faculties to seek approval for new outcomes-based curricula during 2017. We will evaluate the impact of the new curricula structure and processes on flexibility from 2020.

We expect the majority of medical colleges and faculties to have their revised curricula approved for implementation by 2020.

Related curricula will share outcomes across specialties

As medical colleges and faculties develop their new outcomes-based curricula, they will be required to identify components of training that are similar to, or depend on, content from other specialties. Identifying these natural links will be a requirement for approval in our new standards for curricula.

This review found examples where barriers to flexibility in training disappeared when stakeholders collaborated to deliver training across specialties. For example, we already approve training environments shared by specialties and training programmes. Many training programmes already encourage flexibility in practice with opportunities for trainees to explore other interests without changing specialties. Similarly, general practice trainees can develop a paediatric specialist interest. We want to build on and improve these cross-specialty approaches or experiences.

The Royal College of Radiologists explained that 'the clinical oncology curriculum allows for accredited transferable competencies to be brought in from medical oncology training, and we are exploring the possibility of more commonality of oncology training, which we have long wanted to see. For clinical radiology we supported closer integration of nuclear medicine which now has a common recruitment process and first three years of training.'

[9] There are 66 specialties and 32 subspecialties. But there are multiple curricula for some specialties, such as core medical training curriculum, the core surgical training curriculum and the broad based training curriculum. These curricula are not specialties in their own right.

[10] You can read *Promoting excellence* at www.gmc-uk.org/education/standards.asp.

The Acute Care Common Stem programme is an example of effective consensual working across four specialties – acute medicine, intensive care medicine, emergency medicine and anaesthesia. Its purpose is to provide trainees with a broad range of knowledge, skills and attitudes in order to be able to: assess any acutely ill patient and commence resuscitation if necessary; diagnose the most likely underlying problem; initiate appropriate investigations; commence appropriate immediate treatment and identify and liaise with the inpatient teams to ensure appropriate definitive care. Trainees enter the programme through a parent specialty. They usually work in these specialties for up to six months each before progressing to their chosen area of practice. This gives them experience in related fields and provides them with a broader and complementary clinical base. We will learn from this example where common outcomes have been identified and recognised across different specialties.

More common components approved across related specialties will let doctors transfer seamlessly between areas of practice. We recognise that mapping outcomes that are shared across specialties will be complex and we will first focus on areas where the benefits will be greatest. We will work with the AoMRC and others to initially scope out and identify the areas of practice that will most likely result in trainees transferring between them, and where common outcomes will better facilitate these transfers. Examples might include specialties that commonly transfer into general practice.

Some colleges are already identifying common components across specialties. For example, the combined infection training programme was jointly developed with the Joint Royal College of Physicians Training Board and the Royal College of Pathologists. They developed a common pathway and more closely aligned training in the infection disciplines of infectious disease, tropical medicine, medical microbiology and medical virology.

Stakeholders told us that this work may also require resources to implement. We will work with relevant organisations in the four UK countries and the oversight group on flexibility to determine, and mitigate, the impact of changes on resources. By 2019, in these areas, trainees will be able to identify what previous learning will be relevant in a new specialty.

Key commitments and actions

In 2017 we will accelerate working with the AoMRC, colleges and faculties, those responsible for training or service, as well as others to scope out and identify common components of training across groups of specialties. First, we will determine the specialties that are naturally linked and where flexibility is needed most. We will then work towards agreements between these related specialties. We want to complete this work by 2019 with these initial specialties. This will also contribute to the work to revise the *Accreditation of Transferable Competences Framework*.

We will reduce the burden of our approval process

A key ambition across all our regulatory functions is to simplify and streamline our regulatory approach to benefit doctors, patients and education bodies.

To support our new standards, we are already changing our approval process to make it more transparent and facilitative. After the initial transition for all curricula to become outcomes-based and meet our standards, we will move to a more streamlined and less burdensome approvals process. We will also introduce mechanisms to quality assure the development process and impact of the curriculum, through our quality assurance processes. We will still approve new or changed curricula but these will be at a much higher level. Details will be explained in the course outline, which can be changed as professional, service and patient needs require.

We will promote existing mechanisms for flexible training

Working closely with the AoMRC and others, we will review the *Accreditation of Transferable Competences Framework* and refine it as required, by 2019. This is the current system that lets doctors in training transfer to another specialty and credits relevant prior learning. The new version of the *Accreditation of Transferable Competences Framework*, building on the generic professional capabilities framework, will focus on high-level training outcomes and capabilities instead of competencies. Outcomes will have different requirements, some will be common across specialties and some will be specialty specific.

This work will help identify what components can be recognised between different specialties. Trainees, then, will not have to repeat this learning when moving between specialties.

This will particularly benefit specialties that are not listed in Annex V of the European directive and, to a lesser extent, doctors who already have a qualification moving into a new specialty listed in the directive.

Once this updated framework is in place, we will work with the AoMRC to extensively promote its existence to trainees through their professional bodies.

Key commitments and actions

With the AoMRC and those responsible for education and service provision we will review and refine, as needed, the *Accreditation of Transferable Competences Framework* and use our regular communication campaigns to trainees and trainers to raise awareness of it by 2019.

In 2020, we will evaluate the awareness and use of the *Accreditation of Transferable Competences Framework* with doctors and local educational providers and other relevant stakeholders.

We already have a mechanism through the combined programme that lets doctors use evidence from both training and out of training experiences to create a bespoke pathway through training. In 2017 we will raise awareness of this approach among trainees and the professional bodies through a targeted campaign process.

We will ask for the law to be made less restrictive

The legal framework needs to be simplified and ambiguities must be formally addressed and resolved.

The directive restricts exemptions being granted from the minimum duration of training for Annex V specialties. But it may be possible for 'competences' achieved in a previous programme to be recognised as meeting the outcomes required in a different specialty, provided that the minimum training duration is met. This means that doctors would be able to switch to other training programmes without repeating previous learning. The move to outcomes and shared components in training will help to facilitate this.

During 2017 we will engage with the UK Government to seek clarity on the restrictions for doctors transferring from one Annex V specialty to another. The UK Government must, of course, consult with the governments of the other UK countries on this matter.

This approach is supported by our stakeholders, with the Royal College of Anaesthetists agreeing that 'the intention to review the legislative framework governing training is welcome and will go some way to alleviate the frustrations that trainees encounter in terms of the current inflexibility of the rules and regulations.'

Looking further ahead we will also consider, in the context of the UK's departure from the EU, whether there is scope to adopt a different legislative framework in the future – one that provides more flexibility and consistency for trainees.

Key commitment and actions

During 2017 we will engage with the UK Government to seek clarity on the restrictions for doctors transferring from one Annex V specialty to another. The UK Government must consult with the governments of the other UK countries.

We will consider, in the context of the UK's departure from the EU, whether there is scope to adopt a different, more flexible legislative framework in the future.

We will support doctors with specific capabilities or needs

Credentials

There was support by employers, colleges and statutory bodies to introduce a mechanism to support doctors to move into areas where there are patient or service needs. Our approach for credentials will explore recognition of areas of practice where there is a service need but where that expertise is not fully reflected in existing specialties or subspecialties.

We will recognise, through our approval processes, discrete areas of practice outside of specialty areas where there is a need for regulation to protect patients, such as cosmetic surgery. Doctors who have met these agreed learning outcomes will, then, be recognised as meeting the requirements of the credential in the same way that award of a CCT signifies attainment appropriate with the level of a day-one consultant. A credential would not usually cover the breadth of a CCT specialty but could

potentially denote at least a comparable level of competence within a narrower field.

To practise medicine in the UK, a person must be registered and licensed as a doctor with the GMC. Doctors who have completed specialist training are eligible for inclusion on our Specialist Register. The Specialist Register indicates the specialty in which the doctor's specialty training was completed but it does not legally restrict the doctor to working only in the indicated specialty. Nor does it prevent other licensed doctors who are not on the Specialist Register from working in those same fields of medicine. Our model for credentials follows this less restrictive approach. Doctors would not be required to have credentials to work in credentialed areas of practice. We would need legislative change if we were to introduce a mandatory scheme for the registration and enforcement of credentials.

Starting in 2017, we will test our approach to credentials, which we previously consulted upon and published, with an early adopter to make sure our model is feasible and to determine its impact on doctors and health services. As part of this work, we will also look at how to support doctors throughout their careers, leading to new and innovative ways to recognise doctors' learning and development outside of training programmes. We will update on the progress of this pilot in 2018.

The review of the implementation of the Shape of Training report has a broader definition of credentials. Following our modelling work, we will consider how we could potentially apply our approach to credentialing to broader areas of practice. However it is important to recognise that there are divergent ambitions for credentialing and concerns about the consequences these could have upon existing training programmes. These views must be reconciled in order for a solution to be found that is acceptable to all.

Health and disability

We are embarking on a project to update and expand our guidance on improving access to the profession for students and doctors with long term health conditions and disabilities *(Gateways to the professions)*.

Our core aims are to:

- provide clearer guidance on the principles of good decision-making for support and reasonable adjustments
- share best practice in this area
- enrich the resources available on our website to give helpful tools to education providers, students and doctors.

The main outcomes will be:

- an updated version of *Gateways to the professions* that will build on the value of the current guidance and support more consistent decision-making
- increasing awareness among students and doctors about what they can expect from their education providers
- addressing some of the misconceptions in medical education and the profession about practising with a health condition or disability.

Leadership

As we move towards more bespoke career pathways for doctors, they will have to increasingly take on leadership roles to manage their own training and professional requirements. Starting in 2017, we will work with the Faculty of Medical Leadership and Management, NHS Improvement and other key partners to deliver this. Together we will work to enhance the support available for doctors who aspire to senior leadership roles and to increase the opportunities available for doctors to manage and lead projects during their postgraduate training. There are also excellent examples of work to support leadership in doctors in Scotland, which we will build on through this approach.[11] For example, NHS Education for Scotland in partnership with Scottish Government and a range of partner organisations have provided opportunities to trainees to develop leadership capabilities and contribute to aspects of contemporary health- and care-related activity through the Scottish clinical leadership fellowship programme.

Equality and diversity

We have considered the impact of delivering our vision - for enabling doctors to move more easily across specialties - on trainees who share protected characteristics. For example, we will seek to develop our understanding of whether the progression of some groups of doctors, who currently step out of training programmes for periods of time, would benefit from recognition of the experience that they have undertaken during that period.

We have also considered our legal obligations under the equality duty in developing the actions set out in this report. At this stage we have not identified any aspect of these activities that would discriminate against or introduce barriers for any group of trainees. We will keep this under review as we collaborate with others to implement these changes.

Key commitments and actions

Starting in 2017, we will test our approach to credentials with an early adopter to make sure our model is feasible, and to determine its impact on doctors and health services. As part of this work, we will look at how to support doctors throughout their careers, leading to new and innovative ways to recognise doctors' learning and development outside of training programmes. We will update on the progress of this pilot in 2018.

We will publish a revised version of *Gateways to the profession* by mid-2018. The guidance will also be accompanied by a hub of resources on our website, showcasing the guidance in action with a number of case studies, examples of notable practice and shared experiences from students, doctors and educators.

We will encourage others to continue to make working arrangements for trainees more flexible

There must be a balance between service and workforce priorities and bespoke training arrangements. Some stakeholders warned they would struggle to manage disruptions to the workforce as more choice is introduced into training

[11] See www.scotmt.scot.nhs.uk/news-and-events/news/scottish-clinical-leadership-fellow-posts.aspx.

and career pathways become less predictable.

That said, more must be done to recognise employment issues and how employers need to support a better 'work-life balance' for doctors in training. Education and training organisations, employers and others recognise that these are ongoing issues and are actively introducing ways to improve the work-life balance for trainees.

The Royal College of General Practitioners explained 'There is no point in the UK system trying to hold back the changes that this generation have proactively started to implement. It must instead accept these changes, and find ways to facilitate them, while ensuring that they don't impact on patient safety.'

We know that there are specific groups of doctors (in particular, but by no means exclusively, women in training and doctors who care for someone with a disability) who would benefit from increased access to less than full time training. More flexible training will make it easier to plan according to their needs. As this work progresses, we will seek to increase our understanding of the numbers of doctors who would benefit from this work and feed this into our monitoring and quality assurance processes.

Our new standards for medical education and training – *Promoting excellence* – require organisations to design rotas that make sure trainees have appropriate clinical supervision and minimise the adverse effects of fatigue and workload. To better understand the impact of issues like rota gaps and work intensity on trainees, last year we worked with researchers in Scotland and met with groups of trainees in Manchester and Edinburgh to discuss proposals for enhancing our national training survey. With the help of trainees and trainers, we have developed new questions on rota design that we will test in our 2017 survey. With a base of evidence that will help us to better understand the local conditions that trainees are experiencing, we will work with postgraduate training bodies and employers to raise awareness of concerns and take the necessary actions.

We strongly support the introduction of a new system in England for reporting education concerns. Exception reporting is a new mechanism under the 2016 terms and conditions for doctors in approved national training programmes in England that allows doctors to report concerns with their training – such as educational opportunities that have been missed and breaches in hours worked which may compromise their safety, their training or the safety of patients. Once reporting arrangements are working effectively across England, we want to use the information from exception reports to enhance our monitoring of postgraduate training and our ongoing work to protect the quality of doctors' education.

Key commitments and actions

To support these changes in the way trainees are managed, we will revise our current policies related to flexibility by the end of 2018, such as less than full time training. We will make sure we have clear and evidenced reasons for our regulatory position. We will also use our *Promoting excellence* standards and our quality assurance processes to make sure concerns are managed effectively.

We will continue to work with trainees and those who manage education and service provision to explore and address the impact of rota gaps through our national training survey.

Next steps

We have submitted this report to the health ministers of the four UK countries.

It is important that there is strategic oversight of these changes and that the four countries of the UK are engaged with their delivery, to make sure the needs of their healthcare systems and patient populations are balanced with the drive towards greater flexibility.

Working with representatives from the four UK countries, we want to quickly establish whether this oversight can be achieved within existing UK governance arrangements – for example, via the Medical Education UK Reference Group.

We will also establish an effective governance arrangement that will enable us to deliver these changes in partnership with key organisations, such as the medical colleges and those that represent the interests of the medical profession.

Working with these organisations, our first task will be to deliver a more detailed and feasible plan (building on the actions set out at the end of this report) to make sure the majority of these commitments are delivered by 2020.

Our reform agenda

In May 2017, we will publish new standards that will require curricula to identify common areas of training and coordinate any interdependencies between related specialties and other professions. Curricula will describe fewer, high-level generic and specialty outcomes, which will support all doctors better in understanding what is expected of them in their training programme. Alongside these standards, we will launch the generic professional capabilities framework. We will also improve how we approve postgraduate training with the aim of increasing flexibility through approval arrangements.

We will use our quality assurance framework and national training surveys to monitor the progress of our reforms and other developments in the four countries designed to promote flexibility.

Key action	Responsibility	Delivery date
Launch standards for postgraduate curricula, the generic professional capabilities framework and new approvals processes.	GMC	May 2017
Work with four countries of UK to quickly establish appropriate oversight of changes.	GMC, Medical Education UK Reference Group	May 2017
Campaign to raise awareness of the combined programme approach among trainees and the professional bodies through a targeted campaign process.	GMC	Mid-2017
Engage with the UK Government to seek clarity on the restrictions for doctors transferring from one Annex V specialty to another. The UK Government must consult with the governments of the other UK countries. Consider, in the context of the UK's departure from the EU, whether there is scope to adopt a different, more flexible legislative framework in the future.	GMC	2017
Revise our current policies related to flexibility, such as less than full time training, with input from relevant stakeholders.	GMC	2017 onwards
Test our agreed approach to credentials with an early adopter, to make sure our model is feasible and to determine its impact on doctors and health services.	GMC, early adopter organisations	2017 onwards
Continue to work with trainees and their representatives, those responsible for education and service provision and others, to better understand and address the impact of rota gaps, through our national training survey in 2018.	GMC	2017 ongoing
Publish a revised version of *Gateways to the profession*.	GMC	2018
Campaign to raise awareness in trainees and trainers of the revised *Accreditation of Transferable Competences Framework*.	GMC, AoMRC	2019
Identify common outcomes and shared components of training across groups or families of specialties, starting with areas where flexibility is needed most, as part of revising the *Accreditation of Transferable Competences Framework*.	AoMRC, colleges/ faculties, GMC, employers, postgraduate deans, health education organisations	2019 onwards

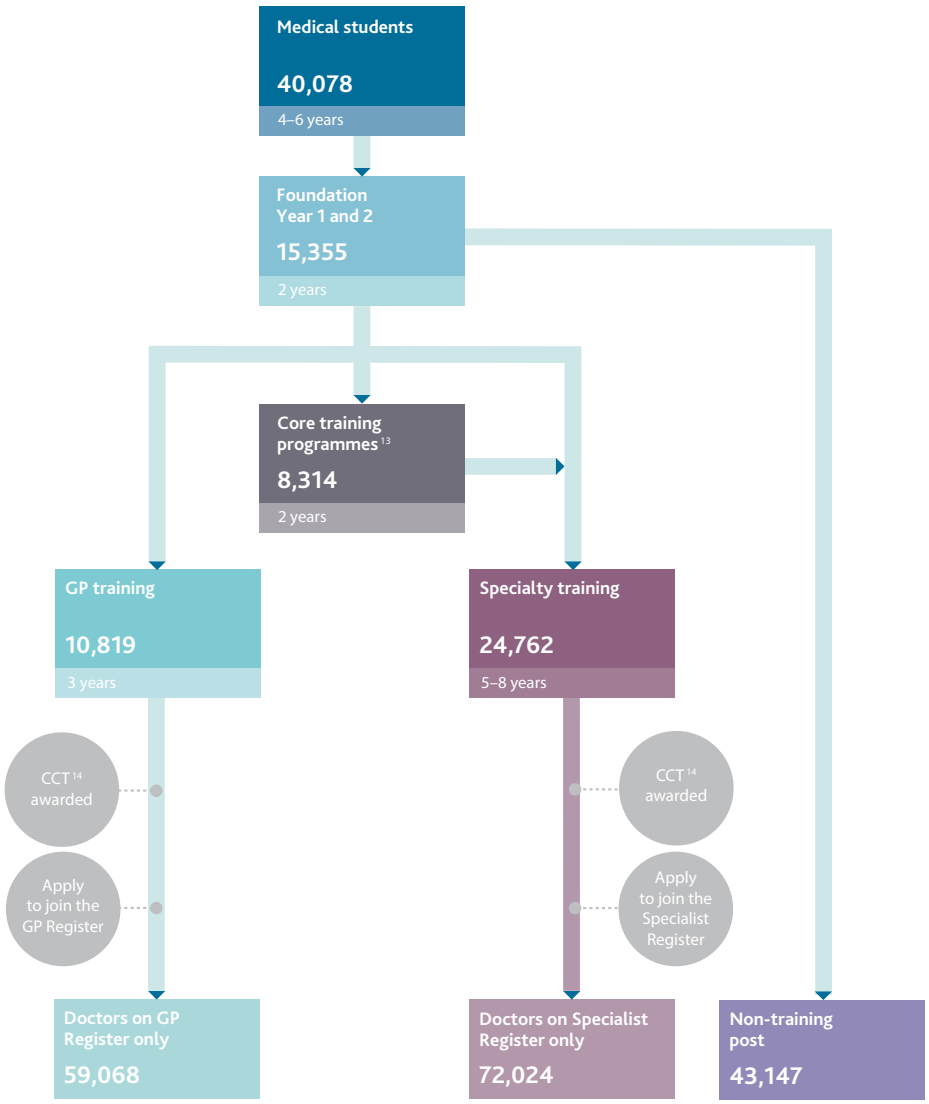
Key action	Responsibility	Delivery date
Most postgraduate curricula are approved against the new standards for curricula.	College/faculties, GMC	2020
Evaluate the awareness and use of the *Accreditation of Transferable Competences Framework* with doctors, local educational providers and others.	GMC, AoMRC	2020
Monitor and improve progress on flexibility through our approvals and quality assurance processes.	GMC	2020 onwards
Evaluate the impact of the revised curricula structures and processes on flexibility, starting with specialties that are approved in 2017.	GMC	2020 onwards

Annex A

Background and structure of postgraduate training

Medical education and training pathways

Training pathways are shown below, with numbers of students and doctors in 2015.[12]



[12] Not all medical students and doctors in training will continue to the next stage – they may pause their training, leave the profession or change their training programme. Doctors who are on both the Specialist and the GP Registers are not counted in this figure.

[13] Core training programmes include acute care common stem, broad based training, and other core training programmes.

[14] Certificates of Completion of Training (CCT).

What previous reports said about flexibility

Tooke inquiry (2008)

The inquiry led by Sir John Tooke looked at areas of concern arising from the Modernising Medical Careers programme, and called for a more flexible and broad based approach to training, integrating both training and service into workforce planning.[15] Tooke said that doctors should be allowed to interrupt their training by agreement to seek alternative experiences that enhance their career and contribute to the NHS.

The Tooke inquiry's recommendations included recommendations about flexibility.

- There must be clear shared principles for postgraduate medical training that emphasise flexibility and an aspiration to excellence.
- The structure of postgraduate training should be modified to provide a broad based platform for subsequent higher specialist training, increased flexibility, the valuing of experience and the promotion of excellence.

Shape of Training (2013)

The Shape of Training Review, led by Professor David Greenaway, reported in 2013.[16] It made a number of recommendations aimed at making postgraduate training more flexible for doctors in training, and for service delivery and workforce management at local levels:

- broader training in specialties
- outcomes-based training programmes that embed generic professional capabilities and transferable competencies
- a more apprenticeship-based model for supervision and support
- opportunities for doctors to change, deepen, or extend their careers with recognised credentials.

The report also recognised the need to have more flexible work patterns for doctors in training to work and train part time. But this would impact on how rotas are currently designed. It emphasised the need for more flexibility in relation to academic training.

[15] Tooke, J (2008) *Aspiring to Excellence: Final report of the independent inquiry into Modernising Medical Careers, led by Sir John Tooke* – available at: www.medschools.ac.uk/AboutUs/Projects/Documents/Final%20MMC%20Inquiry%20Jan2008.pdf.

[16] Greenaway, D (2013) *Securing the future of excellent patient care. Final report of the independent review Led by Professor David Greenaway* – available at: www.shapeoftraining.co.uk/reviewsofar/1788.asp.

Annex B

Methodology of the review

The Secretary of State for Health in England asked us, as the UK regulator of the medical profession, to review flexibility in postgraduate training. This request formed part of the contractual negotiations between the BMA and the Department of Health for England in May 2016. The table below describes extensive engagement that we undertook with colleges, faculties, trainees, their professional bodies, patients and others. These discussions have informed the commitments and actions in the report.

Activity	Key interests	Date
Stocktaking event – underlined the need for system-wide approach	Trainers; trainees; deans; patient representatives; AoMRC; BMA; colleges/ faculties; other professional bodies; employers; medical students; four-country representatives; health education organisations	October 2016
Direction setting discussions with representatives of the four UK countries – identified any country-specific issues; consensus on issues and solutions	Health education organisations; health executives; AoMRC; BMA; colleges; UK Shape of Training Steering Group	November 2016 – January 2017
Legal advice on flexibility options in *Medical Act 1983*	In-house lawyers; counsel	January 2017 and ongoing

Activity	Key interests	Date
Review of data and evidence – evaluated transferring between specialties from NTS data; less than full time training data; use of *Accreditation of Transferable Competences Framework*; concerns about work/life balance; training structure in other countries	Office	February 2017
Evidence panel discussions – identified barriers and areas of good practice; explored vision and proposed solutions	AoMRC; BMA; colleges and faculties	February to March 2017
Trainee round table – discussed barriers and concerns about flexibility and what they wanted out of the review	Trainees; BMA	February 2017
Patient round table – discussed advantages of more flexible training for patients; call for doctors who understand better the complexities of patient care as population changes; plea for more involvement in developing training	Patient representatives; trainees	March 2017
Feedback on commitments and actions	Health education organisations; AoMRC; BMA; colleges/faculties and others	March 2017
Publication – present to the four health ministers of the UK	Health ministers of the four UK countries	March 2017

Annex C

Specialties recognised in the UK

Article 25 of the *European Directive 2005/36/EC Recognition of Professional Qualifications* (the 'directive') establishes legal requirements for specialist medical training. Specialist medical training courses and their minimum duration are listed in Annex V, point 5.1.3.

In the *Postgraduate Medical Education and Training Order* ('PMET Order') we prescribe minimum training periods for recognised specialties. The majority of UK specialties in the Schedule to the PMET Order are listed in Annex V point 5.1.3 of the directive, and are therefore Annex V specialties. The GMC also recognises other specialties which appear in the Schedule to the PMET Order but are not listed in the directive (non-Annex V specialties).

We approve postgraduate curricula. Many of the specialties have longer durations of training than stipulated in Annex V or the PMET Order.

The duration of general practice is established in section 34J(1) of the *Medical Act,* as it requires that the GP training must meet the requirements set out in Article 28(1), the first paragraph of Article 28(2) and Article 28(3) of the directive. The first paragraph of article 28(2) sets the requirement that for a qualification in general practice issued after 1 January 2006 training shall be 'of a duration of at least three years on a full-time basis'. We approve the GP curriculum for three years in duration.

Annex V specialties recognised within the UK

Listed below are the Annex V specialties recognised within the UK in the PMET Order, grouped according to the minimum training period.

Specialty	EU/UK law	UK approved curriculum
Cardio-thoracic surgery (also known as thoracic surgery)	5	8
Emergency medicine (also known as accident and emergency medicine)	5	6
General (internal) medicine	5	5/6
General surgery	5	8
Medical oncology	5	6/7
Neurosurgery	5	8
Paediatric surgery	5	8
Plastic surgery	5	8
Trauma and orthopaedic surgery	5	8
Urology	5	7
Vascular surgery	5	8
Cardiology	4	7/8
Chemical pathology	4	5
Child and adolescent psychiatry	4	6/7
Clinical genetics	4	6/7
Clinical neurophysiology	4	6/7
Clinical oncology	4	7/8
Clinical pharmacology and therapeutics	4	7/8
Clinical radiology	4	5
Dermatology	4	6/7

Specialty	EU/UK law	UK approved curriculum
Gastroenterology	4	8
General psychiatry	4	6
Genitourinary medicine	4	6/7
Geriatric medicine	4	6/7
Histopathology	4	6
Immunology	4	7/8
Infectious diseases	4	6/7
Medical microbiology (listed in Annex V as Medical microbiology and virology)	4	6/7
Medical virology (listed in Annex V as Medical microbiology and virology)	4	6/7
Neurology	4	7/8
Nuclear medicine	4	8/9
Obstetrics and gynaecology	4	7
Occupational medicine	4	6/7
Oral and maxillofacial surgery	4	7
Paediatrics	4	8/9

Specialty	EU/UK law	UK approved curriculum
Public health medicine	4	5
Renal medicine	4	5/6
Respiratory medicine	4	6/7
Rheumatology	4	6/7
Tropical medicine	4	7/8
Anaesthetics	3	7/8
Endocrinology and diabetes mellitus	3	6/7
Haematology	3	7/8
Ophthalmology	3	7
Otolaryngology	3	8

Non-Annex V specialties recognised within the UK

Listed below are the non-Annex V specialties recognised within the UK, grouped according to the minimum training period set in the PMET Order.

Specialty	UK law	UK approved curriculum
Aviation and space medicine	4	6/7
Acute internal medicine	No minimum	6/7
Allergy	No minimum	7/8
Audio vestibular medicine	No minimum	7/8
Community sexual health and reproduction	No minimum	6
Diagnostic neuropathology	No minimum	7
Forensic histopathology	No minimum	6
Forensic psychiatry	No minimum	6/7
Intensive care medicine	No minimum	7/8
Medical ophthalmology	No minimum	7/8

Specialty	UK law	UK approved curriculum
Medical psychotherapy	No minimum	6/7
Old age psychiatry	No minimum	6/7
Paediatric cardiology	No minimum	8/9
Paediatric and perinatal pathology	No minimum	5
Palliative medicine	No minimum	6/7
Pharmaceutical medicine	No minimum	6/7
Psychiatry of learning disability	No minimum	6/7
Rehabilitation medicine	No minimum	6/7
Sport and exercise medicine	No minimum	6/7

Annex D

Glossary of terms

Certificate of Completion of Training (CCT)

This confirms that a doctor has completed an approved training programme in the UK and is eligible for entry onto the GP Register or the Specialist Register. A CCT can only be awarded to a doctor who has successfully completed a GMC-approved training programme.

Certificate of Eligibility for GP Registration (CEGPR)

This is awarded to doctors who demonstrate that their GP training or qualifications together with their experience are equivalent to the GMC-approved GP CCT curriculum. This certificate enables those with full registration to be entered onto our GP Register.

Certificate of Eligibility for Specialist Registration (CESR)

This is awarded to doctors who demonstrate one of the following.

- That their specialist training or qualifications together with their experience are equivalent to the GMC-approved CCT curriculum.
- That their overseas specialist training or qualifications together with their experience are equivalent to a consultant in the UK.
- That their experience gained through academic or research medicine together with their experience are equivalent to a consultant in the UK.

This certificate enables those with full registration to be entered onto our Specialist Register.

Competencies

A specific capability, a discrete skill or a visible behaviour that is learnt and assessed separately.

Credential

A proposed process which provides formal accreditation of outcomes (which include knowledge, skills and performance) in a defined area of practice, at a level that provides confidence that the individual is fit to practise in that area.

Curriculum

A statement of the intended aims and objectives, content, experiences, outcomes and processes of a programme or course, including a description of the structure and expected methods of learning, teaching, feedback and supervision. The curriculum should set out what learning outcomes the learner will achieve.

Generic professional capabilities

Generic professional capabilities are broader human skills, such as communication and team working, needed by doctors to help provide safe and effective patient care. They are common to doctors across all medical specialties.

Outcome

The capabilities that a learner must acquire by the end of a period of education or training.

Quality assurance

The quality assurance of medical education and training in the UK includes all the policies, standards, systems and processes in place to maintain and enhance quality. We carry out systematic activities to assure the public and patients that medical education and training meets the required standards.

Rota

A work pattern or schedule of similar work performed by a group of individuals in the same field of work or profession.

The design of rotas must be safe for doctors in training and safe for the patients they care for. Our standards for medical education and training – *Promoting excellence* – require organisations to design rotas that make sure doctors in training have appropriate clinical supervision and minimise the adverse effects of fatigue and workload.

Specialty

Specialties are areas of medicine that require particular sets of knowledge, skills and experience, for example paediatrics is a specialty focusing on the medical care of children. Once a doctor has completed their foundation training, they can apply for training in a particular specialty.

Training programme

A formal alignment or rotation of posts that together comprise a programme of postgraduate training in a given specialty or subspecialty. A programme may deliver the full curriculum through linked stages to a CCT, or the programme may deliver different component elements of the approved curriculum.

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