

## Medical training and careers – the employers' vision

### Key points

- Employers favour a modular approach to postgraduate medical training built around care pathways that provide recognised 'credentialing' to support doctors' development over a range of flexible career routes.
- A multidisciplinary approach to workforce planning based on the needs of health service provision, with more refined tools and systematic engagement with employers, is essential.
- A clear balance between service delivery and creating a supportive environment for learning and development is required.
- A small planned oversupply in the medical workforce is desirable to enable a flexible response to changing staff and patient demographics.
- The future NHS will not require all doctors to progress to the current role of consultant. New roles and structures must be developed that will meet the needs of employers and patients with the flexibility to adapt the structure to suit local circumstances.

The medical workforce in the UK has received intense scrutiny within the NHS and in the public arena over the last 18 months. In delivering his report on the future NHS for the NHS Next Stage Review, Professor Lord Ara Darzi outlined a healthcare system which needed strong clinical leadership to succeed.

In the year that the NHS turned 60, this briefing sets out the employers' vision for the future direction of medical careers, ensuring that we are training the doctors that we need to provide high quality healthcare for all.

### Background

NHS Employers, in consultation with employers and key stakeholders, set out its position on medical workforce issues in October 2007 in our publication *The future of the medical workforce*.

Difficulties recruiting to Modernising Medical Careers (MMC) training programmes in 2007 prompted parliamentary and independent inquiries, not just into the recruitment and selection systems, but covered the entire training structure

and what this will mean for our doctors of the future.

Since then the Douglas Review into MMC recruitment and *Aspiring to Excellence*, the final report of the Tooke inquiry into MMC, have been published. There has also been a Health Select Committee Inquiry, and a Government response to it, and lastly *A High Quality Care For All: the NHS Next Stage Review* final report and its associated report on *A High Quality Workforce*.

The reports all made clear suggestions and proposals for

the future, although also invited further debate in some areas. Employers are now clear on how training and career structures should be developed in order to ensure that any further reform and development are sustainable and in line with efforts to develop high quality and responsive patient services.

Implementation of new contracts for consultants and GPs from 2003, and for the new specialty doctor grade in 2008, is now complete, providing greater transparency on the contribution these doctors make to patient care.

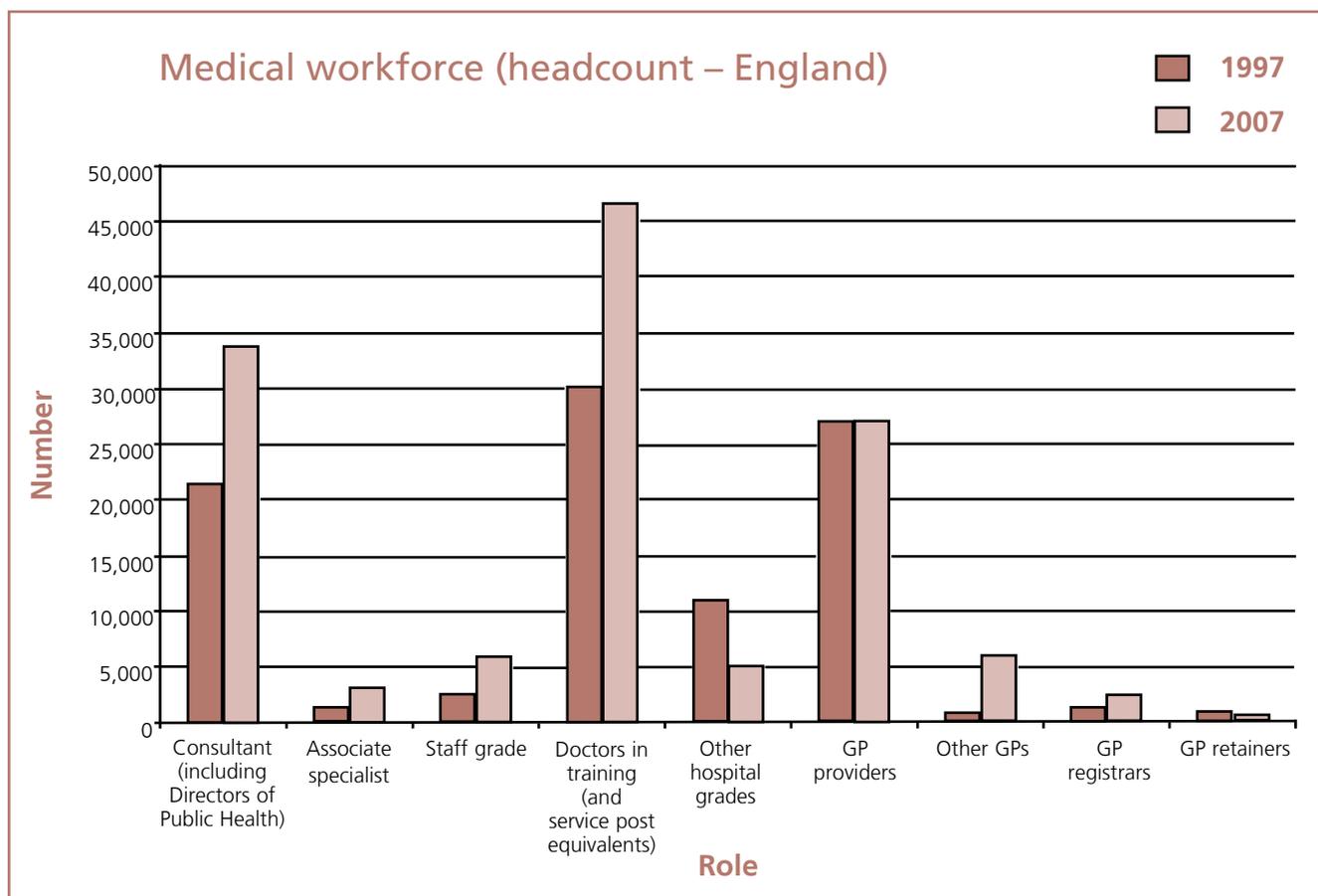
In October 2008, doctors and stakeholders from across the UK agreed a consensus statement on the role of the doctor, in response to recommendations set out in the Tooke report. The statement provides a focus for doctors on the unique attributes they need to maximise their contribution to patient care in a modern healthcare system.

This *briefing* draws from earlier work, discussion and position papers and employer and stakeholder events to present a clear employer-led vision for the future training and career structure of the medical workforce.

### Looking back to shape the future

In 2000, the NHS Plan set out ambitious targets to expand the medical workforce based on commitments to bring the level of NHS funding up towards the average of OECD countries. This was underpinned by an expansion in the number of UK medical school places with a view to developing greater UK self-sufficiency in medical workforce supply.

Despite this growth, there was little change in the medical career structure until 2007, when MMC



introduced specialty training. The overall 'shape' of the medical workforce in secondary care has remained fairly constant, with similar ratios of junior doctors to consultants and other specialists.

In primary care, expansion has not been so rapid, although there has been an overall shift towards employing salaried GPs rather than engaging GP principals.

### Current training and career structure

The current mix of 'run-through' and 'uncoupled' specialty training programmes, where programmes are split between core and higher specialty training with competitive entry for each, sits alongside a career structure of specialty doctor posts (including the Staff and Associate Specialist grades). Additionally, employers can take on trust grade doctors at any level. The route to specialist or consultant posts is the achievement of a certificate of completion of training (CCT) or, for those following non-training pathways, a certificate of eligibility for specialist registration (CESR).

This structure arose in the aftermath of difficulties experienced on the introduction of the new MMC training system for specialty training in 2007. This will now be subject to further review by the new body overseeing clinical training,

## Medical Education England

Medical Education England (MEE) is a new strategic advisory body for doctors, dentists, healthcare scientists, pharmacists and low volume specialties. Membership will be drawn from employers, professional bodies, staff organisations, the Department of Health and other stakeholder organisations.

MEE is expected to provide a coherent voice on matters relating to education and training and high-level scrutiny of, and advice on, the quality of workforce planning at a national level.

Medical Education England (MEE), when it is established in January 2009.

### The employers' vision for the future

Throughout 2008, NHS Employers has been discussing future plans for the medical workforce with employers, doctors, medical students and stakeholders, culminating in a series of workshops in June and July.

These views have helped us to describe the employers' vision for the relationship between training and service, the roles employers expect to develop in order to meet the needs of patients, the flexibilities that are required throughout the training and career structure, and how this fits together to deliver fulfilling and rewarding careers for doctors of all grades.

### Foundation training

Employers have welcomed the formal evaluation of

the foundation programme recommended by the Health Select Committee. They widely support the two-year programme, believing it to provide a good opportunity for medical graduates to develop basic competences and experience a range of specialties.

However, employers would strongly prefer a move from four-month to six-month placements. The longer periods would provide better learning opportunities for the doctor and encourage the doctor to integrate with the clinical team. There is recognition this would limit the range of specialties that could be experienced during the programme, but this could be addressed with planned and funded 'taster' sessions, underpinned by better career information, beginning in medical schools.

There is considerable support for the option of a third foundation year, either for all foundation doctors or on a voluntary basis

for those who are not clear about their specialty choice. This should be by way of a 'themed' third foundation year to help the doctor decide on a choice of specialty training, although the funding for this would need some serious consideration.

### Specialty training

Employers shared the concerns expressed by many doctors, that run-through training programmes across all specialties were too rigid and provided little opportunity to redirect doctors as workforce needs changed, or where their training or personal needs suggested a change in career direction.

Broad, modular, basic specialty training, which covers core medicine, mental health, and surgery, would enable a doctor to safely perform a range of tasks across as broad a range of specialties as possible. Employers envisage that such doctors would be able to support overnight cover, be suitably proficient to enter career grade opportunities, embark on higher training across a range of specialties, including general practice, or pursue academic research.

There is still support for run-through programmes in some areas, recognising that some fields of medicine specialise from the outset and have less in common with other

specialties. Experience in 2008 has also shown that run-through programmes make an attractive option for trainees and provide a significant incentive to attract good quality applicants to traditionally hard-to-fill programmes. However, the absence of a 'break point' with competition for entry to higher specialty training means that the performance and progress monitoring of run-through trainees needs to be robust.

Whatever their structure, all training programmes will need regular review to ensure that programmes adapt to the development of new technologies and community-based services, and, as new care pathways become established, that there is better integration of training across primary and secondary care.

Employers agree that a national process, with consistent standards and a more transparent recruitment system is important. A single, co-ordinated national recruitment timetable is also seen as helpful for recruiting good candidates across a range of specialties. However, there are lingering concerns that the 'big bang' recruitment for August induction each year is unsustainable for service continuity and patient safety, unless the processes around this

are adapted to support it.

### Primary care and the role of general practice

The medical workforce and its training programmes need to follow locally-developed pathways of care. Varying across regions, this could involve secondary care work being undertaken by specialists and consultants working in primary care or by outreach teams from an acute trust. There will be no national one-size-fits-all solution and the role of commissioning primary care trusts will be key to shaping the pattern of care and the medical workforce to match.

The planned expansion of general practice will need to be considered alongside the future role general practitioners (GPs) will be expected to play, the way in which primary care services are commissioned and the development of new community-based roles. All will influence whether doctors work as partners and GP providers or become increasingly employed as salaried practitioners.

Following Tooke inquiry recommendations, training for general practice is currently being reviewed, with stakeholders gathering evidence on the case for extending the period of training from a minimum of three to a minimum of five years. However, employers believe that

flexibility is also needed, which would facilitate the ease of movement from other specialty training programmes into GP training at higher entry levels, commensurate with the relevant knowledge and skills they have already acquired.

### Specialty doctors

Employers have told us that they expect to see this section of the workforce grow significantly, becoming the new backbone for the delivery of hospital-based care. At the same time, the implementation of the 48-hour week, more structured MMC education and learning, and the introduction of education funding that is tariff based, will reduce the service contribution from trainees.

Once UK medical student numbers and training posts at all levels have reached their expected plateau (around 2010), the number of training posts proportionate to other medical grades will decrease. Specialty doctors and other members of multi-disciplinary teams are likely to fill much of any future expansion in capacity needed to deliver commissioned services.

The new specialty doctor contract and supporting guidance has clarified the expectations of these roles and the potential for career progression they provide. Employers recognise

the importance of this group of staff and are keen to develop opportunities, which they believe now offer attractive and fulfilling career options.

Employers want to enable specialty doctors and their trust equivalents to gain recognition for the knowledge, skills and experience they acquire throughout their careers. There is a commitment to offer learning and development opportunities, including, for some, opportunities to learn alongside colleagues in deanery-recognised training posts. There is strong support for the development of a standardised system of recognition, or 'credentialing', which would, in time, support doctors to better evidence their skills when applying for entry to the specialist register via the CESR route and achieve greater autonomy of practice where their competence has been accredited.

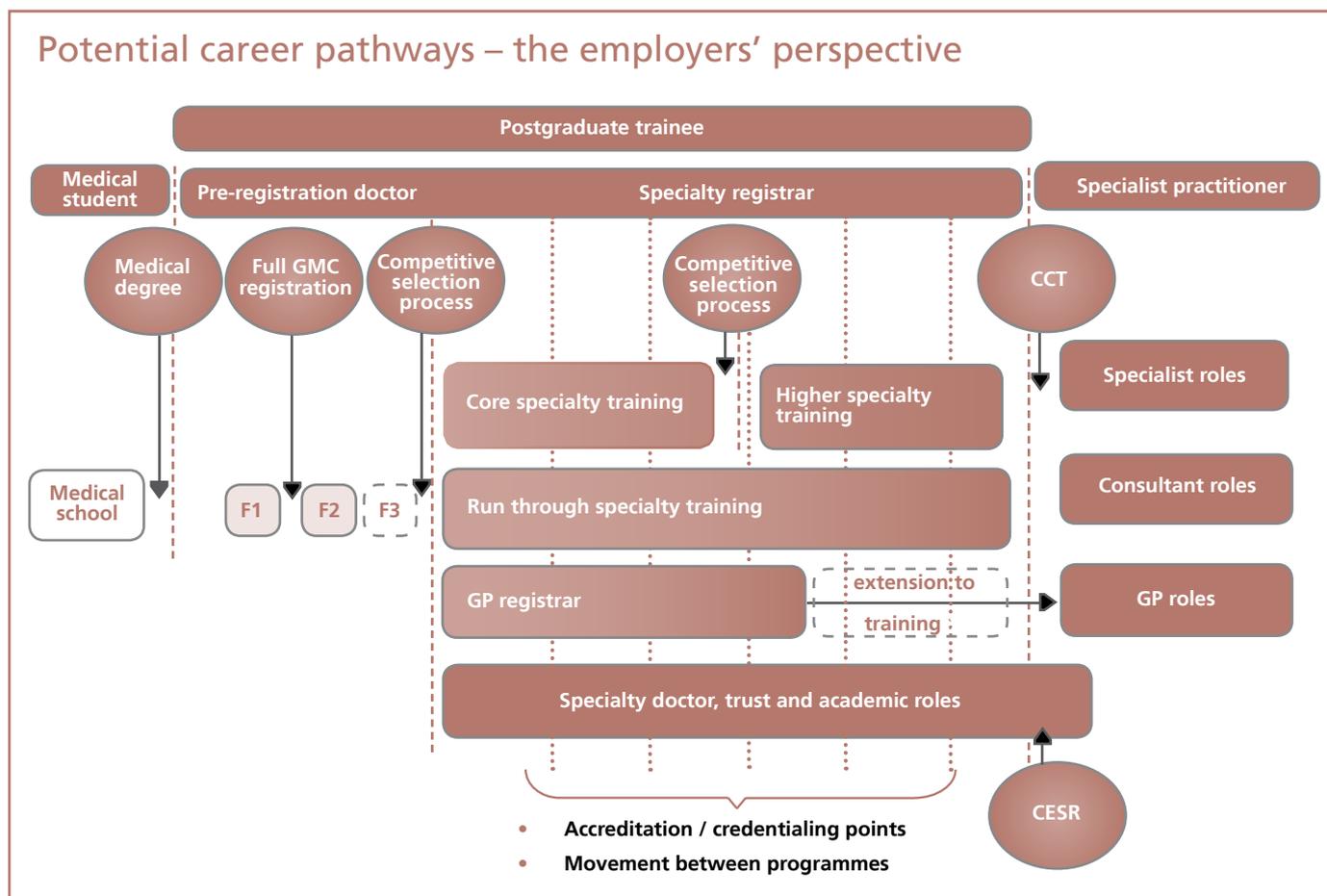
### The future role of the specialist

The number of doctors who will qualify as hospital specialists over the next ten years will be substantially greater than those who have historically been employed as consultants – a workforce which has already grown by 30 per cent since 1997. This has stimulated debate among employers over the cost and the nature of what being a consultant will mean, particularly

as the relative proportion of trainees is reduced. Some employers are also watchful over the impact of reducing participation rates at more senior levels and the effect this could have on overall demand for qualified specialists.

Employers are clear that the future role for doctors on the specialist register, whether achieved through CCT or CESR, is going to be different to the current role of consultant, working as they do today. They will continue to make use of consultant roles where this reflects value for money, but the expansion expected in the number of CCT and CESR holders cannot all be accommodated in the current consultant grade.

Many employers already feel that although CCT holders have achieved the competences set out by PMETB many have not attained, or are unlikely in the short term to be able to attain, the confidence and experience seen in existing consultants who have had longer training programmes, greater experience or both. Some believe these elements could be achieved with a period of employment in a post-CCT career post focused on service delivery. This would provide a quality service for patients, an opportunity to acquire more experience, and would enable the doctor to



become a better applicant for a ‘traditional’ consultant post after two to five years.

Many employers are beginning to develop medical workforce models based around a hierarchy within the group of medical specialists. This is likely to include doctors predominantly engaged in service delivery, without significant management or teaching commitments who are perhaps still building their experience, taking responsibility for patients under their care.

More senior doctors would be responsible for the service overall. Within the current consultant grade differential roles may develop, with some doctors taking on management, teaching, and other roles to varying degrees.

In some specialties employers envisage a ‘chef de service’ model where a single consultant works with a team of specialist doctors to deliver a service. These teams could be quite large, and would provide some element of

succession planning for the next generation of clinical leaders.

There is some evidence that patients are less concerned with doctors’ job titles and more concerned with having experienced, qualified people in place to meet their healthcare needs promptly and effectively. The important point is that it is for individual employers and their clinical managers to decide what is appropriate to their particular circumstances and the healthcare needs of their local population.

The tools to deliver these changes already exist. The specialty doctor and consultant contracts are similar in structure and terms and could be adapted locally to support new or developing roles. However, employers will need to consider appropriate remuneration for such roles to ensure they meet their obligations in terms of providing equal pay for work of equal value.

### Flexibility

Future flexibility will enable a more rapid response to changes in services and workforce supply. Employers believe there are several components to delivering flexibility.

Employers need the freedom to determine their staffing structures according to local need but based on the principle that every patient must ultimately be under the care of a specialist. They must also be equipped with the knowledge and freedom to decide the numbers of consultants, specialists, specialty doctors and others required to deliver high quality, sustainable and cost effective care.

A system of 'modular

credentialing' would facilitate the 'career ladder' approach, encouraging doctors to step in and out of training, research, academia and service delivery, take career breaks or spend more time on the management of clinical services. This approach could result in the development of a whole range of roles, from foundation programme trainees to senior consultants or GPs, each with a defined range of competences and capabilities. In the longer term, it could remove the need for an artificial distinction between training and non-training posts and so facilitate better movement between the two.

Employers also need to be closely involved in the commissioning of education and training, which should be based on their long-term understanding of service needs. Medical training needs to be designed with as much flexibility as possible, delaying specialty decisions until as late as is practically possible.

### Conclusion

With the right training and career structures in place, the UK's medical workforce will be

free to explore its full potential while delivering high quality healthcare for patients.

Employers believe that greater flexibility in training will encourage more doctors to undertake periods of research or gain valuable service experience before competing for higher specialty training. A small planned oversupply in the medical workforce would facilitate this, while allowing for the flexibility to respond to changing staff and patient demographics.

A multi-disciplinary approach to workforce planning is needed and employers, who constantly have to juggle patient expectations with staffing and financial resources, must be central to this.

Finally, honesty and transparency about the realistic career opportunities available, the support that doctors can expect from their employers, and employers' expectations of them, will provide our doctors of the future with clear personal and professional goals to achieve, within multi-disciplinary clinically led teams.

## NHS Employers supporting • promoting • representing

NHS Employers represents trusts in England on workforce issues and helps employers to ensure the NHS is a place where people want to work. The NHS workforce is at the heart of quality patient care and we believe that employers must drive the workforce agenda. We work with employers to reflect their views and act on their behalf in four priority areas:

- pay and negotiations
- recruitment and planning the workforce
- healthy and productive workplaces
- employment policy and practice.

NHS Employers is part of the NHS Confederation.

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Ref:EBRI05201



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