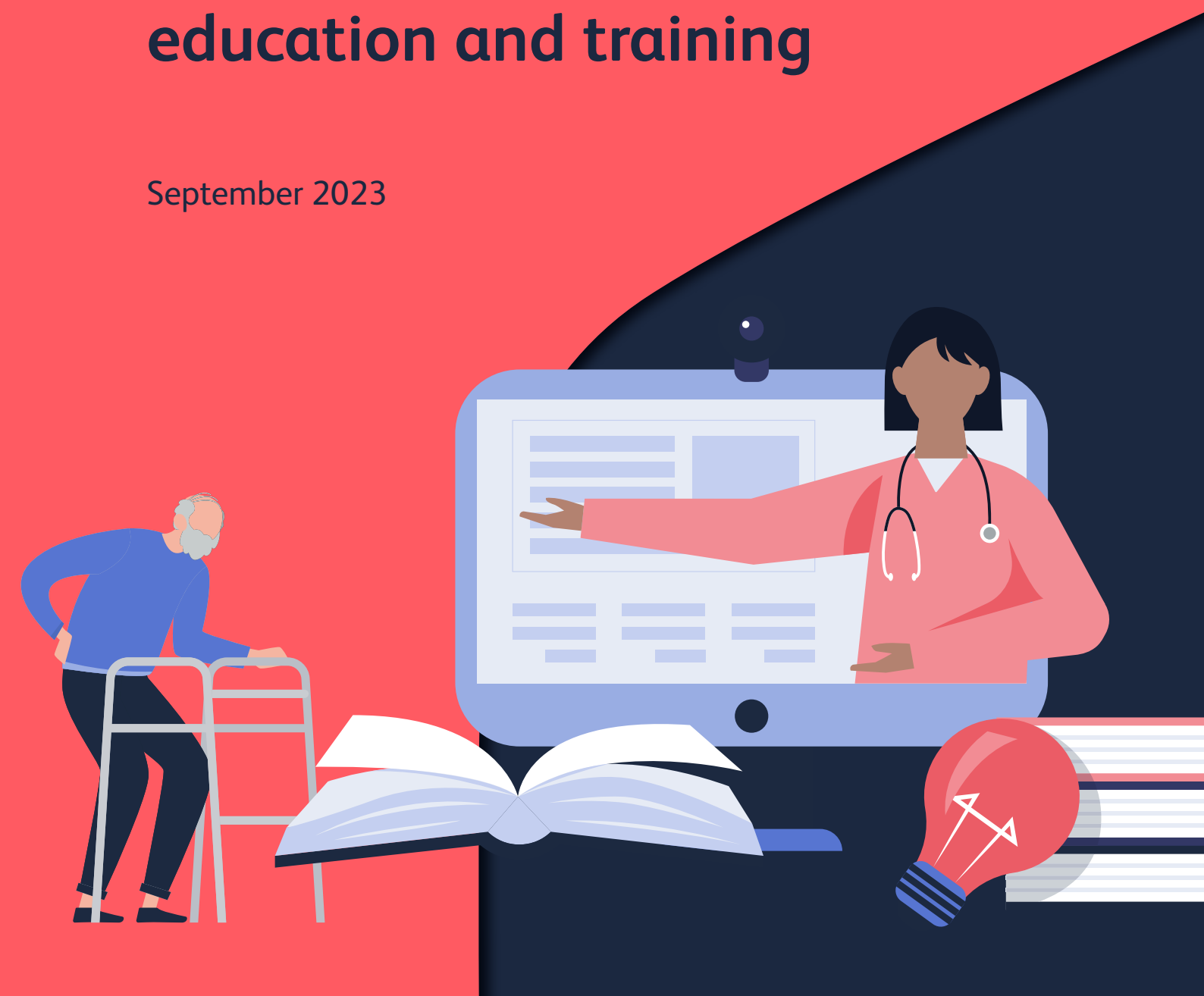
Royal College of Physicians

The shape of medicine

The future of the workforce, education and training

September 2023



Foreword

The Royal College of Physicians has always focused on being part of the solution, in support of healthcare leadership and government decision-makers. This means that, as an organisation, we respond quickly when asked for advice, help and support. It also means that we seek to work collaboratively to highlight contemporary issues of importance, all focused on our vision of the best health and care for all.

This discussion paper also illustrates that, at different times in our 505-year history, we produce documents that question current policy direction and offer thought leadership and challenge to support the whole healthcare system. The shape of medicine raises a number of key observations regarding the future healthcare workforce and what is needed for high-performing multidisciplinary teams to deliver timely, safe and effective care.

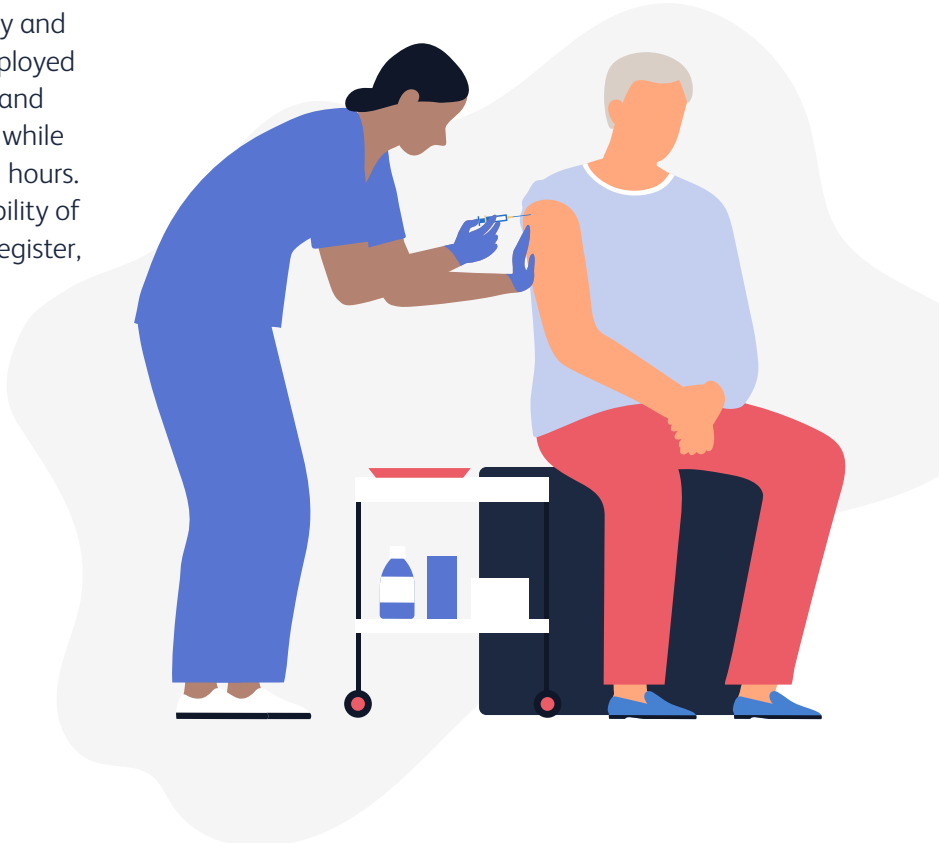
It benefits from all we learn through our ongoing conversations with our fellows and members, and has been shaped through iterative discussions with key representatives. Many RCP volunteers were involved, and we thank them on behalf of the Strategy Executive Group: the director of the medical workforce unit, SAS lead, Linacre fellow, co-chairs of the Trainees Committee, chair of the New Consultants Committee, JRCPTB medical for director for training and development, chair of the Patient and Carer Network, censors, college tutors, elected councillors, regional advisers, the president of the Faculty of Physician Associates, and of course all the members of our Council, who approved it at their meeting in July as part of their role in setting our policy direction.

It is published on the 10-year anniversary of two key documents for medicine – the GMC's *Shape of Training* review and our own *Future Hospital Commission* report. We highlight the positive observations made in both of these key reports, and also point to the pressing need for planning for the future, to ensure a workforce capable of meeting the diverse and increasing demands we will experience. In the NHS's 75th anniversary year, we commend it to you and commit to continue working collaboratively to deliver the changes needed for our workforce and patients in the future.

Dr Sarah Clarke, RCP president
Dr Ian Bullock, chief executive

Executive summary

1. On the 10th anniversaries of the publication of the *Shape of training review* (SoT) and the RCP's Future Hospital Commission (FHC) report, we are undeniably at a turning point for the NHS and the medical workforce. With the publication of this discussion paper, the RCP is seizing the opportunity to take stock and make sure that we are well prepared to both shape and respond to developments.
2. The ambition of SoT for trainee doctors to spend more time with patients, more time outside the hospital and more time in one place, and to learn in different ways in response to patient and service need, has not been realised. A lack of investment in training, the NHS, public health and social care has hindered more doctors and services being placed outside the hospital.
3. Because the size of the medical workforce has not kept pace with the demand for care, trainees are experiencing burnout, they are unable to meet the demands of training while also meeting service need, and training rotas are less flexible than those of other roles they could take up. This is forcing an increasing number of trainees to do things differently, with a growing number opting out of the traditional training route.
4. They are finding ways of working and developing skills that fit with their other ambitions and interests. This includes taking up specialty and associate specialist (SAS) and locally employed (LE) doctor positions, clinical fellowships and similar roles, to develop portfolio careers while having greater control over their working hours. There is increasing professional acceptability of such alternative routes to the specialist register, reducing the fear of stigma.
5. If current trends continue, we will have more SAS and LE doctors than trainees or consultants. This poses questions for the future of the workforce, as current structures are built around the consultant role. We could end up with many fewer consultants and a training system that is much more directive in terms of the specialty that someone trains in and where they train.
6. Changes to registration requirements are going to introduce different routes to the specialist register. This represents a significant change in practical arrangements, but also in the status and perception of current UK medical training and qualifications. The traditional training pathway may become significantly less attractive unless working conditions improve and flexibility increases.
7. The RCP needs to better support the growing number of doctors who are not on the traditional training pathway or the specialist register, and members of the wider medical team working in extended roles, in particular medical associate professions (MAPs) and advanced clinical practitioners (ACPs). This is true in terms of our offer both as a professional association and as an educator. Healthcare is changing, and so must we.



The RCP believes that

8. We need more doctors, who can practise as both generalists and specialists, and other healthcare professionals who help to make up specialist teams.
9. To train a good doctor who can provide generalist care together with specialist expertise requires adequate time. The RCP and others would need to scrutinise carefully any proposals to shorten the traditional training pathway, to make sure that they upheld standards and were practical.
10. New routes to specialist registration are being and will be developed and, while we might have concerns if a route meant a shorter period of study, we are and will be fully supportive of all new routes which ensure that someone has met General Medical Council (GMC) requirements.
11. While physicians remain our primary focus, all members of multidisciplinary teams are valuable, and we can and should seek to support and develop all clinical professionals.

The RCP will

12. Work with our partners in the Federation of the Royal Colleges of Physicians of the UK, the NHS and trainees to look at how we can improve the trainee experience.
13. Explore whether the current growth in SAS and LE doctors is likely to be a long-term change, and how these changes are impacting trainees on the traditional pathway and the consultant role.
14. Work with our members to understand how they feel about an increase in routes to the specialist register and a system in which there could be fewer consultants, more SAS and LE doctors, and more physician associates and advanced clinical practitioners.
15. Work with patients and carers, and the organisations that involve and represent them, to understand the impact of changes to the health and care workforce on patients and the public, and consider the implications of what we learn for medical education and training.
16. Work with SAS doctors to understand and develop the support, guidance, education and training that they need to develop in their chosen career.
17. Work with LE doctors to understand and develop the support, guidance, education and training that they need to progress their development.
18. Work with consultants to make sure that we are offering the credentials and other education and training products that they need.
19. Explore the role of the RCP in making sure that competence from self-directed learning and training is assessed sufficiently to ensure that all trainees meet the same standard, whatever route they take to the specialist register.
20. Explore the role of the RCP in supporting other members of the multidisciplinary team.
21. Monitor the development and impact of medical degree apprenticeships closely.
22. Consider the implications of these changes on how the RCP involves its members in its work and governance. This will include election arrangements, paid and voluntary opportunities, and how we gather views and opinions that inform our strategic direction.

We want to hear from you

We are keen to hear from all members of the medical workforce – whether or not they are RCP members – about the ideas and intentions within this document. We will be reaching out via our regions and committees. Please feel free to contact us via policy@rcp.ac.uk to register your interest in being consulted or to share your responses to what you have read.

The future of the medical workforce, education and training

23. 2023 sees the 10th anniversaries of the publication of the *Shape of training review* (SoT) and the RCP's Future Hospital Commission (FHC) report, and the 75th birthday of the NHS. In the FHC report, we were already saying that hospitals were struggling to cope with the challenge of an ageing population and increasing admissions. Then, when the NHS turned 70, we said that it had to adapt significantly to survive the next 70 years. The number of people needing care, and the complexity of their problems, had risen year on year. We needed to invest in the NHS workforce, agree a new financial settlement for health and social care, and support people to live healthier lives by investing in public health.
24. Five years later, as a result of political decisions over many years and the recent pandemic, we are undeniably at a turning point for the NHS and the medical workforce. The SoT review did change medical education and training so that it would better produce the doctors we need now. But it failed to recommend a significant increase in the number of doctors that we train in order to realise its vision. Coupled with years of cuts in funding to the NHS, it is no surprise that, when the pandemic struck, the health service was ill prepared. It became clear very quickly that the NHS can either deliver day-to-day care or manage a national emergency – not both.

25. Other factors are also having an effect on the current and future make-up of the workforce, and the nature of medical education and training. They include a growing desire for flexible working, more doctors working less than full time, more women (who provide more unpaid care than men) in the workforce, changing demographics, the ongoing development of advanced practice, the introduction of medical associate professionals (MAPs), the advent of doctor apprenticeships, the embedding of credentialling, a revised Certificate of Eligibility for Specialist Registration (CESR) process, and new medical schools that may produce graduates with a different approach to their career than those the system is used to.
26. But ultimately, underfunding of the medical workforce and the NHS as a whole has accelerated some changes introduced by SoT and militated against others taking effect. As a result, a growing number of trainee doctors are finding their own ways to the specialist register, and the role of consultant may be less attractive to them than it was.
27. These developments are relevant to the RCP as a professional association, an educator of the medical workforce, and an influencer and improver of the health and care system. The RCP has been at the forefront of recognising and responding to developments in the medical workforce and education and training. Our chief registrar and portfolio careers programmes, support for SAS doctors, creation of the Faculty of Physician Associates and embracing of credentialling are a few examples. What we are witnessing now may be a passing phase, or it may be a more fundamental shift. With the publication of this discussion paper, the RCP is seizing the opportunity to take stock and make sure that we are well prepared to both shape and respond to developments.

The Shape of training review

28. SoT considered how postgraduate medical education and training might be reformed. Its aim was to make sure that we continue to train effective doctors who are fit to practise, provide high-quality and safe care, and meet the needs of patients and the service now and in the future. It is the third element of the aim that was the greatest driver of change.

29. SoT identified the need to produce more doctors with generalist skills, while also recognising that patients value being cared for by specialists and that specialists improve patient outcomes. We said the same in the FHC report: that we needed a cadre of doctors with the knowledge and expertise necessary to diagnose, manage and coordinate continuing care for the increasing number of patients with multiple and complex conditions. SoT said that the need was mainly due to demographic changes – more people of all ages living with multiple conditions, a growing number of older people, and health inequality between deprived and affluent areas. These are all increasingly the case as we near the end of the first quarter of the 21st century.

30. In order to do this, SoT said that the 'broad, generalist nature of the early years of medical training, during medical school and the Foundation Programme, should continue into the later stages of training'. The aim would be to produce doctors 'capable of caring for patients more holistically, even if they end up working in focused practice areas'. This would lead to better patient experiences and outcomes, shorter hospital stays and fewer emergency admissions.

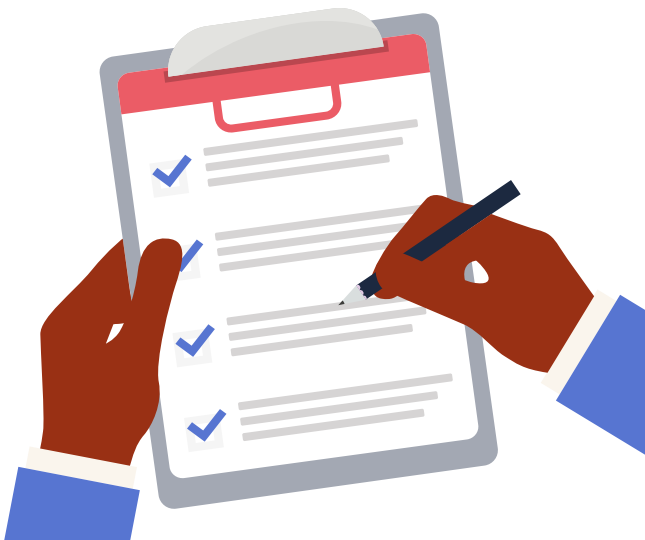
31. SoT said that trainees would be better doctors if they spent more time with patients, more time outside the hospital and more time in one place, and were able to learn in different ways in response to patient and service need. It went on to say that training more doctors capable of managing acute and emergency cases would 'reduce the stress and intensity of the workload'. It would also 'break the vicious cycle of unattractive areas of medicine failing to recruit staff and so becoming more understaffed, more stressful and more unattractive'.

32. But this simply hasn't happened: a lack of investment in medical training, the NHS (particularly primary and community care), public health and social care has hindered more doctors and services being placed outside the hospital. Due to rises in demand for both generalist and specialist care, coupled with stagnation or falls in supply of care, the stress and intensity have increased. More and more doctors are having to deliver primarily acute and emergency care.

33. At the time, SoT seemed to bemoan the fact that doctors were limited in the number of hours that they worked due to legislation setting maximum weekly working hours – although, when the GMC asked them, younger doctors said that they did not want to work 100-hour weeks. Rather than mourning the past, at that point the focus should have been on significantly increasing medical school places to prepare for what everyone knew was coming.

34. As it was, in 2013 trainees were already working more than they should have been. Due to the pressures of service delivery – and a mismatch between service and training needs – they were having to do training in their own time. Today, because workforce expansion didn't happen and demand for care has risen, trainees are experiencing burnout, they are unable to meet the demands of training while also meeting service need, and training rotas are less flexible than those of other roles they could take up. This is forcing an increasing number of trainees to do things differently.

35. SoT still expected all, or the vast majority of, trainees to complete specialist training. At the moment there's no reason to suggest that the vast majority don't still have that as their aim. But there is very good reason to think that how they fulfil their aim, and the roles that they are likely to take up once their training is complete, are already changing.

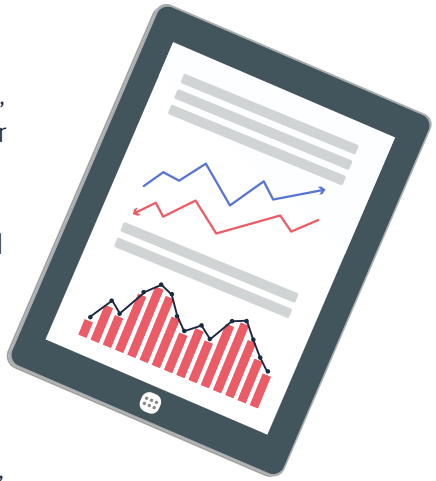


Current trainee behaviour

36. Because of the pressure that they are under, and because of the desire for a better work–life balance among younger people, a growing number of trainees are opting out of the traditional training route. The fact that there are not enough doctors is enabling them to do so, as they can be confident that refusing a position, wanting to work flexibly or taking a break will not result in them subsequently being unable to find a role.
    a. In a joint report in February 2022 [PDF], Health Education England (HEE) and the RCP said that the majority of doctors completing foundation training are moving to F3 – pausing their participation in postgraduate training – so that it 'has become a new norm, which is embedding'.
    b. 21% of the CESR applications that the Joint Royal Colleges of Physicians Training Board (JRCPTB) managed for the GMC in 2021 and 2022 were from UK graduates, 50% more than the number from India and Pakistan (both 14%).
    c. The JRCPTB is seeing an increased number of trainees leaving training programmes to pursue their own route to the specialist register. This will likely lead to a future increase in CESR applications.
    d. The GMC has shown that, on current trends, SAS and LE doctors will become the UK's largest register group by 2030. While the majority of people in these roles are international medical graduates (IMG), the numbers of IMGs, EEA graduates and UK graduates in these roles have increased at the same rate.
37. We are hearing from an increasing number of our trainee and consultant members that, in the current context, they view the role of consultant as unattractive. They perceive the role, as key diagnostician and decision maker, to carry significant responsibility and a high level of risk. Indeed, in the FHC report we said that the majority of trainees saw the role of medical registrar – the last step before specialist registration – as difficult, onerous and poorly supported. We found that excessive workload was the most common reason cited by trainees for not wanting to be a registrar. It had become less desirable in terms of work–life balance, with a majority believing that the volume and intensity of their workload while on call could be overwhelming.
38. So a growing number of trainees are in no rush to reach specialist registration, but they do still want to practise medicine. They are finding ways of working and developing their skills that fit with their other ambitions and interests. This includes taking up SAS and LE doctor positions, clinical fellowships and similar roles, to develop portfolio careers while having greater control over their working hours. There is increasing professional acceptability of such alternative routes to the specialist register, reducing the fear of negative repercussions.

The potential impact

39. If current trends continue, and we have more SAS and LE doctors than trainees or consultants, this poses questions for the future of the workforce. Current structures are built around the consultant role, so if other posts are becoming more attractive, it could have wide-ranging effects. For example, we could end up with many fewer consultants, in which case we need to consider the role and significance of those posts, including their capacity for supervision of other clinicians, and who would be eligible to fill them.
40. If this were to happen, it would require the system to be more directive when it comes to training. At the moment, some specialties have enough consultants while others struggle to fill those roles. Some areas of the country have more than enough consultants, and others far from enough. Demographic change will mean that we need more consultants in some specialties and places at some times, and in others at other times. For those who did want to become a consultant, it would of course be more competitive and directed in terms of the clinical or geographic area in which they specialise, which could make it less attractive as a career.



41. The 'market' will respond to this as it responds to local need, but greater centralised intervention – such as the current movement of training places to areas of greatest need – may be required. In any case, we need better workforce planning that is focused on meeting the needs of local populations, improving population health and reducing health inequality.

Changes already underway

42. On 28 February 2023 the GMC issued a briefing, 'Changes to how doctors demonstrate the standard required for specialist and GP registration.' It said that changes to legislation will come into effect on 30 November 2023 that will allow doctors to demonstrate that they have the knowledge, skills and experience (KSE) to practise as a specialist or GP in the UK, rather than having to demonstrate that their training is 'equivalent' to a certificate of completion of training (CCT). It said that this will mainly apply to those who have undertaken their specialist training outside the UK or Europe, and are using the CESR or Certificate of Eligibility for GP Registration (CEGPR) pathways. But, given that more UK graduates are using the CESR pathway, it will also apply to a growing number of them.
43. Evaluators will assess whether a doctor's evidence shows that they have achieved high-level learning outcomes and skills, rather than how they have demonstrated progression or completed prescribed assessments. The evaluation framework that they will use will be the high-level outcomes set out in UK specialty curricula.
44. The briefing went on to say:
    a. 'Additionally, the move away from equivalence to CCT as the standard will break down the perception that CCT is a higher-value route to the specialist and GP registers than any other pathway.'
    b. 'The legislative changes which introduce the new standard will also enable evidential flexibility, such as being able to consider the minimum evidentiary requirements to demonstrate capability rather than mirroring evidence that a CCT trainee would need to provide. This will mean a better experience for applicants and evaluators and make the CESR/CEGPR pathways more attractive pathways to the registers.'
    c. 'The amendments to the legislation will also enable us to consider developing new pathways. We are in the early stages of thinking about the new pathways and there is considerable further work that we need to do to develop and progress our policy in this area. We will update doctors and key stakeholders in due course.'
45. Legislative changes will also come into effect on 30 November 2023 that will enable a new Recognised Specialist Qualification (RSQ) pathway for doctors from outside the UK and EEA who are applying for specialist or GP registration. The GMC will identify qualifications that meet a set of criteria, meaning that anyone holding those qualifications will be eligible for registration, rather than having to submit evidence.
46. In essence, these changes are going to introduce different but equally valid routes to the specialist register. This represents a significant change in practical arrangements, but also in the status and perception of current UK medical training and qualifications. This latter impact is likely to grow over time, but it will be significant.
47. The traditional training pathway may become significantly less attractive unless working conditions improve and flexibility increases. The aim is to create a better balance between work and the rest of a trainee's life, making caring and other responsibilities much less stressful. This may include (but is not limited to):
    a. allowing any trainee to transfer deanery for any reason
    b. making it easier to work less than full time, especially during exam periods
    c. reducing the number of rotations and the geographical area that they are spread across
    d. making sure that we are not erecting barriers to timely completion of training
    e. changing the way that progression is assessed.
48. At the same time, the RCP needs to better support the growing number of doctors who are not on the traditional training pathway or the specialist register, and members of the wider medical team working in extended roles, in particular MAPs and advanced clinical practitioners (ACPs). This is true in terms of our offer both as a professional association and as an educator. Healthcare is changing, and so must we.

Our next steps

49. Over the next year, the RCP will review all its activity in light of the ongoing changes impacting the medical workforce. This review will inform the development of our strategy beyond 2024.

50. We are beginning the review by publishing this document and seeking a wide range of opinions, comments and suggestions. We are keen to hear the opinions of all medical professionals – whether or not they are RCP members – about the ideas and intentions within this document. In particular, we will value your thoughts on what we believe and what we intend to do with respect to medical education and training.

What the RCP believes

51. The role of the consultant has changed significantly over time. While consultants still have autonomy and individual accountability, the reality is that they work as members of multidisciplinary teams that make collective decisions. All members of those teams are valuable; they bring different skills and experiences that complement each other and enhance care. While physicians remain our primary focus, the RCP can and should seek to support and develop all clinical professionals, not least because all have the potential to support, train and educate each other.

52. At the time of SoT, the RCP agreed that we would need more doctors with general medical skills: we said in the FHC report that a greater proportion of doctors will need to be trained and deployed to deliver expert general internal medical care. Today we are saying that we need more doctors, who can practise as both generalists and specialists, and other healthcare professionals who help to make up specialist teams. The emphasis is still on generalism, given that the population is ageing and its health declining. We also said that to train a good doctor who can provide generalist care together with specialist expertise requires adequate time. The RCP and others would need to scrutinise carefully any proposals to shorten the traditional training pathway, to make sure that they upheld standards and were practical.

53. The RCP also recognises that new routes to specialist registration are being and will be developed. At the same time, people are finding their own route to the specialist register. These routes could help to tackle workforce shortages and improve socio-economic diversity among doctors. While we might have concerns if a route meant a shorter period of study, we are and will be fully supportive of all new routes which ensure that someone has met GMC requirements.

What the RCP intends to do

54. We will work with our partners in the Federation of the Royal Colleges of Physicians of the UK, the NHS and trainees to look at the structure and delivery of training and explore how we can improve the trainee experience. This will include operational issues such as level of fees and facilities for payment in instalments, as well as how to increase flexibility within training - for example, reducing the number of rotations and the geographical area that they are spread across, making sure that assessment is relevant and proportionate, and improving general working conditions.
55. We will explore whether the current growth in SAS and LE doctors is likely to be a long-term change. We will also explore how these changes – whether transient or permanent – are impacting and will impact trainees on the traditional pathway and the consultant role.
56. We will work with our members to understand how they feel about an increase in routes to the specialist register and a system in which there could be fewer consultants, more SAS and LE doctors, and more physician associates and advanced clinical practitioners. It will include the role and significance of those consultant posts, including their capacity for supervision of other clinicians, and who would be eligible to fill them.
57. We will work with patients and carers, and the organisations that involve and represent them, to understand the impact of changes to the health and care workforce on patients and the public. This will include the skills that they want all medical professionals to have, such as the ability to explain complex information, facilitate shared decision making, and guide someone through a complex system. We will consider the implications of what we learn for medical education and training.
58. We will work with SAS doctors to understand the support, guidance, education and training that they need to develop in their chosen career. We will develop education and training products and a membership offer that meets those needs.
59. We will work with LE doctors to understand the support, guidance, education and training that they need to progress their development, whether they ultimately intend to become a consultant or not. We will develop education and training products and a membership offer that meets those needs.
60. We will work with consultants to make sure that we are offering the credentials and other education and training products that they need.
61. We will explore the role of the RCP in making sure that competence from self-directed learning and training is assessed sufficiently to ensure that all trainees meet the same standard, whatever route they take to the specialist register. This may include widening access to the ePortfolio so that future doctors can make use of it earlier in their career path.
62. We will explore the role of the RCP in supporting other members of the medical workforce.
63. We will monitor the development and impact of medical degree apprenticeships closely.
64. We will consider the implications of these changes on how the RCP involves its members in its work and governance. This will include election arrangements, paid and voluntary opportunities, and how we gather views and opinions that inform our strategic direction.

Hearing from you

We will be reaching out to all medical professionals via our regions and committees. Please feel free to contact us via policy@rcp.ac.uk to register your interest in being consulted or to share your responses to what you have read.

Royal College of Physicians
11 St Andrews Place
Regent's Park
London NW1 4LE

www.rcp.ac.uk
policy@rcp.ac.uk

Royal College of Physicians