



# Unfinished Business

Proposals for Reform of the Senior House Officer Grade

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## Consultation in Scotland

The following Report of the Chief Medical Officer in England, Sir Liam Donaldson, sets out proposals to reform the SHO grade. This Report has been informed by the deliberations of a working group that was tasked to advise UK Health Ministers on a modern structure for basic specialist training throughout the UK.

We have decided to consult on this Report separately in Scotland within the context of our ongoing activity in workforce planning and development, much of which is detailed in the August publication *Working for Health – The Workforce Development Action Plan for NHSScotland*. This Report is also clearly linked to the July 2002 Report *Future Practice – A Review of the Scottish Medical Workforce*, and to the working groups we have established as part of the Scottish Executive's Response to it.

The challenges facing the SHO grade are well recognised. We in Scotland wish to consider this Report within the unified context of the whole NHS workforce and for this consultation to also inform our ongoing work in the areas detailed above. You are therefore invited to submit your comments on this Report by **13 November 2002** to:

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Scottish Executive Health Department  
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# Summary

- Most young doctors seek a senior house officer (SHO) appointment when they complete their first postgraduate year as a pre-registration house officer.
- There have been significant reforms of pre-registration and higher specialist training and improvements to vocational training for general practice. In contrast, long-standing problems with the job structure, working conditions and training opportunities of SHOs remain.
- The Government is committed to reform the SHO grade. This Report sets out proposals for progressing that reform.

## The case for change

- The problems of the SHO grade are widely accepted but, unlike the emphasis on education and training for other groups of professional staff, SHOs have not benefited from a substantial or coherent investment in their professional development.
- In England about:
  - half of all doctors in training are SHOs;
  - one third of SHOs are non-UK graduates;
  - half of the UK graduates in the grade are women and that proportion is increasing.

- Although these ratios may vary across the United Kingdom, the pattern is broadly similar.
- Reform must take account of:
  - poor job structure: half of all SHO appointments are short-term and do not form part of any training rotation or programme;
  - poorly planned training: there is no defined end-point to SHO training. Time spent in the grade varies and is often independent of training requirements;
  - weak selection and appointment procedures: these are not standardised and are frequently not informed by core competencies;
  - increasing workload;
  - inadequate supervision, assessment, appraisal and career advice;
  - insufficient opportunities for flexible training;
  - unsatisfactory arrangements for meeting the training needs of non-UK graduates;
  - the relationship between Royal College examinations and their relevance to training programmes varies greatly.

## A new framework for training of SHOs

- **Experience from comparable reforms to higher specialist training**

The relatively recent implementation of the specialist registrar system provides important lessons for change to the SHO grade. For example in a reform of medical training it is important to:

- set out a clear set of principles to guide reform;
- publish programme curricula;
- ensure a coherent approach to setting standards and managing the delivery of training;
- provide robust and reliable information systems to support the management of training;
- ensure a consistent and valid approach to assessment;

- place a strong emphasis on the quality assurance of training;
  - introduce a sound process for the selection of trainees;
  - manage training – service tensions.
- **Five principles for reform of SHO training**
- Training should:
- be programme-based;
  - be broadly-based to begin with for all trainees;
  - provide individually-tailored programmes to meet specific needs;
  - be time-capped;
  - support movement of doctors into and out of training and between training programmes.

- **The proposed reforms to SHO training**

**Structure.** Following graduation, all doctors will enter:

- *first* a two year *foundation programme* which includes the current pre-registration year. An objective of the foundation programme would be to develop and enhance core or generic clinical skills essential for all doctors (e.g. team-working, communication, ability to produce high standards of clinical governance and patient safety, expertise in accessing, appraising and using evidence as well as time management skills).
- *second* one of eight (or so) broad-based, time-capped *basic specialist training programmes* including training for general practice. During the foundation years, the doctor would have had the chance to sample a range of practice and would then compete to enter one of the basic specialist training programmes.

A limited number of *individual programmes* will be provided designed to meet specific training needs of individual doctors.

**Programmes.** These would ensure that as many doctors as practicable wishing to enter higher specialist or general practice training can do so. The programmes will enable doctors in SHO training to gain the right knowledge, skills, attitudes and experience in the minimum time and will:

- deliver training to a high standard;
- be flexible in design and operation;
- respond to changing service needs;
- address the needs of non-UK graduates;
- provide opportunities for flexible training;
- be time-capped;
- provide opportunities to leave and re-enter training;
- present a robust structured framework to support compliance with the requirements of the European Working Time Directive;
- provide a foundation to support moves towards more integrated training along the continuum.

- **A single training grade**

The advantages of moving to a single training grade encompassing: foundation; basic specialist; general practice; higher specialist; and individual training programmes should be urgently explored. In such an arrangement doctors in training would move seamlessly through the grade subject to satisfactory performance and assessment. This could not be implemented immediately and some element of application and competition may still need to be retained to meet the needs of the service and availability of training places. This should be explored specialty by specialty.

## Assessment and examination

- The proposals for reform to SHO training place greater emphasis on competency-based assessment throughout training as evidence of successful completion of training. Progress through training will continue to be informed by success in medical Royal College examinations and increasingly through the Record of In Training Assessment (RITA) process as it is introduced for SHOs.
- An analysis has found a striking variation in examination practice across medical Royal Colleges and Faculties:
  - pass rates for Royal College Part I examinations ranged between 33.3% and 81.4%;

- pass rates for Royal College Part II examinations ranged between 27.5% and 79.0%;
  - pass rates for UK graduates ranged between 44.4% and 78.8%;
  - pass rates for non-UK graduates ranged from 28.0% to 66.7%;
  - the minimum costs for candidates completing the examination ranged from the cheapest college examinations at £530 to the most expensive at £1,460.
- Royal College examinations will remain a vital component of medical training, but there has been no comprehensive and fundamental review of the College examination system in the round and the ‘fitness’ of the examinations for purpose. Nor are the examinations subject to any external quality assurance, which is unusual compared to other fields of education and training. It is proposed that a system of external accreditation of medical Royal College examinations should be introduced. It is understood that the Academy of Medical Royal Colleges has already started a fundamental review of the examination system.

## Managing training and recruitment

It is proposed that:

- postgraduate medical deans should be responsible for the overall management of programme-based training, using programme directors accountable to them;
- postgraduate deans would also be responsible for ensuring that trainers were adequately supported and trained, and for ensuring the quality of training placements;
- it is also proposed that postgraduate deans should be responsible for the appointment arrangements to all programmes (foundation, basic and higher specialist and individual).

## Non-UK trained doctors

- The provisions for basic specialist training should ensure that the needs of non-UK qualified doctors are fairly and properly taken into account and that they have equal access to high quality training programmes.

## Wider Proposals

- The consideration of the reform of the SHO grade has implications for other aspects of the medical workforce and in this respect two further proposals are made:
  - that doctors in higher specialist training should be awarded a Certificate of Completion of Specialist Training (CCST) earlier than at present and that this would make them eligible for appointment to a ‘generalist’ consultant post in their chosen specialty. This would be followed by a period of more highly specialised training for those who wished to undertake it, and for which there was a service need.
  - that the non-consultant career grade should be restructured so that some of the stigma associated with this grade is removed, its prestige is enhanced and the opportunities to enter (or re-enter) higher specialist training from it are much greater than at present.

## Conclusions

- The 19 proposals set out in this report are for consultation. They aim to reform the Senior House Officer grade, a grade occupied by half the doctors in training in this country.
- The opportunity of this fundamental review of the SHO grade has raised wider points about the structure of the medical workforce and as a result proposals are made to change the nature and timing of the Certificate of Completion of Specialist Training (CCST) and to reform the non-consultant career grade.

# 1

## Introduction

- 1.1** Most young doctors seek an appointment as a senior house officer (SHO) on completing their year as a pre-registration house officer. During their time in the SHO grade they undertake increasing supervised responsibility for patient care and develop a wide range of general and basic specialist skills needed for their chosen specialty.
- 1.2** After working in a number of SHO posts, they then complete training in general practice or enter a higher specialist training programme in hospital or public health medicine. This is the route by which doctors obtain the qualifications and experience to become either consultants or principals in general practice. Some, however, will seek work in hospital practice in non-training or non-consultant career grade posts.
- 1.3** Over the last decade, there have been major reforms to higher specialist training including a new specialist registrar grade to replace the previous registrar and senior registrar grades. There have also been important improvements to the education, training and working conditions of pre-registration house officers and of general practice registrars.
- 1.4** SHOs have been left behind. They have not benefited from the reforms enjoyed by trainees in other training grades. As a group they have been described as ‘the workhorses of the NHS’ (implying a disproportionate amount of service work compared to training) and a ‘lost tribe’ (suggesting a lack of coherence in the organisation of training).

- 1.5** The Government accepted the recommendations in '*A Health Service of all the talents: Developing the NHS workforce*'<sup>1</sup> to “sort out the senior house officer grade” and made a commitment in *The NHS Plan*<sup>2</sup> to reform SHO training. This commitment is mirrored by the administrations in Scotland, Wales and Northern Ireland.
- 1.6** This Report takes into account the thinking of a Working Group convened to consider the options for modernising SHO training and the many organisations that gave evidence to its Sub-Group. It also reflects work in the Department of Health to analyse the workforce implications of reform and the effect of the Working Time Directive.
- 1.7** Members of the Working Group (Annex A) were invited in a personal capacity to provide expertise on postgraduate medical and dental education as well as a service, management, educational and lay perspective.
- 1.8** The Working Group established a Technical Sub-Group (Annex B) to gather evidence and views on reform. It invited comments from 48 stakeholder organisations. Replies from 34 organisations informed a series of focus-group sessions convened by the Sub-Group (lists of contributors at Annex C).

1 *A Health Service of all the talents: Developing the NHS workforce*, Department of Health, 2000.

2 *The NHS Plan: A Plan for Investment A Plan for Reform*, The Department of Health, 2000.

# 2

## The Case for Change

This section describes current arrangements for SHO training, identifies the different aims of doctors training in the SHO grade and describes the current problems and issues particular to this group of trainee doctors.

- 2.1** Doctors entering the SHO grade hold Full or (for most non-UK graduates) Limited Registration with the General Medical Council. The grade represents the phase of training now commonly called *basic specialist training*, and is supervised by two ‘competent authorities’<sup>3</sup> appointed by the Government.
- 2.2** The number of doctors in SHO posts is large: in England, they represent almost half of all doctors in training.

### Numbers of NHS medical staff in training

	England (2001)	%	Scotland (2000)	%	Wales (2002)	%	Northern Ireland (2001)	%
PRHOs	3,685	11.0	718	16.6	213	10.7	188	13.1
<b>SHOs</b>	<b>15,384</b>	<b>45.8</b>	<b>2,134</b>	<b>49.3</b>	<b>1,054</b>	<b>52.7</b>	<b>720</b>	<b>50.2</b>
GP Registrars	1,883	5.6	261	6.0	99	5.0	54	3.8
SpRs	12,648	37.6	1,217	28.1	632	31.6	471	32.9
<b>Total</b>	<b>33,600</b>	<b>100</b>	<b>4,330</b>	<b>100</b>	<b>1,998</b>	<b>100</b>	<b>1,433</b>	<b>100</b>

PRHO = Pre-Registration House Officer, GP = General Practitioner, SpR = Specialist Registrar

<sup>3</sup> The Specialist Training Authority of the Medical Royal Colleges and the Joint Committee on Postgraduate Training for General Practice.

### 2.3 At any one time there will be SHOs:

- in vocational training for general practice;
- in basic specialist training;
- gaining broader training or experience (often before making a career choice);
- ‘marking time’ waiting for an opportunity to progress their career;
- choosing to remain in the SHO grade, sometimes for many years.

However, the current service pressure on SHOs is great. In service terms their numbers are potentially inflated further by an increasing cohort of ‘trust doctors’ who undertake work equivalent to that of an SHO, although they are in reality a non-consultant career grade.

### 2.4 It is generally accepted that SHO training requires radical overhaul. Reforms already undertaken in other areas of the medical training continuum have identified deficiencies in SHO training, in particular:

- the General Medical Council’s report *The New Doctor*<sup>4</sup> which led to improvements in pre-registration house officer training;
- the ‘Calman’ reforms of higher specialist training<sup>5</sup> now fully implemented;
- several reports supporting better management of general practitioner vocational training;
- the ‘Savill Report’<sup>6</sup>, addressing training for academic medicine, identified bright SHOs being effectively forced into undertaking pre-Specialist Registrar doctoral research in order to enhance their competitiveness to gain entry to specialist registrar programmes.

### 2.5 In recent years a number of reports have been published by different organisations on SHO training (a bibliography is at Annex D). They have explored ways to improve training, but almost all have sought changes to existing training structures and focused mainly on educational issues. There has been little analysis of the case for more radical reform, for strategic or structural change, or of the need to take into account the wider implications of reform on service delivery now and in the future.

4 The New Doctor, The General Medical Council, 1997

5 Reforming Higher Specialist Training in the United Kingdom – a step along the continuum of medical education, K C Calman, J G Temple, R Naysmith R G Cairncross, S J Bennett; Medical Education, 1999, 33.

6 The Tenure-Track Clinician Scientist, The Academy of Medical Sciences, 2000.

### The senior house officer grade – principal challenges:

- job structure;
- planning training;
- selection and appointment procedures;
- supervision, assessment and appraisal;
- tension between service and training needs;
- arrangements for flexible training;
- career advice;
- meeting the needs of non-UK graduates;
- workforce planning;
- the role of Royal College examinations;
- adapting higher specialist training to changing service demands.

## Job structure

**2.6** About half of all SHO posts are free-standing and do not form part of any training rotation or programme. As a consequence:

- many SHOs receive limited career guidance and are left to decide on and to follow their own career pathways in the hope that their choice of posts will support their final career choice;
- even where posts have been grouped to form a *rotation* this does not usually meet the requirements of a managed programme of training;
- the quality of training can be indifferent;
- the constant need to secure short-term posts means frequent job applications and participation in appointments committees. This creates uncertainty for trainees and is an added burden for the service.

## Planning training

**2.7** There is no defined end point to SHO training. The length of time spent in the grade varies greatly. Progress beyond the grade is largely dependent on a doctor's ability to secure a specialist or general practice registrar position. This in turn depends on:

- the number of places available in programmes of higher specialist or general practice vocational training;
- the requirement in most specialties to pass medical Royal College examinations before entry to higher specialist training.

**2.8** Many trainees spend considerably longer as SHOs than is required to satisfy training requirements and, although continuing to gain some experience, are effectively repeating training. Additional time spent in basic specialist training does not normally count towards higher specialist training.

## Selection and appointment procedures

**2.9** Selection and appointment procedures are often inefficient and expensive:

- appointment procedures have not been standardised as they have for appointments to specialist registrar programmes and there is a risk they may not always comply with good employment or equal opportunities practice;
- selection is not always based upon meeting and assessing the competencies SHOs require to provide good quality care and to progress through training. There has been insufficient progress made in defining these competencies.

## Supervision, assessment and appraisal

**2.10** There have been recent improvements in the supervision of SHOs but there are still no robust mechanisms for regularly appraising performance nor for formal assessment. These are difficult to introduce without the support of a structured training programme. Poor performance is not reliably recognised or addressed. An SHO's suitability to progress to the specialist registrar grade is measured largely on success at passing Royal College examinations and on ability to secure further posts.

## Tension between service and training needs

**2.11** In an apprentice-based training system, tension between the competing demands of training and service is to be expected. This is nothing new and should be a positive dynamic especially where working and learning are not always easily separated. However, within the SHO grade this tension is often addressed in an inadequate and *ad hoc* way:

- there is no general understanding of the appropriate service contribution that SHOs should make;
- the potential benefits of SHO ability to ‘cross-cover’ between related disciplines, or their participation in multi-professional teams, have not been fully explored.

As a result there are marked variations in the amount of service SHOs provide in different posts and inconsistency in the quality of the training they receive.

**2.12** SHOs make a major contribution to the provision of health services. Implementation of the European Working Time Directive for doctors in training will impact on the way they work and will force a fresh look at how the demands of providing service and training are met.

## Flexible training

**2.13** As more women graduate from UK medical schools, so more become SHOs, creating an important need for family friendly policies and for flexible training. Men too are seeking more flexible working arrangements. In 1986 women doctors made up 25% of the hospital medical workforce in England. By 2001 that proportion had risen to 34%.

## Numbers of women doctors in training and proportion in different grades

	England (2001)	% women	Scotland (2000)	% women	Wales (2002)	% women	Northern Ireland (2001)	% women
PRHOs	1,838	49.9	369	51.4	118	55.4	107	56.9
<b>SHOs</b>	<b>6,917</b>	<b>45.0</b>	<b>1,029</b>	<b>48.2</b>	<b>429</b>	<b>40.7</b>	<b>327</b>	<b>45.4</b>
GP Registrars	1,152	61.2	165	63.2	64	64.6	34	63.0
SpRs	4,768	37.8	486	40.6	255	40.4	188	39.9
<b>Total</b>	<b>14,675</b>	<b>43.7</b>	<b>2,049</b>	<b>47.5</b>	<b>866</b>	<b>43.4</b>	<b>656</b>	<b>45.8</b>

PRHO = Pre-Registration House Officer, GP = General Practitioner, SpR = Specialist Registrar

### **The case for improved flexible or part-time training in the SHO grade:**

- 58% of medical school intake are women;
- 34% of the hospital medical workforce are women;
- 49% of UK graduates holding SHO posts are women.

## **Career advice**

**2.14** SHOs have to make important career decisions. Yet many receive poor career advice and guidance. Improvements are necessary but need to be flexible, recognising that not everybody can or indeed wishes to make definitive career decisions early in their postgraduate training. For example, a cohort study<sup>7</sup> of medical graduates found that:

- 24% of doctors entering the SHO grade changed their career preference at least once within the three year period following entry to the SHO grade; and
- five years after graduation:
  - 7% were still undecided as to their preferred career;
  - 17% had changed their main specialty in the previous twelve months.

**2.15** Doctors should not be pressed or expected to make premature career decisions. This is neither in their interests nor that of patients. Exposure to a variety of settings and experiences early in their postgraduate career can help them to make an informed career choice.

## **Meeting the needs of non-UK graduates**

**2.16** Graduates from overseas and elsewhere in the European Economic Area form a significant part of the training workforce.

<sup>7</sup> British Medical Association, *Career intentions of First year Senior House Officers: Cohort study of 1995 Medical graduates: Third report*, London: BMA; 1998.  
British Medical Association, *Cohort study of 1995 Medical graduates: Sixth report*, London: BMA; 2001.

## Numbers of non-UK graduates in training and proportion in different grades

	England (2001)	% non-UK	Scotland (2000)	% non-UK	Wales (2002)	% non-UK	Northern Ireland (2001)	% non-UK
PRHOs	509	13.8	52	7.2	35	16.4	na	na
<b>SHOs</b>	<b>5,414</b>	<b>35.2</b>	<b>510</b>	<b>23.9</b>	<b>431</b>	<b>40.9</b>	<b>na</b>	<b>na</b>
GP Registrars	459	24.4	na	na	na	na	na	na
SpRs	4,455	35.2	303	24.9	209	33.1	na	na
<b>Total</b>	<b>10,837</b>	<b>32.3</b>	<b>865</b>	<b>20.1</b>	<b>675</b>	<b>33.8</b>	<b>na</b>	<b>na</b>

(na = not available)

PRHO = Pre-Registration House Officer, GP = General Practitioner, SpR = Specialist Registrar

### 2.17 Their reasons for seeking to train in the UK differ:

- many come to fulfil a specific training goal and then return to their home country;
- others come to undertake full postgraduate training in the UK leading to a Certificate of Completion of Specialist Training and then return to their home country;
- others plan to complete their training here and settle in the UK;
- some may be undecided about their ultimate career aspirations;
- some are refugees with particular needs.

Most arrive after varying levels of training, qualifications and experience and consequently have different training needs. Many encounter real difficulties in securing an initial appointment (particularly in their chosen specialty). They often hold short-term SHO contracts or face unemployment between posts when their contracts end. Their aspirations for career advance are frequently unmet.

## Workforce planning

**2.18** SHO numbers are not planned nationally and have not so far taken account of educational goals or of the longer-term needs of the medical workforce. Numbers have largely been influenced by the output of new medical graduates and service pressures, and are currently primarily controlled by exercising broad financial constraints (an education levy or equivalent system). Training programmes and the numbers within them to support service needs have not been routinely identified. Even now when a more flexible approach to workforce planning is being adopted these criticisms remain valid.

**2.19** In contrast, the number of specialist registrar placements is planned to ensure an adequate supply of consultants to the NHS geared to the needs of individual specialties. NHS Trusts, however, continue to seek more SHO posts (or use NHS Trust grade doctors working at SHO level) because of their current excellent value for service and, until the European Working Time Directive begins to take effect, their versatility to cover out of hours work and emergency care.

**2.20** Trainee preferences are a further factor contributing to an imbalance between SHO and specialist registrar training opportunities in different specialties. The situation varies between parts of the country. The example given below illustrates the marked imbalances that have arisen over time.

**Imbalance in career prospects for SHOs – some examples from one region:**

*there were:*

- 35 SHO applicants for every specialist registrar post in neurosurgery;
- 53 SHO applicants for every specialist registrar post in urology.

*compared with:*

- 0.8 SHO applicants for every specialist registrar post in child psychiatry;
- 2.3 SHO applicants for every specialist registrar post in medical microbiology.

**2.21** The excess of SHOs attempting to enter higher specialist training in some specialties means not all doctors can pursue their chosen specialty and have to make alternative training or career choices. With little good career advice, many seek repetitive posts hoping eventually to advance their particular career choice. In other specialties, insufficient trainees wishing to enter higher specialist training or to enter general practice causes a shortfall in applicants for consultant or general practice posts needed to meet service requirements.

## The role of Royal College examinations

**2.22** Entry into higher specialist programmes is governed by minimum entry requirements set by the Specialist Training Authority of the Medical Royal Colleges on the advice of the Royal Colleges. In many cases, these require that a candidate for higher specialist training has been successful in the relevant Royal College examination. Therefore, for many trainees the primary goal of the SHO grade is simply to pass the necessary examination.

**2.23** Evidence provided to the Working Group on all Royal College examinations demonstrated wide variations in success rates across different examinations and in the minimum costs for completing the examinations. The differences were striking. In summary:

<b>Pass rates:</b>	<b><i>as a percentage</i></b>
Part I examinations	(range 33.3 to 81.4)
Part II examinations	(range 27.5 to 79.0)
UK graduates	(range 44.4 to 78.8)
Non UK graduates	(range 28.0 to 66.7)
<b>Minimum costs to complete examinations:</b>	(range £530 – £ 1,460)

[Note: data from 2000]

There appeared no ready explanation for these findings other than the traditions, practice and attitudes of Royal Colleges differed greatly. In many Colleges significant numbers of overseas doctors, who have not trained in the United Kingdom, take the examinations.

**2.24** The important function of examinations within the training continuum is recognised. However, the relationship between these examinations and their role within specialist training varies greatly between the Royal Colleges. Success in their examinations may mean that the candidate:

- has the knowledge, skills and attitudes to be eligible to apply in open competition to enter higher specialist training;
- is eligible to enter the final stages of higher specialist training;
- has demonstrated evidence to support the award of a Certificate of Completion of Specialist Training;
- is an overseas doctor wishing to use an examination pass as an important demonstration that they have reached an identified level of skill and knowledge, but does not wish to proceed through the UK training system.

**2.25** Neither the timing nor the content of these examinations is clearly linked to doctors' progress through training. Indeed, examination failure may lead to '*dead time*' in which doctors, ready to move on to the next phase of training, cannot do so and mark time until they pass the required examination.

## Adapting higher specialist training to changing service demands

- 2.26** Following basic specialist training, many doctors move on to higher specialist training. There are almost 60 higher specialist training programmes varying between two and six years in length dependent upon the specialty. Successful completion of a programme results in the award of a Certificate of Completion of Specialist Training and the opportunity to become a consultant.
- 2.27** There is now a growing view that patient care would be enhanced if delivered by doctors whose training is not as deeply specialised as some of the current Certificate of Completion of Specialist Training programmes demand. If properly grounded in the medical career structure there could be clear benefits to both the service and individual doctors in developing new, shorter Certificate programmes designed to produce fully-trained specialists with a wide range of skills more closely attuned to the current needs of the NHS. Some doctors would acquire further specialist and sub-specialist skills in their careers in response to service needs.
- 2.28** To benefit fully from such shorter, more broadly-based higher specialist training programmes, a trainee must be properly prepared, with the appropriate grounding at the basic specialist stage. The current SHO training system is in the main unstructured and would be entirely unsuitable in preparing doctors for new higher specialist training programmes. Reform of the SHO grade is, therefore, an essential ingredient in establishing the right platform experience and broad specialty training for entry into higher specialist training.
- 2.29** The case is made elsewhere in this report for a more integrated approach to training and for more thought on the benefits of a single training grade – a clearer link between structured basic specialist training and reformed higher specialist training will add to the impetus to integrate training more fully.

# 3

## A New Framework for Training

**This section describes the principles on which it is proposed to base a new framework for training. It sets out a series of recommendations to reform basic specialist and general practice training.**

### Setting the scene

- 3.1** If reforms to the SHO grade are to be successful they will need to operate within the continuum of training, with clear and effective links to career posts and appointments and with explicit training pathways leading to clear training goals. A key element is flexibility – the ability to support and accommodate varying needs of trainees and to respond to changing and challenging service demands.
- 3.2** The components of the new system and the principal training pathways that link them are set out in the diagram at Annex E. They are also all addressed in this chapter.

### Lessons from the reform of higher specialist training

- 3.3** It is useful to draw on experience of commissioning the most recent major change to medical training. Reform of higher specialist training began ten years ago. It represented a fundamental change not only for doctors in training but for supervising consultants, educational bodies and NHS organisations. It affected: career structure; professional development; employment; service delivery; planning of the medical workforce; assessment and research. The programme of reform was unprecedented and delivered successfully over a short period of time. It provides many important lessons<sup>8</sup> which can guide reform of the SHO grade. Key messages are:

- to set out a clear set of principles to guide reform at the outset;

<sup>8</sup> Evaluation of the Reforms to Higher Specialist Training 1996–1999, The Open University Centre for Education in Medicine, 2001.

- to publish programme curricula – geared to deliver clear standards and be understandable by supervisors, trainers and trainees;
- to ensure a coherent approach to setting standards and managing the delivery of training. This should involve competent authorities, postgraduate deans, educational supervisors, medical Royal Colleges and the service;
- to place strong emphasis on the quality assurance of training;
- to ensure a consistent and valid approach to assessment;
- to provide robust and reliable information systems to support the management of training;
- to introduce a sound process for the selection of trainees;
- to have robust and effective processes in place to provide career counselling and advice;
- to manage training–service tensions. Specifically to ensure:
  - a strong ‘apprentice-based’ focus, especially in the craft specialties;
  - the ‘knock-on’ effects of change on other career and training grades and the local delivery of services are anticipated and understood;
  - flexibility in training arrangements;
  - that any increased consultant workload can be supported.
- to ensure that medical research is not disadvantaged by the changes;
- to prepare adequately for managing change, ensuring that doctors in training are able to influence and participate in implementing reforms.

## Five principles for reform for SHOs

3.4 Key principles underpin the organisation and delivery of the proposed reforms.

### Five Key Principles for reform of training for SHOs

- training should be programme-based;
- training should begin with broadly-based programmes pursued by all trainees;
- programmes should be time-limited;
- training should allow for individually tailored or personal programmes;
- arrangements should facilitate movement into and out of training and between training programmes.

3.5 These principles should be underpinned by commitments to provide flexible training (less than full-time training) and early and regular career advice. Young doctors should get advice about career planning, recognising both the needs and competence of the individual and the likely demands of the service.

### Proposals:

1. **The five key principles should be the basis for reform of basic specialist or general practice training.**
2. **There should be sufficient opportunities for flexible (part-time) training.**
3. **There should be access to early and regular career advice.**

## A programme-based approach to training

3.6 A programme-based approach to training would substantially address the problems of the SHO grade. The approach would ensure that as many doctors as practicable, wishing to enter specialist or general practice training, are able to do so.

### Features of a programme-based approach to training:

- is accountable and closely managed;
- is curriculum-based;
- requires formal entry requirements;
- provides planned and structured training including assessment and appraisal;
- is time-capped to prevent post or programme-blocking.

**3.7** Two types of programme would apply during this first phase of postgraduate training:

- *broadly-based programmes* pursued initially by all doctors seeking to enter higher specialist training or general practice;
- *more tightly-focused individual programmes* entered subsequently by a limited number of trainees. These will provide a high degree of supervision to support those needing further development to meet agreed, individual training goals.

**3.8** Trainees would follow a co-ordinated series of placements within a managed programme delivering defined training goals. The approach would:

- support flexibility (enabling switching between specialties, including general practice);
- enable common inter-programme training activity to be recognised and credited;
- improve opportunities to re-enter training from, for example, doctors:
  - on career breaks;
  - undertaking research;
  - wishing to move from and to general practice;
  - who are not in designated training posts;
- necessitate formal systems of appraisal and assessment (moving to competence-based assessment as practicable) which would also support General Medical Council revalidation;

- introduce a training number system which would support workforce planning as well as educational and financial management;
- provide for non-UK graduate entrants.

**3.9** Following graduation and during the first four or five postgraduate years (encompassing what are the current pre-registration house officer and SHO grades), all doctors require:

- training in generic skills and competencies;
- the basic skills of a chosen specialty or specialty group.

Both are essential and should be delivered through training programmes providing a breadth of clinical experience. This balance, however, may differ between different specialties or specialty groups.

**3.10** This phase of training would have two main building blocks or programmes:

- a *foundation programme*; and
- a *basic specialist training programme* (including training for general practice).

## Foundation programmes

**3.11** All doctors would undertake an integrated, planned two-year *foundation programme* of general training:

- *the first year* would equate to the current pre-registration year leading to Full Registration;
- *the second year* would be post-registration and build on the first year by providing further generic training.

**3.12** *Foundation programmes* would have two key purposes:

- to develop core or generic skills essential for all doctors. Training would extend and consolidate the knowledge, skills, values and attitudes acquired in medical school and set out in the General Medical Council's *Good Medical Practice*<sup>9</sup>. They would also provide skills in those essential requisites of modern medical practice: for example, the ability to form effective partnerships with patients, the ability to work towards high standards in clinical governance and patient safety, skills in the use of evidence and data, competence in communication, team-working and multi-professional practice, as well as capability in time management and decision-making;

<sup>9</sup> Good Medical Practice, General Medical Council, 2001.

- to provide direct experience of different specialties (especially those disciplines that do not form a significant part of the medical school curriculum) and to gain experience in dealing with seriously ill patients.

The first year would form part of basic medical education, shaped by existing requirements for pre-registration house officers. The second would count towards meeting the requirements for specialty or general practice training and would be the responsibility of the relevant competent authority.<sup>10</sup> A shared arrangement between the General Medical Council and the proposed Postgraduate Medical Education and Training Board would be required to supervise *foundation programmes*.

- 3.13** An objective of the *foundation programme* would be to give new graduates broader experience of medicine and of the career options available to them. Such experience would strengthen insights into the essential links between different specialties and between primary and secondary care, and in the roles of other health professionals and how to work within them in teams. It is not proposed that *foundation programmes* be any more ‘classroom-based’ than existing arrangements for pre-registration house officers and first year SHOs. As now, the major portion of time would be spent in service settings – although those settings are envisaged as having more variety than at present. During the second year of a *foundation programme* the trainees would be much better equipped to provide flexible service cover than current first-year SHOs.

### Basic specialist training programmes

- 3.14** By the second year of the foundation programme the doctor would have had an opportunity to sample a range of practice. It is during this second year that all trainees would compete to enter one of a number of broadly-based basic *specialist training programmes*. These would allow them:

- to gain experience and develop their clinical skills in a broad specialty grouping;
- to prepare for competitive entry to higher specialist training in their chosen specialty; or
- to enter general practice and undertake further post-certification education.

<sup>10</sup> Currently the Specialist Training Authority of the medical Royal Colleges (STA) and the Joint Committee on Postgraduate Training for General Practice (JCPTGP); although it is proposed that a Postgraduate Medical Education and Training Board (PMETB) replaces the STA and the JCPTGP.

- 3.15** There should be enough places in these programmes for all SHOs who have completed foundation programmes and also to accommodate some EEA and overseas-qualified doctors coming to the UK for further training. However, trainees entering *basic specialist training programmes* will not necessarily be successful in obtaining a place in the programme of their first choice. It will be important to incorporate support structures into the new system.
- 3.16** These programmes would provide a breadth of education and training but would focus increasingly on basic specialist or discipline-based skills. As far as practicable, career flexibility would be encouraged with the option of switching career paths. There should be provision for relevant training to be ‘credited’ to any new programme which the doctor might seek to follow.
- 3.17** The composition and number of these *basic specialist training programmes* should be decided during the implementation phase of the reform programme and take into account:
- links to programmes of higher specialist training;
  - general practice training requirements;
  - workforce requirements;
  - the needs of patients and the service.

However, the model tested by the Working Group, which was generally accepted by those submitting evidence, envisaged eight programmes as follows:

- Medicine in General;
- Surgery in General;
- Child Health;
- General Practice;
- Obstetrics & Gynaecology;
- Mental Health;
- Anaesthetics;
- Pathology in General.

**3.18** These programmes will differ. Their exact composition and duration will require further discussion but they should provide for the needs of general practice and most specialties. However, the requirements of other specialties such as public health, radiology, and occupational medicine would require specific consideration.

**Proposals:**

- 4. After graduating doctors should undertake an integrated, planned two-year *foundation programme* of general training:**
  - the first year equating to the current pre-registration house officer year;
  - the second (post registration) year incorporating a generic first year of current SHO training.
- 5. After completing their *foundation programme*, doctors should enter a *basic specialist training programme* providing a breadth of education and training within certain broad clinical disciplines.**

**3.19** An important feature of this process is that programmes should be time-capped. It will not be acceptable for individual trainees to spend significant periods as SHOs beyond that necessary to complete this stage of training. Trainees will be expected to make reasonable progress through to completion of training and then to move on. This will generally be into higher specialist or general practitioner training but may, for example, be into an *individual programme* (see below) or temporarily into a service post outside the training structure.

### Individual training programmes

**3.20** A limited number of placements on more tightly-focused *individual programmes* designed to meet the specific training needs of individual doctors will be required.

**3.21** *Individual programmes* would:

- be managed closely with clear criteria for assessing eligibility for entry and regular assessment of trainees' progress within the programmes;
- provide a strictly limited number of placements;
- not provide a temporary 'sanctuary' for those requiring more time to study for Royal College examinations.

**3.22** An *individual programme* would be suitable for:

- *re-direction of training*: For most doctors seeking to change career path, the expected route will be to apply in competition for a new basic specialist training programme. Wherever practicable they should enjoy recognition of equivalent or accepted training already undertaken. ‘Transferable credits’ in areas of education and training common to the new and old programmes should ease transfer. However, for some doctors the additional training needed to meet the requirements for a switch of career path could be met instead through an *individual programme*;
- *return to training*: Many doctors seeking to re-enter training from non-consultant career grades, research or wishing to move to or from general practice could find the support of an *individual programme* useful. It should help them prepare for competitive entry to advanced or higher levels of specialist training or for general practice training;
- *doctors entering training from elsewhere in the EEA and from overseas*: Individual programmes might provide one route for preparing some of these doctors for competitive entry to training *or* short periods of specific training to meet individual needs before returning home;
- *remedial training*: For those who have not made the necessary progress through *basic specialist training programmes*.

**Proposal:**

- 6. A limited number of placements on *individual training programmes* should be provided for those doctors requiring: remedial help; support in changing career direction; or who wish to re-enter training to prepare for competitive entry to higher specialist or general practice training.**

### Time-capping programmes

**3.23** All programmes will be time-capped but this must be flexible enough to reflect, for example, the requirements of those doctors whose training is part-time or whose training is interrupted. Time taken to complete a programme will be governed by the needs of the particular programme but must also take the needs of the individual trainee into account.

### 3.24 Time-capping:

- is an inherent part of sound programme management;
- helps trainees to move through programmes designed to meet their requirements;
- enables trainees to make decisions about future career directions;
- reduces uncertainty for trainees.

3.25 Trainees cannot remain in a training programme for extended periods of time but they should have reasonable opportunities to complete the programme. For sound educational reasons some may take longer to complete a programme than the time agreed for the programme. In such special circumstances:

- the time-capped period for the programme may be extended to meet their particular needs, subject to an upper limit beyond which further extensions cannot be made; or
- the doctor, after counselling, may seek:
  - a place on an individual programme;
  - to re-train in another programme.

3.26 These arrangements are separate from circumstances where:

- the programme is extended to accommodate an agreed career break or leave of absence due to illness;
- a time-capped '*period of grace*' is granted to a doctor at the end of a programme to enable her or him to make arrangements to move to the next stage of professional development. For example, those doctors who have completed basic specialist or individual programmes, but who have not been successful in securing a place on a higher specialist or general practice training programme, should benefit from a time capped '*period of grace*'. Although *in-grade but out-of-programme*, the postgraduate medical dean remains responsible for their development. This '*period of grace*' would allow the doctor:
  - to prepare for the next phase of training;
  - to gain further managed, assessed and supervised service experience;
  - to consolidate skills;
  - to complete medical Royal College examination requirements.

**3.27** Time spent in placements or posts during the '*period of grace*' would be limited, but could vary depending on the needs of both doctor and service. To some degree this reflects the present situation where doctors can consolidate experience by spending a further period in the SHO grade. As a consequence there are service benefits which may help to meet the increasing demands of the European Working Time Directive.

## Leaving training

**3.28** Time-capping basic specialist and individual training programmes will mean that there will be a group of doctors who will not have been able to progress to higher specialist training or to general practice. For example, at the end of a '*period of grace*' doctors would have to move on and, if they were not moving into higher specialist training or general practice training, leave the training grades. This could mean taking a post in a non-consultant career grade. This subject is discussed again later in the report.

### **Proposal:**

- 7. Following completion of a basic specialist or individual training programme, those trainees unable to progress directly to higher specialist or general practice training should be allowed a *period of grace* before leaving training.**

## Assessment and examination

**3.29** The proposals support a greater emphasis on competency-based assessment throughout training and as evidence of successful completion of training. This will take time to achieve. Thus, progress through training will continue to be informed by success in medical Royal College examinations and increasingly, by the Record of In Training Assessment (RITA) process as it is introduced for SHOs.

**3.30** There is striking variation in examination practice across medical Royal Colleges and Faculties and in the arrangements for setting and quality assuring the standards of examination practice. In their present form, Royal College examinations are not clear indicators of satisfactory progress through specialist medical training.

**3.31** It is proposed that a new Postgraduate Medical Education and Training Board will be required to ensure that, throughout training, all assessments and examinations (with the consequent classification of trainees) are appropriate, valid and reliable.<sup>11</sup>

<sup>11</sup> Postgraduate Medical Education and Training: The Postgraduate Medical Education and Training Board, Statement on Policy, The Department of Health, 2002

**3.32** Royal College examinations will remain an important component in the assessment of trainees complementing in-course assessments and appraisal. However, no comprehensive and fundamental review has been undertaken of Royal College examinations in the round. Nor are they subject to any external quality assurance, which is unusual compared to other fields of education and training. Examinations should be “fit for purpose”, supporting evidence that a doctor has reached a required standard for clinical practice. There needs to be greater co-ordination of the timing of examinations with trainees’ progress through programmes. The amount of ‘marking time’ by trainees waiting to achieve the entry requirements of the next phase of training could be reduced by ensuring that the examinations take place before trainees are due to complete their programme and that the standards of the examination are linked to the programme objectives. A review of the medical Royal College examinations by them would be very valuable and it is understood that the Academy of Medical Royal Colleges has already started work on this.

**Proposals:**

- 8. Progress through programmes should be determined by assessment.**
- 9. In the longer-term assessment should move towards a competence-based system.**
- 10. The purpose of the Royal College examinations should be reviewed and a system of external accreditation introduced.**

## **Managing training**

**3.33** Postgraduate medical deans are responsible for managing the delivery of postgraduate training to standards set by the competent authorities. The medical Royal Colleges and their faculties work through the competent authorities and have a key role in supporting postgraduate training.

**3.34** In recent years there has been significant change driven by reform of higher specialist and pre-registration training and better management of training for general practice. In England postgraduate deans now work closely with Workforce Development Confederations, universities, medical Royal Colleges, NHS employers, supervising consultants and general practitioners to ensure effective delivery of postgraduate training. There are equivalent arrangements in the other UK countries.

**3.35** The SHO grade, with multiple stand-alone NHS trust appointments, has proved difficult to manage. A programme-based approach to training will enable postgraduate deans to extend the same level of supervision and management as presently apply elsewhere in the training continuum. Under the proposals the postgraduate dean would be responsible for:

- ensuring that the doctor in training receives, in advance, information relating to her or his intended training programme;
- the appointment of trainees to programmes;
- managing the delivery of the new programme-based training arrangements. These should become the responsibility of programme directors rather than individual NHS trusts. Programme directors should be part of the postgraduate deanery, accountable to and appointed by the postgraduate medical dean after consultation with the relevant Royal College or Faculty;
- ensuring that trainers are adequately supported and trained. The introduction of programme-based training will mean greater emphasis on both the quality of the training placements within programmes and therefore on the skills of trainers.

**Proposals:**

- 11. Programmes should be managed by programme directors appointed by, and accountable to, postgraduate medical deans.**
- 12. Trainers should be supported and trained.**
- 13. Key information on programmes: the arrangements for appointment and induction; the curriculum to be followed and the procedures for assessment must be made available to all trainees.**

## Recruitment and appointment to training programmes

**3.36** Postgraduate deans should be responsible for the recruitment arrangements to all programmes: foundation; basic and higher specialist and individual programmes, as they are now for specialist registrar posts. They and employers will need to ensure that NHS equal opportunities and sound employment practice prevail. In particular:

- a national system of matching may suit appointment to foundation programmes;

- doctors will compete for entry to basic specialist programmes during the second year of their foundation programme and, as not all will be admitted to their first-choice programme, there will need to be provision to enable alternative applications. Equally, there will need to be provision for those seeking to switch programme and who seek credit for training undertaken.
- the arrangements for appointment to the limited placements on individual programmes will need particular consideration. It will be necessary to reconcile different interests: those seeking further time in basic specialist training, those returning to training and the possible placement of some non-UK graduates entering the country for the first time.

#### **Proposal:**

**14. The appointment arrangements to all programmes should be the responsibility of the postgraduate medical dean. They should meet published nationally agreed standards and practice.**

## **Funding training**

**3.37** At present in England, 50% of the basic salary of SHOs is funded from an education levy. The remainder of the salary including additional costs falls to the employing NHS trust. Currently 100% of the basic salary of pre-registration house officers and specialist registrars is funded from the levy. In Scotland funding now provides 100% of basic salary costs of all trainees. This raises the question of whether 100% of SHO salaries should be met by this method in England. There are arguments in favour. For example, it may be easier to fund less attractive posts, it may help fund cross-Trust placements and the development of programmes and it should aid integrated planning. There are counter-arguments. The balance of arguments will have to be weighed carefully following consultation.

## **Specific training requirements**

### **General Practice**

**3.38** General practice should be regarded as a specialty equivalent to other specialties for the purposes set out in this report.

**3.39** All doctors, whatever their career choice, should follow a similar model of training beginning with a two-year generic foundation programme, followed by competitive entry to one of eight or so time-capped basic specialist training programmes. Where practicable, all doctors on foundation or basic specialist training programmes should benefit from some training in general practice.

**3.40** One of the basic specialist training programmes will provide specific training leading to certification in general practice. The principles applying to foundation or basic specialist programmes must apply equally to general practice programmes. For example, it must be possible for doctors at this stage of training to switch between hospital specialist and general practice programmes in the same way as they may switch between different specialist programmes.

**3.41** The minimum period of vocational training is determined by statute and is currently three years. This requirement might be met by:

- the second year of the two-year foundation programme in which some time could be spent in general practice; and
- a two-year general practice programme. Trainees would follow, as now, a mixture of hospital and general practice-based training with a period of not less than 12 months training in general practice. Doctors would compete to enter this programme. The programme must ensure that the hospital components of the training programme take into account the needs of trainee general practitioners.

**Proposal:**

**15 The SHO element of general practice training programmes should follow a similar model to those for hospital disciplines.**

## Dentistry

**3.42** High standards of practice in dentistry are based upon sound training and clearly defined educational programmes which broadly parallel those in medicine. There are many core skills which are held in common with medicine with considerable overlap of the educational and training processes. However, there are areas of difference. Specific recommendations for the future of the house officer and the senior house officer grades in dentistry are at Annex F.

## Doctors qualifying outside the United Kingdom

**3.43** Doctors who qualified outside the UK currently make up over a third of the SHOs in England. They are an important group who should have fair and equal access to high quality training programmes. They are not a homogeneous group. Some may already have extensive clinical experience in the UK while others will have recently come to this country.

**3.44** The requirements for each doctor would best be met by:

- appreciating their career aspirations;
- recognising and assessing training already received outside the UK;
- providing career advice where sought;
- identifying clear and achievable training goals;
- advising points of entry into training;
- ensuring equality of opportunity in recruitment practice;
- delivering effective induction arrangements.

**3.45** As a consequence of the reforms proposed here, the role of direct placement schemes (*otherwise known as sponsorship*) will require review. These provide for non-competitive placement of non-UK graduates into posts or programmes, which do not lead directly to certification. A particular issue is whether these doctors should be eligible for ‘direct placement’ into individual programmes.

**Proposal:**

**16 The provisions for basic specialist training should ensure that the needs of non-UK qualified doctors are properly and fairly taken into account and that they have equal access to high quality training programmes.**

## A single training grade

**3.46** Neither the EU Directive on mutual recognition of specialist medical qualifications nor the relevant UK legislation (the European Specialist Medical Qualifications Order 1995) make a distinction between basic and higher specialist training. Instead the period of specialist training begins in practice when the doctor achieves Full Registration with the General Medical Council. Despite this, the current arrangements are often, incorrectly, taken to mean that the Certificate of Completion of Specialist Training programme begins upon appointment to the specialist registrar grade.

**3.47** The report of the Working Group on Specialist Medical Training (the ‘Calman Report’)<sup>12</sup> recommended a combined career registrar and senior registrar grade and that consideration be given to further integration of the training grades.

<sup>12</sup> Hospital Doctors: Training for the Future, The Report of the Working Group on Specialist Medical Training, The Department of Health, 1993.

**3.48** The introduction of a programme-based approach to basic specialist and general practice training will unify mechanisms for delivery, assessment and appraisal across the training continuum. A doctor's progress through the continuum may then best be defined by advancement through a programme or series of programmes, rather than through a grade or series of grades. Within a single grade, all programmes would have entry criteria, normally met through open competition, and exit criteria, determined by successful completion of the programme. Workforce planning mechanisms would continue to determine the estimated numbers for each programme. Such an approach would strengthen the role of:

- the competent authorities and the medical Royal Colleges in determining the appropriate structure for training programmes leading to certification; and
- the role of the postgraduate deans in managing training.

**3.49** The proposal is *not* that the NHS generally moves immediately to a 'run-through' training grade in which all entrants to basic specialist training, subject to satisfactory progress, automatically obtain places at higher specialist level. There may always be a need for some competition in some specialties depending on the needs of the service. However, the concept of a 'run-through' grade should be actively explored for each specialty. Provided there are appropriately defined entry and exit points for each programme and means of assessing progress through the programme, it could become unnecessary to expect a doctor to change grade during a programme or to link a particular programme to a grade. In some specialties (e.g. some of the surgical disciplines) it may be desirable to create a more direct path to specialist qualification and these should be examined.

**3.50** A 'programme-' rather than a 'grade-' based approach to training would:

- allow greater flexibility in planning training providing, for example, opportunities for doctors to change career direction and for shorter programmes leading to a more 'general' Certificate of Completion of Specialist Training;
- more readily enable progress to be linked to demonstration of competence;
- allow for programmes of differing duration and structure determined by specialty need;
- re-affirm the importance of basic specialist training within the overall requirements for the award of a Certificate of Completion of Specialist Training;
- be consistent with moves to introduce shorter Certificate of Completion of Specialist Training programmes in some specialties;

- promote greater flexibility for doctors outside formal training programmes to re-enter training.

**Proposal:**

**17. It is proposed that urgent work is undertaken to explore, specialty by specialty, the appropriateness of creating a ‘run-through’ training grade in which doctors would move seamlessly through training with satisfactory progress checks. This could not be implemented immediately. Given the needs of the service and the availability of training places, the need for application and competition prior to progression should be explored.**

## Links to higher specialist training

**3.51** Reformed SHO training will improve the quality of early postgraduate training and provide a better platform for doctors wishing to progress to higher specialist training:

- foundation programmes will provide a coherent and thorough grounding in general professional training with opportunities to gain experience in a range of different disciplines;
- structured programmes of basic specialist training within broad specialty groupings will allow the development of skills and provide the appropriate experience for doctors to progress smoothly to higher specialist training in their chosen specialty.

**3.52** The SHO period forms the initial phase of a doctor’s specialist medical training, the end point of which is the Certificate of Completion of Specialist Training. Reform of the SHO grade consequently provides an ideal opportunity to consider the aims behind, and delivery of, UK specialist medical training as a whole. Both the trainees’ educational goals and the needs of the service need to be considered.

**3.53** While the changes to higher specialist training introduced by the Calman reforms appear to have served both trainees and the NHS well, there are a number of emerging issues which need to be addressed. In particular:

- the Government is committed to a service which is increasingly delivered by trained doctors rather than trainees;
- the current pattern of training produces highly-skilled specialists at a time when there is a growing demand from the NHS for more ‘generalist’ consultants to provide safe and effective care to patients;

- the period of training before reaching Certificate of Completion of Specialty Training level is comparatively long by European standards;
- training is still heavily based on time in grade rather than on mastering the competencies required to progress;
- training programmes are based on the assumption that all trainees will wish, and be able, to progress to consultant status;
- it will be increasingly important to ensure that training arrangements (and career posts) provide for those who wish to train and work on a part-time basis;
- the development of new roles for nurses and other members of the healthcare team will affect the way in which doctors will work in future.

**3.54** There could be considerable advantages in introducing a new range of training programmes which would enable doctors in higher specialist training to be awarded a Certificate of Completion of Specialist Training earlier than at present (e.g. after three or four years). This would be followed by a period of more highly specialised training for those who wished to undertake it, and for which there was a service need.

**3.55** Such a model would work best if at the point of completion of the shorter first phase period of higher specialist training, the doctor was eligible for a consultant level post in their chosen specialty. So they would become a consultant in for example: general internal medicine or general paediatrics. This would make a distinction between two categories of specialist: the ‘generalist’ consultant and what some have dubbed the ‘ologists’.

**3.56** Such a restructuring of specialist training and certification would have considerable advantages, for example:

- shortening the path to a consultant post for some doctors;
- meeting the needs of the many patients who do not require the skills of a highly specialised doctor;
- opening up more opportunities for doctors in non-consultant career grades to re-enter training and become a consultant.

**3.57** These ideas were not part of the original objectives of this Report, but inevitably arose as the ‘knock-on’ effects of a modernised SHO grade were thought through.

**Proposal:**

**18. The arrangements for awarding a Certificate of Completion of Specialist Training (CCST) should be changed. New and shorter higher specialist training programmes should lead to the award of an earlier CCST for those satisfactorily completing training in the ‘generalist’ elements of a specialty. At that point a doctor should be able to apply for a consultant post in their chosen specialty – say general internal medicine or general paediatrics.**

### Implications for the consultant and non-consultant career grades

- 3.58** These proposals relating to SHOs will have other important implications. In particular, for the consultant and non-consultant career grades.
- 3.59** There may be an impact on the number of doctors in the non-consultant career grades as:
- more doctors may leave training on completion of basic specialist training and move into non-consultant career grade posts before entering higher specialist training;
  - implementation of the European Working Time Directive and changed patterns of training may reduce the service output of SHOs and increase the demand for non-consultant career grade doctors.
- 3.60** The non-consultant career grade has for a long time been a source of concern. Many doctors in non-consultant career grade posts undertake valuable roles for the NHS. However, they are not always valued. There are few opportunities to leave the grade and return to full time training. As a result the concept of the non-consultant career grade has come unfairly to carry a degree of stigma.
- 3.61** Although the NHS will continue to need non-consultant career grade doctors, there should not be a profligate expansion of this grade on grounds of expediency or perceived cost savings. An important goal of the NHS is still that more patients should be seen by a consultant.
- 3.62** The position of the non-consultant career grade post could and should be transformed. It should be a post in which a doctor gains valuable service experience but from which many will be able to move (or move back) into specialist training should they so wish.

- 3.63** A doctor who chose for whatever reason to remain in a non-consultant career grade should be able to do so with pride, knowing that their experience and expertise in an area of medicine (whether it be for example, emergency medicine, ultrasonography or breast cancer care) was something which the NHS valued and cherished.
- 3.64** Thus a necessary consequence of these proposed SHO reforms will be to undertake a comprehensive review of the non-consultant career grade and to complete this as quickly as possible.

**Proposal:**

**19. A review of the role, educational support, professional development and career opportunities and pathways for non-consultant career grade doctors should begin in the autumn.**

## Implications for service provision

- 3.65** With an apprenticeship model of training, service and training are inevitably linked. It is important to consider the possible implications of training reform on service provision. The principal effects of reform to address would be:
- a greater focus on training might suggest the service output of individual SHOs will diminish; and
  - improved workforce planning and time-limiting of programmes will impact on the number of SHOs and doctors in the non-consultant career grades.
- 3.66** However, overall levels of service should be maintained as:
- training reforms will deliver fully-trained – and better trained – doctors more quickly. This will be especially so if the reform of basic training is coupled with shorter, more generalist Certificates of Completion of Specialist Training. Reform, therefore, answers an important service need;
- time-limiting basic specialist training programmes means doctors will not provide service *within* the SHO grade for long periods as they do now. The number of SHOs coming through the system will be more carefully identified through improved workforce planning. On completion of SHO training they will be encouraged to progress to higher specialist training or move to a non-consultant career grade post. Levels of service can be maintained through careful control of the relative numbers of trainees and doctors in the non-consultant career grades. Where less service is delivered by SHOs more will be provided by those who have completed training and by those who are following a non-consultant grade pathway.

**3.67** SHO reform would take place against a background of rapid and significant expansion in the medical workforce. The planning model is not, therefore, a static one but one which will see important changes in the flows through training and in the relationships between doctors in training and service grades. Delivering doctors into the right specialties in the right numbers is a fundamental aim and better linkage between SHO training and specialist registrar training will enable the planning of a better-balanced workforce. There will be more grounding in primary care as a result and an accent on working across professional boundaries and in teams.

### Impact of the European Working Time Directive

**3.68** New training programmes would be introduced at a time when implementation of the European Working Time Directive for doctors in training will lead to major changes in working arrangements for these doctors and for other members of the healthcare team. Implementing the European Working Time Directive is an important challenge. However, it provides an opportunity to look critically at how service is delivered and the workforce is organised. It needs to be addressed by the service and by the health professions in a creative way. For example, making more effective use of available resources, by innovative service delivery, new ways of working and better skill-mixes.

**3.69** Training reform has an important part to play. It is a necessary element in the response to the European Working Time Directive since the best use of the time available for educational benefit will have to be made. The way forward is to acknowledge that trainees will be available for shorter periods and will be engaged in new working patterns and then to build new approaches to training. Such approaches should increase its quality, the opportunities to learn and the ways in which skills and training are acquired in the most meaningful way from the experience available. A programme-based system proposed here offers a way to structure training and to monitor progress against clear goals achieved with a greater ability to make the most of the experiential component of training.

**3.70** Simply maintaining the *status quo* is not an option in meeting European Working Time Directive implementation nor, indeed, in a rapidly changing and expanding NHS constantly faced with new challenges. It is not productive to see the solution to implementing the Directive simply as a matter of producing trainees and non-consultant career grade doctors in ever-greater numbers. This will add to, rather than solve, the problem.

**3.71** The European Working Time Directive and training reform are mutually interdependent. The European Working Time Directive requires reform in training and this in turn can support implementation of the Directive. Together they can support the wider changes required in the NHS, increasing flexibility while maintaining a clear focus on providing safe, high quality services.

## Implementation and timing

**3.72** Implementation of these proposals for reform would represent a significant task for the service, postgraduate deaneries, the Royal Colleges and the proposed Postgraduate Medical Education and Training Board. For example:

- the postgraduate deaneries, in concert with NHS Trusts and Workforce Development Confederations would need to identify and formalise training rotations at both foundation programme and basic specialist training programme level;
- new appointment processes would be required giving access to programmes;
- educational and training supervisors would need to be secured;
- basic specialist training programmes would have to be designed and put in place;
- the Royal Colleges with the proposed Postgraduate Medical Education and Training Board would need to develop new curricula for both foundation and basic specialist training programmes and to agree with the Departments of Health on the length and number of SHO programmes;
- implementation might straddle the period when the European Working Time Directive is coming into force for doctors in training.

**3.73** For these reasons, implementation would need to be planned and timed very carefully. There are a number of options available. These range from, for instance:

- a staged, gradual introduction of the reforms for new trainees coming through the system over a period of years;
- through to
- a single, one off process through which all trainees at SHO and pre-registration house officer level were subject to a short transition period into the new structure.

**3.74** The options will be subject to careful analysis but, clearly, views on the main issues which implementation will expose is a necessary component during the consultation process on this report.

# 4

## A Call for Views on the Proposals to Reform the SHO Grade

**4.1** We would welcome comments and ideas on any aspects of the issues covered in this document but would particularly welcome comments on the proposals made. These are summarised here:

Proposals	Paragraph Numbers
1 The five key principles should be the basis for reform of basic specialist or general practice training.	3.4
2 There should be opportunities for flexible (part-time) training.	3.5
3 There should be access to early and regular career advice.	3.5
4 After graduating doctors should undertake an integrated, planned two-year foundation programme of general training:  – the first year equating to the current pre-registration house officer year;  – the second (post registration) year incorporating a generic first year of current SHO training.	3.11 – 3.13

Proposals	Paragraph Numbers
5 After completing their foundation programme, trainee doctors should enter a basic specialist training programme providing a breadth of education and training within certain broad clinical disciplines.	3.14 – 3.18
6 A limited number of placements on individual training programmes should be provided for those doctors requiring: remedial help; support in changing career direction; or who wish to re-enter training to prepare for competitive entry to higher specialist or general practice training.	3.20 – 3.22
7 Following completion of a basic specialist or individual training programme, those trainees unable to progress directly to higher specialist or general practice training should be allowed a period of grace before leaving training.	3.23 – 3.28
8 Progress through programmes should be determined by assessment.	3.29 – 3.32
9 In the longer-term assessment should move towards a competence-based system.	3.29 – 3.32
10 The purpose of the Royal College examinations should be reviewed and a system of external accreditation introduced.	3.29 – 3.32
11 Programmes should be managed by programme directors appointed by, and accountable to, postgraduate medical deans.	3.33 – 3.35
12 Trainers should be supported and trained.	3.33 – 3.35
13 Key information on programmes: the arrangements for appointment and induction; the curriculum to be followed and the procedures for assessment must be made available to all trainees.	3.33 – 3.35
14 The appointment arrangements to all programmes should be the responsibility of the postgraduate medical dean. They need to be transparent and should meet nationally agreed standards and practice.	3.36

Proposals	Paragraph Numbers
15 The SHO element of general practice training programmes should follow a similar model to those for hospital disciplines.	3.38 – 3.41
16 The provisions for basic specialist training should ensure that the needs of non-UK qualified doctors are properly and fairly taken into account.	3.43 – 3.45
17 It is proposed that urgent work is undertaken to explore, specialty by specialty, the appropriateness of creating a ‘run-through’ training grade in which doctors would move seamlessly through training with satisfactory progress checks. This could not be implemented immediately. Given the needs of the service and the availability of training places, the need for application and competition prior to progression should be explored.	3.46 – 3.50
18 The arrangements for awarding a Certificate of Completion of Specialist Training (CCST) should be changed. New and shorter higher specialist training programmes should lead to the award of an earlier CCST for those satisfactorily completing training in the ‘generalist’ elements of a specialty. At that point a doctor should be able to apply for a consultant post in their chosen specialty – say general internal medicine or general paediatrics.	3.51 – 3.57
19 A review of the role, educational support, professional development and career opportunities and pathways for non-consultant career grade doctors should begin in the autumn.	3.58 – 3.64

### Other Issues

- Dentistry – see Annex F.
- What level of the basic salary of SHOs should come from a multi-professional education & training levy or equivalent arrangement – should it remain at 50%?
- What factors need to be considered, and over what timescale, should the reforms be implemented?

## How to respond

- 4.2** The three-month consultation period will close on 22 November 2002.

Your comments should be sent by post to:

Andrew Matthewman  
Department of Health  
Room 2E56  
Quarry House  
Quarry Hill  
Leeds LS2 7UE

or by Email to: [andrew.matthewman@doh.gsi.gov.uk](mailto:andrew.matthewman@doh.gsi.gov.uk)

Separate consultation arrangements will be publicised for Scotland, Wales and Northern Ireland.

- 4.3** Your comments may be made public. If you would prefer them to remain private, please make this clear when replying.

# Annex A

## SHO Modernisation Working Group – Membership

### **Chair**

Sir Liam Donaldson

Chief Medical Officer

### **Membership**

Professor Sir George Alberti

President, Royal College of Physicians

Dr Karen Bradley

Specialist Registrar, John Radcliffe Hospital

Mrs Pat Cantrill

Director of Workforce Development,  
Trent Regional Office

Professor Sir Graeme Catto

Chair, General Medical Council  
Education Committee

Professor John Cox

President, Royal College of Psychiatrists

Mr Carl Eley

National Assembly for Wales

*replaced Mrs Kim Tester*

Dr David Ewing

Scottish Executive

Dr Monica Gupta

Senior House Officer, Great Ormond Street Hospital

Ms Judy Hargadon

Director, Changing Workforce Programme

Professor Peter Hill

Chair, Conference of Postgraduate Medical Deans  
of the UK (COPMeD)

Mrs Avril Imison

Head of Policy for Therapy Services and  
Physiotherapy and Allied Professions,  
Health Services Directorate, Department of Health

Mr James Johnson

Chair, Joint Consultants Committee

Dr Susanna Lawrence

General practitioner and chair of Leeds HA

Ms Sue Page

Chief Executive, Northumbria Healthcare  
NHS Trust

Dr Trevor Pickersgill	Chair, Junior Doctors Committee
Professor Michael Pringle	Chairman of Council, Royal College of General Practitioners
Dame Margaret Seward	Chief Dental Officer
Dr Jenny Simpson	British Association of Medical Managers
Mr Malcolm Stamp	Chief Executive, Norwich and Norfolk NHS Trust
Professor Joan Stringer	Lay representative, Scottish Council for Postgraduate Medical and Dental Education and Principal, Queen Margaret University College, Edinburgh
Professor John Temple	President, Royal College of Surgeons of Edinburgh and Chair of Technical Sub Group
Dr Paddy Woods	Department of Health, Social Services and Public Safety, Northern Ireland

**Secretariat**

Dr Robin Cairncross	Education and Training Division, Department of Health
Mr Paul Loveland	
Mr Chris Bostock	
Mr Andrew Matthewman	

# Annex B

## SHO Modernisation Technical Sub-Group – Membership

### **Chair**

Professor John Temple

President, Royal College of Surgeons of Edinburgh

### **Membership**

Mr James Barbour

Chief Executive, Sheffield Health Authority

Mr Chris Bostock

Medical Education Unit, Department of Health

Dr Hugh Bradby

Medical Director, Sandwell Hospital NHS Trust

Dr Graham Buckley

Chief Executive, Scottish Council for Postgraduate  
Medical and Dental Education (SCPMDE)

Dr Shelley Heard

Postgraduate Dean, North Thames

Professor Tim van Zwanenberg

Chair, Committee of General Practice  
Education Directors (COGPED)

Mr Paul Williams

Chief Executive, Bro Morgannwg  
NHS Trust, Bridgend

# Annex C

## SHO Modernisation Technical Group – Contributors

### **List of organisations that submitted written evidence**

Royal College of Obstetricians and Gynaecologists  
Royal College of Paediatrics and Child Health  
Royal College of Physicians of London  
Royal College of Psychiatrists  
Royal College of Surgeons of England  
Royal College of General Practitioners  
Royal College of Physicians and Surgeons of Glasgow  
Royal College of Physicians of Edinburgh  
Royal College of Surgeons of Edinburgh  
Faculty of Dental Surgery  
Faculty of Accident & Emergency Medicine  
Faculty of Occupational Medicine  
The Intercollegiate Board for Training In Intensive Care Medicine

General Medical Council  
Specialist Training Authority  
Joint Committee on Postgraduate Training for General Practice

The Academy of Medical Sciences  
The Association for the Study of Medical Education  
Council of Heads of Medical Schools  
The Centre for Education in Medicine at the Open University

British Medical Association  
Junior Doctors Committee  
Central Consultants and Specialists Committee  
Locum Doctors Association

Conference of Postgraduate Medical Deans of the UK  
Flexible Training Sub-Group of COPMeD  
COPMeD Overseas Doctors Sub-Group  
Committee of General Practice Education Directors  
Conference of Postgraduate Dental Deans  
Changing Workforce Programme, Human Resources Directorate, DoH  
Workforce Planning, DoH  
Scottish Council for PGMDE  
National Association of Clinical Tutors  
NHS Confederation

## SHO Modernisation Workshops

### Attendees

Dr Acquilla	Faculty of Public Health Medicine
Dr Al-Jalili	Arab Medical Association
Dr Baker	Royal College of General Practitioners
Dr Beattie	Royal College of Physicians and Surgeons of Glasgow
Dr Biggs	The Association for the Study of Medical Education
Dr Cairncross	Medical Education Unit, DoH
Ms Cass	NHS Confederation
Dr Cassoni	Royal College of Radiologists
Dr Chapman	JCPTGP
Mr Cook	Royal College of Ophthalmologists
Dr Currie	Junior Doctors Committee
Dr Eaton	Flexible Training Sub-Group of COPMeD
Dr Field	COGPED
Mr Frenchi-Christopher	General Medical Council
Dr Goodman	CCSC
Dr Goodyear	Medical Womens Federation
Dr Graham	COPMeD Overseas Doctors Sub-Group
Professor Grant	Open University
Professor Hall	Royal College of Paediatrics and Child Health
Ms Hargadon	Changing Workforce Programme
Dr Harling	Specialist Training Authority
Mr Henderson	NHS Confederation

Dr Ingram	Royal College of Anaesthetists
Sir Barry Jackson	President, Royal College of Surgeons
Dr Jarvis	BMA
Dr Joshi	Royal College of General Practitioners
Professor Katona	Royal College of Psychiatrists
Professor Kopelman	Council of Heads of Medical Schools
Professor Lingham	Overseas Doctors Association
Mr Loveland	Medical Education Unit, DoH
Mr Lowry	Faculty of Dental Surgery
Dr Macdonald	COPMeD
Mr Macleod	Royal College of Surgeons of Edinburgh
Dr Moore	Workforce Development, DoH
Dr Neville	Royal College of Physicians of London
Dr Paice	COPMeD
Dr Pickersgill	Junior Doctors Committee
Professor Pringle	Royal College of General Practitioners
Professor Quirke	Royal College of Pathologists
Dr Seeley	COPMeD
Professor Shaw	Royal College of Obstetricians and Gynaecologists
Dr Short	The Intercollegiate Board for Training in Intensive Care Medicine
Dr Sim	Junior Doctors Committee
Mr Skinner	Faculty of A&E Medicine
Mr Smith	COPDEND
Miss Somjee	Locum Doctors Association
Surgeon Captain Sykes	Faculty of Occupational Medicine
Dr Thomson	National Association of Clinical Tutors
Dr Toby	JCPTGP
Dr Watson	Royal College of Physicians of Edinburgh
Dr Zuckerman	Faculty of Pharmaceutical Medicine

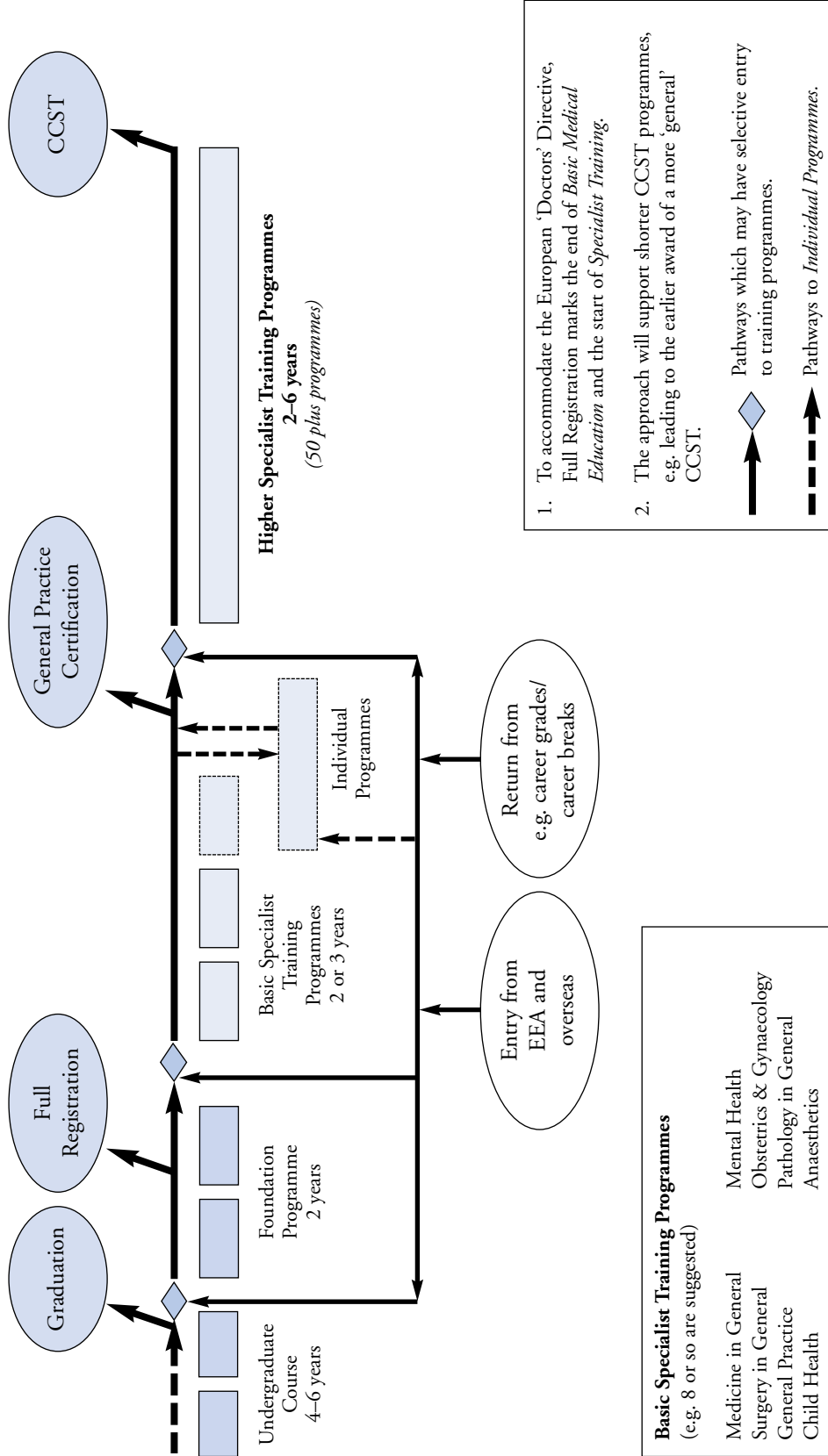
# Annex D

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# Annex E

## Postgraduate Training Programmes: principal pathways



# Annex F

## Dentistry

The concept of general professional training within dentistry has been enthusiastically received provided it remains voluntary, flexible and broadly based. It is crucially important that there are adequate numbers of house officer and SHO posts in dental hospitals and district general hospitals to provide general professional training with an appropriate element of basic specialist training.

Many graduates undertaking general professional training eventually follow a career in general dental practice. Workforce planning is therefore more complex as SHO numbers are not directly linked to consultant numbers.

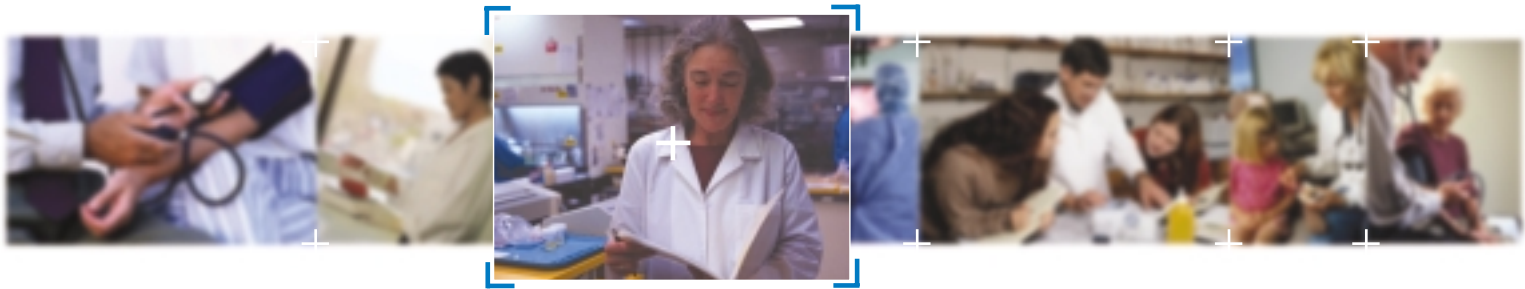
SHOs in dentistry provide a valuable infrastructure of dental expertise within hospitals thereby influencing the quality of patient care.

### Proposals

1. House officer/SHO posts in dentistry should continue as a component of general professional training.
2. Formal programmes of general professional training with training in both primary and secondary care should remain with graduates having the opportunity of selecting posts matched to their individual requirements.
3. Standards should be set by the Dental Faculties and the Committee for Vocational Training with local programmes co-ordinated by Postgraduate Dental Deans.

4. Where training has been approved by the Faculty of Dental Surgery and the Postgraduate Dental Dean, additional posts should be established to improve availability of GPT.
5. Further work should be undertaken by the Chief Dental Officer to demonstrate how house officer/SHO posts in dentistry may be matched to the main recommendations of this Report.





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