Classification: Official

NHS England

Medical Education Review – call for evidence

Publication reference: PRN01835

Contents

Introduction

1. The Medical Training Review is conducting an extensive programme of engagement and listening to ensure that doctors, educators, patients and NHS leaders have the opportunity to shape medical training in England for the future. This activity forms the 'diagnostic' phase 1 of the review, which will report in summer 2025. These outputs will inform reform options, to be developed in phase 2.

2. This call for evidence will run for 6 weeks, **from Tuesday 8 April to 23:59 on Monday 20 May**. Responses will form part of the review's evidence base, alongside the outputs of listening events and targeted focus groups with stakeholders, including patients and patient advocacy groups.

3. While the call for evidence is open to the public, the questions are tailored towards those with experience of undertaking and/or delivering postgraduate medical education or delivering clinical services. This exercise will therefore be supplemented by engagement, such as the focus groups, to widen opportunities for other groups, such as patients, to respond to the review and capture a breadth and plurality of perspectives.

4. The questions have been informed by listening events to date, the academic literature and a desktop review into the current challenges facing medical training and options for addressing these.

5. Questions 1 to 11 are grouped to explore 3 themes:

    i. whether medical training meets the needs and expectations of patients, healthcare services and postgraduate doctors

    ii. training delivery, capacity and quality

    iii. how postgraduate medical education could be reformed to deliver the 3 strategic shifts for the NHS

6. We provide a brief summary of the evidence and feedback the review has received so far for each subtheme within the 3 themes above. Respondents are asked to rate their agreement with a statement for each subtheme, explain their response and share any supporting evidence that will further understanding of the current issues within postgraduate medical education.

7. The final questions (Q12 to Q15) are aimed specifically at medical students, postgraduate doctors (residents, locally employed doctors and specialist and associate specialist doctors), consultants and GPs, and medical educators. They focus on the factors that contribute to a rewarding and satisfying postgraduate training experience, the current barriers to this experience, and the interventions that can be prioritised to address the issues.

8. All questions are optional. Supporting evidence can be submitted to england.medicaltrainingreview@nhs.net. To note, we are seeking evidence-based

submissions that demonstrate effective practice and we cannot accept promotional material, non evidence-based assertions of effectiveness, opinion pieces or editorial reviews.

9. The data collected will be used to inform the 'diagnostic' phase 1 of the Postgraduate Medical Training Review and the findings will be included in the phase 1 report, scheduled for publication in summer 2025.

About you

Q1) Are you responding on behalf of a committee, department or organisation?	**Yes**	No
Q1a) If you answered yes to Q1, which of the following categories best describes your committee, department or organisation?	• Body representing a non-medical clinical profession • Body representing doctors • Charity or body representing patients and/or the public • Government / arm's length body • Independent service provider • **Medical Royal College** • Medical school • NHS service provider • Regulatory body • Research funding body • Other (please state)	
Q1b) If you answered yes to Q1, what is the name of your organisation?	**The Royal College of Physicians of Edinburgh.**	
Q2) What is your profession / role? (please tick all that apply)	• Doctor – locally employed doctor • Doctor – on the Specialist Register or GP Register • Doctor – specialty / specialist grade • Doctor in postgraduate training (Core) • Doctor in postgraduate training (Foundation)	

	• Doctor in postgraduate training (Higher Specialty / Run through / GP Specialty Trainee) • Medical degree student • Senior training faculty (director of medical education, associate or deputy dean, postgraduate dean) • Trainer / educator (training programme director, college tutor, head of school, educational or clinical supervisor or clinical trainer) • Other clinical professional • Employer / service manager • Patient • Policy-maker • Other (please state) **Medical Royal College** • Prefer not to say
Q3) Which NHS region are you based in?	• East of England • London • Midlands • North East and Yorkshire • North West • South East • South West • Northern Ireland • Scotland • Wales • **National organisation**

Theme 1: Is postgraduate medical training meeting the needs and expectations of patients, healthcare services and doctors?

Subtheme 1.1 – Workforce distribution

Medical workforce distribution is identified as a key challenge, with literature exploring the extent to which doctors are ‘active agents’ in their working lives within existing structures, and where doctors prefer to work and train.

Distribution of medical training posts across England has been based on historical arrangements and these do not fully align with the current or future health needs of local populations. Competitive recruitment can have a cumulative effect on care quality in less popular training locations, as those resident doctors who require additional support are more likely to be allocated to placements offering less support.

Q1a) To what extent do you agree or disagree with the following statement? **The current system of recruitment to and distribution of training posts meets the health needs of patients and the population.**					
1 – Strongly disagree	2 – Disagree	3 – Neither agree nor disagree	4 – Agree	5 – Strongly agree	6 – Don’t know

Q1b) If you disagree, what changes are needed to better align the distribution of training posts with local health needs?

The Royal College of Physicians of Edinburgh shares the concerns that have been expressed by many medical organisations that the current system of recruitment to and distribution of training posts is not fit for purpose and is not meeting the needs of patients, doctors or the health services in the four nations. We welcome this opportunity to contribute our views in this consultation.

We consider that significant investment in supporting educational supervision and developing a culture that facilitates this supervision will be key to delivering meaningful workforce expansion, especially in those areas with low numbers of clinical posts, therefore enabling high quality patient care into the future.

There needs to be both a national and deanery/LETB level approach. A coherent national plan for patient care is required- we need to consider what care patients need and where and what the likely developments in care are over the next 1-2 years; 5 years; 10 years; 15-20 years including the use of AI; remote reporting; new developments in diagnostics including metagenomics; advances in therapies. Then the multidisciplinary service required to deliver that care needs to be planned considering the roles of doctors of different grades and specialties, nurses, allied health professionals, healthcare scientists, pharmacists, MAPs etc as well as associated infrastructure and support colleagues (IT, Digital).

Subsequently then we need to plan the workforce numbers required- broadly at national level but with devolvement to deaneries/LETBs with input from Trusts. Trusts should **not** have the final say- this needs an evidence- based approach with the above as its foundations. At deanery/LETB level, there should be consideration of local/regional population, geography, patient demographics, existing vacancies, LTFT working patterns. Ideally, curriculum mapping should occur within each specialty and within each Deanery across all potential training sites to identify opportunities as well as barriers- with support from Trusts to address barriers if appropriate. Discussions should be had with doctors in training/prospective doctors in training within deaneries to identify personal and professional needs and opportunities e.g. doctors preferring to undertake longer placements in remote/rural locations. There is an excellent example of collaborative work in the North of Scotland in this area in the medical specialties with collaboration between NES, Boards including DME teams and Associate Medical Directors and most importantly, doctors in training. DiT identified who wished to train and remain in rural sites and work was undertaken with DME teams to address challenges eg access to echo/lack of trainers. Over 6 years, 5 doctors have now completed training and achieved CCT and have been appointed as consultants in rural sites and training, patient care and doctor experience are vastly improved- North of Scotland IMT stage 1 programme number 1 in UK for 3 years running. Once indicative numbers are decided and agreed, placement discussion can happen in conjunction with DiT, and education and training can be robustly planned and delivered and developed where new needs are identified. Ideally, education and training should have a multiprofessional component reflecting real world practice as well as the different needs of different groups of staff.

Members of the College's Trainees & Members' Committee emphasised there needed to be a recognition of WTE rather than the number of training posts filled to account for the LTFT gaps on rotas and fund appropriately service provision affected by this. They said that currently there were both large numbers of unfilled posts in some specialties (at training and consultant level) whereas there were bottlenecks at other training points and no consultant posts for those post CCT. This results in some doctors having been trained for 15+ years at the expense of the taxpayer not then being employed as a consultant in that specialty and either have to re-train or leave the profession. We also need to understand why so many doctors are deciding not to continue from foundation into core or specialty training and look at how we can reduce levels of burnout throughout the system.

Fellows in Scotland again highlighted that there is a particular inequity of training posts especially in Northern and remote and rural areas and we are aware this challenge affects many remote and rural areas across the UK. This means less potential for trainees to stay on in these areas as a consultant. The consultant workforce in these areas is particularly strained compared with more central belt Scotland. We also recognise that rotating postgraduate trainees away from the bigger centres will not be successful until there are sufficient consultants/GPs to train our trainees. Attracting and retaining more senior doctors so we have a robust 'trainer' base to teach and to train younger colleagues to expand that pool is essential.

One must also not forget about academic clinical posts and the need to expand these to ensure high quality care is delivered but is part of the training of all doctors. As stated by the GMC, 'Research is vital in improving our understanding of health conditions, and increasing the availability of options for effective prevention, treatment, and care. You should consider opportunities to conduct or participate in research that may benefit current and/or future patients, and help to improve the health of the population.' This also requires consideration of the time needed form educational and academic supervisors. It also is critical due to the decline in clinical researchers. The Office for Strategic Coordination of Heath research made several important recommendations including:
making the career pathway more flexible
having greater and more visible leadership and mentorship
embedding research as a key performance indicator (KPI) in all NHS trusts at a board level.

Fundamentally, workforce planning must genuinely align with medical school posts, training and consultant posts to minimize inefficiency/financial waste/direct vacancies and so that these marry with the service provision required by patients.

Q2a) To what extent do you agree or disagree with the following statement? **The current distribution of training posts meets the needs of healthcare service providers in delivering healthcare and developing their future medical workforce.**					
1 – Strongly disagree	2 – Disagree	3 – Neither agree nor disagree	4 – Agree	5 – Strongly agree	6 – Don't know
Q2b) If you disagree, what changes would better align training post distribution with service and workforce needs? In addition to the comments in the section above, we are very aware of the serious concerns of so many of our UK medical graduates and believe it is essential to understand fully all of the reasons behind rising competition ratios in internal medicine training at postgraduate level and address these comprehensively.					

If there is any evidence not reflected here that should be considered by the review, please submit this to england.medicaltrainingreview@nhs.net quoting your unique survey reference number, which will be generated when you submit your response to this call for evidence.

Subtheme 1.2 – Experience of being a resident doctor

The published literature and feedback from listening events highlight the issues of wellbeing and morale. A consistently high proportion of doctors in training programmes report that they are at high risk of burnout in the GMC National Training Survey. However, rates of overall satisfaction with teaching remain high (78%) and 70% report a supportive environment.

Competition for specialty training places and the impact of this on career progression are identified as a significant stressor in the current system. Workload, access to pastoral support, access to high quality training opportunities and supervision, and issues of isolation associated with rotational training are also common factors impacting on wellbeing. The hidden costs of training were also highlighted, for example examinations, preparatory courses and college portfolio fees.

Q3a) To what extent do you agree or disagree with the following statement? **The current model of postgraduate medical training meets the personal and professional needs of most doctors.**					
1 – Strongly disagree	**2 – Disagree**	3 – Neither agree nor disagree	4 – Agree	5 – Strongly agree	6 – Don't know

Q3b) If you disagree, what changes would have greater impact in supporting the personal and professional needs of doctors in training?

We are concerned that increasingly training is delivered to meet the requirements of the relevant curriculum rather than thinking about the role that the doctor is being trained for. Training can feel 'dictated' rather than a programme of learning and educational opportunities being developed and delivered with an individual doctor or cohort of doctors in mind. This reflects the squeeze on educator time and lack of investment in educator infrastructure and support. More could be done to support high quality rotations, avoiding fragmentation and maximising opportunities to build meaningful relationships with teams and thereby also to develop leadership skills and participate in parallel work including governance, education, QI and service development such streamlining treatment pathways etc.

Opportunities for doctors to sit in on and, over time, contribute to activities consultants undertake should be encouraged throughout training and certainly towards the end of training including vetting referrals, MDTs, Morbidity and Mortality meetings, Significant Event Analyses, Complaints, Root Cause Analyses, etc. We continue to need to do more to support key transitions- from UG to FY; FY into core and specialty training; training to consultant roles- and could strengthen peer networks through some of the measures above. Including doctors in training in rota design and service planning is also valuable- understanding how this happens and giving a degree of autonomy in planning can add value.

More has to be done to enable the wider team that doctors in training work in to come together as a team to innovate, learn, establish community and collegiality and improve sense of value and belonging. Frustration at singling out resident doctor wellbeing and support are real and feel tokenistic or worse, to gloss over/avoid tackling the core issues impacting healthcare colleagues, namely high and often unmanageable workload; poor IT and infrastructure; lack of autonomy and control over work patterns and placements; fragmented teams; challenges with accessing relevant education and training and other professional development opportunities.

Trainer support- with protected time in job plans under huge pressure given the current squeeze on all non-patient facing clinical activity- is essential to allow service provision to be educational such as giving feedback/involving trainees in opportunities such as observed ward rounds/clinic/MDTs/service planning activity/vetting/answering complaints).

Doctors in training should be able to complete their training at work – not by default be expected to seek training opportunities in their evenings/weekends/days off because the service provision pressure of the job has replaced training. Their zero days should be protected and those for regional teaching to ensure no burnout.

Reasonable expenses must be covered– currently there can be huge financial costs to undertake mandatory training.

Some of our members feel that currently the service is often run by relying on goodwill and individual exceptionalism; this is not a sustainable model and therefore results in an unproductive environment which is not conducive to training.

Subtheme 1.3 – Flexibility in training

The desire for flexibility, greater autonomy and a more sustainable work-life balance are recurrent themes. Flexibility can refer to flexible working, less rigid training structures and progression routes, and/or opportunities to pursue a portfolio career or extracurricular interest areas, such as academia, clinical informatics or medical entrepreneurship.

A range of flexible training options are available (for example, the ability to train less than full time (LTFT); the opportunity to take a training pause and have competencies gained while out of training assessed on return to the training programme; and other opportunities to step out of programme for a defined reason). There is, however, varying confidence among residents in their ability to access these initiatives.

Q4a) To what extent do you agree or disagree with the following statement? **Current training processes are flexible enough to meet the needs of most doctors.**					
1 – Strongly disagree	**2 – Disagree**	3 – Neither agree nor disagree	4 – Agree	5 – Strongly agree	6 – Don't know

Q4b) If you disagree, which areas of flexibility need improvement?

Structured and transparent processes for flexible training/work patterns should be established and applicable across the UK- this includes application processes to train LTFT; processes of decision making by Boards/Trusts and right to appeal; processes for leave and study leave applications and budgets. Some Colleges and Faculties (notably RCR and RCPath) have produced guidance on flexible training including consideration of where aspects of training might be delivered in different settings e.g. at home.

The impact on trainers supporting flexible training has been woefully omitted from all considerations- trainers should have remunerated time to reflect the headcount of the programme they have responsibility for rather than the establishment- e.g. respiratory programme in deanery X has an establishment of 10 funded posts but there are actually 16 doctors in the programme due to LTFT training etc. In addition to this 'simple' reflection of numbers, doctors training LTFT often require a more bespoke approach to ensure curriculum competencies are being met and therefore need more educator time; rotas are harder to plan and manage with variable numbers of LTFT colleagues and time needs to be allocated to those designing and adapting rotas; more consistent rota management generally across the UK should be supported with the input of digital and rota planning colleagues (eg Scottish Govt workforce lead for rota management/compliance). Where doctors might require adjustments in the workplace to support health or other conditions, a more consistent approach is required in England at least and across the UK. NES works with Access to Work to provide consistent yet tailored support to doctors, enabling more robust support frameworks to be put in place to enable flexible training.

Members of the Trainees and Members' Committee said improved equality assessments were required as currently 'patient safety' was often used to justify inflexible training pathways and processes that can disadvantage those who are carers, those taking maternity/paternity leave or those who have disabilities.

More flexible movement between training pathways was also required; often doctors in training may have to repeat previous experience i.e. a surgical trainee moving to GP training having to undertake a surgical resident doctor placement again. Credit should be awarded for experience to allow trainees to change between career paths.

Many of the flexible training options described above require a number of hoops to be jumped through and can only be accessed at specific times; streamlining these processes would help.

If there is any evidence not reflected here that should be considered by the review, please submit this to england.medicaltrainingreview@nhs.net quoting your unique survey reference number, which will be generated when you submit your response to this call for evidence.

Theme 2: Training capacity, delivery and quality

Subtheme 2.1 – Preparation for future practice

Resident doctors and newly appointed GPs and consultants identify that they do not always feel prepared for their roles. Both domestically and internationally, research has focused on how best to prepare doctors for the professional requirements of their future roles within a rapidly changing healthcare and societal context.

Research has considered whether postgraduate medical education is sufficiently responsive to societal needs and whether there should be a greater focus on sustainability and community health. The need for doctors to be adaptable, to manage resources effectively, to lead diverse clinical teams and to respond to clinical uncertainty have all been highlighted.

Researchers and event participants also queried whether the current system of postgraduate medical education provides appropriate educational and career support for locally employed (LE) and specialty and associate specialist (SAS) doctors. These doctors are an essential part of the medical workforce, with record growth in doctors taking up LE roles and SAS doctors possessing a diverse range of skills, knowledge and experience that the NHS relies on. However, retention among these groups is a significant issue and represents a major loss of talent and expertise from the NHS.

Q5a) To what extent do you agree or disagree with the following statement? **The current postgraduate medical training adequately prepares doctors for the professional and clinical demands of their future roles.**					
1 – Strongly disagree	2 – Disagree	3 – Neither agree nor disagree	4 – Agree	5 – Strongly agree	6 – Don't know

Q5b) If you disagree, which of the areas contributing to preparedness require the most improvement?

We are concerned that training falls short on providing doctors the opportunity to participate in activities that consultants undertake- service design and improvement; leading QI; governance activities; training others and taking responsibility for this (different from providing teaching); and also on providing opportunities to carry risk and to practice autonomously (with appropriate supervision).

Members of the Trainees and Members' Committee indicated that final year medical registrar and first day medical consultant jobs are often completely different and there is variable support for this large transition.

They gave examples of training pathways not necessarily matching future service needs i.e. one region refusing to train renal trainees in inserting TCVCs despite this being a required service elsewhere in the country.

They were also concerned that leadership and quality improvement training was very poor and often completely absent. This has an impact on the ability of new consultants to lead service improvement/support staff in their team appropriately.

If there is any evidence not reflected here that should be considered by the review, please submit this to england.medicaltrainingreview@nhs.net quoting your unique survey reference number, which will be generated when you submit your response to this call for evidence.

Subtheme 2.2 – Quality of the learning environment

High quality postgraduate medical education provides a broad range of relevant learning experiences in both formal and informal teaching settings. Engagement and connection with senior doctors during patient care is essential to this. A psychologically safe learning environment will value and support doctors both as learners and practitioners. It will also

provide opportunities to influence the working environment, while being clear on a resident doctors remit.

Understaffing and other service pressures can present a significant challenge to this ideal. Fractured working patterns and insufficient time with seniors are also inhibiting factors. While rotational training provides exposure to a broad range and variety of clinical settings and patient groups, frequent rotations can undermine a sense of stability and belonging.

Q6a) To what extent do you agree or disagree with the following statement?

The current system of postgraduate medical education provides doctors with a high quality learning environment.

1 – Strongly disagree	**2 – Disagree**	3 – Neither agree nor disagree	4 – Agree	5 – Strongly agree	6 – Don't know

Q6b) If you disagree, which of the areas contributing to preparedness require the most improvement?

A range of key factors contribute here: understaffing; lack of service planning and design of care; high and often unsustainable clinical workloads due to the above; inevitable squeeze on time for other professional activities including training; poor IT and infrastructure; disparity and inequity in employment processes and training functions across Trusts.

More must be done to ensure there is a sustainable balance between service provision and time to train given huge workloads and the increased complexity of patients and therapies available.

Far better planning is required to tackle fragmented teams affected by LTFT working and shift patterns. Protected weekly teaching should be guaranteed at each career stage.

Subtheme 2.3 – Educator capacity

Educator capacity is a recognised issue. Service demands place significant pressure on trainers as increasing clinical workloads compete with their ability to train. Furthermore, routes into medical educator careers are less formalised compared with those for clinical research and management.

Researchers and event participants discussed the merits of introducing more formal protections of trainer time to improve the quality of postgraduate supervision; expanding faculty development programmes to ensure medical educators are supported with

continuous professional development; and establishing clear and incentivised pathways for doctors to become educators.

Q7a) To what extent do you agree or disagree with the following statement? **Trainers in postgraduate medical education have sufficient time, support and resources to deliver quality supervision and training.**					
1 – Strongly disagree	2 – Disagree	3 – Neither agree nor disagree	4 – Agree	5 – Strongly agree	6 – Don't know

Q7b) If you disagree, which factors could better support medical educators?

If there is any evidence not reflected here that should be considered by the review, please submit this to england.medicaltrainingreview@nhs.net quoting your unique survey reference number, which will be generated when you submit your response to this call for evidence.

Trainers feel squeezed and not prioritised. Quite aside from the lack of remunerated time, training of trainers is inconsistent and often falls short. Some deaneries have excellent programs but each deanery/Trust should have a consistent programme of induction and trainer support and development with regular sessions including opportunities for peer support within the group. Supporting quality training and supporting individual doctors in training can often be extremely challenging, compounded by increasing flexible training, increasing recognition of neurodiversity etc. with resources and processes slow to catch up to ensure adequate support. We must stop paying lip service to supporting the educator workforce and growing numbers and address the issues highlighted GM State of Medical Education and Practice 2024. In addition it is critical that the educator workforce has a detailed understanding of the changing curriculum and competencies required and this needs time and training and regular updates.

We would wish to emphasise that trainers having sufficient time in their job plans to provide training is of fundamental importance to the system and that this is lacking in the system currently in far too many cases. We consider that after direct patient care, the most important role of any doctor is to teach and train those who will follow them. It is vital that every new medical school place created is genuinely accompanied by a commensurate expansion in foundation and specialty training posts.

Some of our physicians suggested there should be a system of holding the health board/trust to account if not providing adequate support to trainers and that the creation of trainer networks to share ideas and resources would be beneficial.

Careers must be “shaped to retain”. This is pertinent towards the end of senior doctors careers. They can be of use in training, education thereby releasing others for other work. Also as detailed above there is insufficient time for Supporting Professional Activities (SPA), for educational and training which is already frequently overridden by time for direct clinical care (DCC).

Subtheme 2.4 – Equality, diversity and inclusion

Doctors from minority ethnic groups and those with disabilities often face additional challenges, including microaggressions, exclusionary behaviours and unequal opportunities for career progression, which result in differential attainment. Sexual harassment and discrimination are also a known issue. Systemic biases must be addressed to ensure that postgraduate medical education is fair, equitable and reflective of the diversity of the workforce and the communities it serves.

Effective channels for raising concerns, with clear routes of escalation, and effective communication of outcomes are crucial to addressing issues of discrimination and exclusion, while building confidence and trust. An inclusive and supportive learning environment will facilitate a dialogue between learners and educators at all levels of seniority.

Q8a) To what extent do you agree or disagree with the following statement?

Postgraduate medical training creates an equitable and inclusive environment for doctors from diverse backgrounds, including those from minority ethnic groups and those with disabilities.

1 – Strongly disagree	**2 – Disagree**	3 – Neither agree nor disagree	4 – Agree	5 – Strongly agree	6 – Don't know

Q8b) If you disagree, how can things be done differently to address differential attainment, sexism and microaggressions for doctors from diverse backgrounds?

Further progress could be made through implementing some of the above measures- adequately staffed services with time for development and more consistent and structured placements; time to build relationships within teams and embed; time for all staff to undertake appropriate professional and team development etc.

Members of the Trainee and Members' Committee suggested consideration should be given to incorporating EDI training from medical school and ensuring equality impact assessments were undertaken on all training programmes and new initiatives.

There was a need to provide adequate inductions for IMG doctors to the NHS; rota pressures mean this is often not done and may create hostility amongst staff when these doctors struggle to navigate the system/need extra support from other residents.

If there is any evidence not reflected here that should be considered by the review, please submit this to england.medicaltrainingreview@nhs.net quoting your unique survey reference number, which will be generated when you submit your response to this call for evidence.

Theme 3: Enabling and reforming postgraduate medical education to achieve the 3 NHS mission shifts

Subtheme 3.1 – Hospital to community

There is growing recognition that more postgraduate medical education should take place in diverse community settings to better equip doctors with the skills to meet the evolving needs of patients and local communities, closer to home. By providing training opportunities outside of hospital environments, doctors can gain a deeper understanding of public health, social determinants of health and the complexities of delivering care in community settings.

Greater involvement of local health systems, such as integrated care boards, in shaping training placements and specialty allocations could ensure that training aligns more closely with local population health needs.

We are seeking insights on how community-based learning, social accountability and public health principles can be more effectively embedded in postgraduate medical education.

Q9a) To what extent do you agree or disagree with the following statement?

Postgraduate medical training should include more opportunities in community-based settings to better align with patient and community needs.

1 – Strongly disagree	2 – Disagree	**3 – Neither agree nor disagree**	4 – Agree	5 – Strongly agree	6 – Don't know

Q9b) If you disagree, please explain why you believe postgraduate education should not provide more community-based opportunities.

It is entirely appropriate for some services and training to extend into the community and provide more care closer to people's homes. It is not necessarily appropriate or even practical for others and there is risk in generalising. Rather than focusing on a single aspect of care like this, we would emphasise the necessity of undertaking wider system planning before devolving areas to specialties/regions for tailored/bespoke solutions. That said, we need to properly invest in primary and social care which very appropriately should be providing training in community based settings. Provision of care in communities by some traditionally hospital based specialties can be positive but we must ensure that this is not in a move to disguise shortfalls in primary care investment and provision.

As an example intensive care as a specialism, does not lend to community care. However Intensivists are spending more time outside of ICUs (and therefore not on the in-patients), with ageing, more complex patients making escalation plans and helping with end of life care.

Subtheme 3.2 – Treatment to prevention

Researchers and event participants considered how postgraduate medical training can better equip doctors to address health inequalities. This would require a stronger focus on prevention, population health and the broader social determinants that impact health outcomes.

By expanding generalist training opportunities, the medical workforce could be better prepared to address the evolving healthcare needs of diverse populations and to adapt to a rapidly changing healthcare environment. Similarly, in the USA, systems-based practice has

been embedded in postgraduate medical training, requiring residents to demonstrate an awareness of and responsiveness to the larger context and system of healthcare.

There could also be more formal opportunities within postgraduate medical curricula to offer dual accreditation in generalist and specialist fields, for example paediatrics and public health.

Q10a) To what extent do you agree or disagree with the following statement?

Postgraduate medical training curricula should include a stronger focus on addressing health inequalities, social determinants of health and population health.

1 – Strongly disagree	2 – Disagree	3 – Neither agree nor disagree	**4 – Agree**	5 – Strongly agree	6 – Don't know

Q10b) If you disagree, please give your reasons.

We think very few would disagree with this but we need to consider how we translate this into real life practice, either of training or of care, and how do we ensure we are equipping people with the right skills. Much of this should be embedded with early years and school education and then continue throughout learning stages as 'core business'. We are also mindful that post graduate curricula are already very squeezed and address how we add in more in a meaningful way that actually improves the care we deliver and the lives and health of our population.

Currently the allocation of doctors does not follow a population health needs model and relies on historical utilization dominated by high profile conditions. This needs to be more flexible as the needs of the population change and both technology and therapeutics advance at great pace and hopefully patients take more control of their health and wellbeing.

If there is any evidence not reflected here that should be considered by the review, please submit this to england.medicaltrainingreview@nhs.net quoting your unique survey reference number, which will be generated when you submit your response to this call for evidence.

Subtheme 3.3 – Analogue to digital

The literature identified opportunities to harness extended reality technologies, artificial intelligence (AI) and machine learning to make educational processes more efficient, build training capacity and personalise learning experiences. For instance, AI and machine learning could be used for curriculum development, personalised education, medical simulation, enhancing assessments and developing clinical reasoning skills. Digital innovation is recognised as a key reform option for expanding training capacity and developing clinical confidence and competence within a safe learning environment.

Researchers and event participants also considered whether postgraduate training should better prepare doctors for a digital future by incorporating more content on digital health, AI and technology-enabled remote care delivery.

Q11a) To what extent do you agree or disagree with the following statement? **Postgraduate medical training should incorporate more content on digital health, AI and remote care, including the use of technologies such as extended reality, AI and machine learning, to enhance learning experiences and improve training capacity.**					
1 – Strongly disagree	2 – Disagree	3 – Neither agree nor disagree	**4 – Agree**	5 – Strongly agree	6 – Don't know

Q11b) If you disagree, please explain your reasons.

As with the developments of new medications, diagnostics and surgical techniques, we should ensure that our curricula are adaptive and flexible and continue to meet the needs of the population and of doctors undertaking training. This should happen in the curricula reviews regularly undertaken within Colleges and Faculties. These processes could be improved and this critical work should really be recognised and supported by governments. Robust curriculum development and design and quality assurance and review is essential to ensure standards remain high and that we can support proactive or even generative design and incorporation of new technologies.

It is important to be part of the roll-out of AI across specialties, including administration, diagnostics, patient care, and reporting, so that we maximise its benefit to patients and to trainees. This is the same for the roll-out of digital health across relevant specialties.

If there is any evidence not reflected here that should be considered by the review, please submit this to england.medicaltrainingreview@nhs.net quoting your unique survey reference number, which will be generated when you submit your response to this call for evidence.

Career expectations and system gaps / issues impacting on satisfaction

Questions 12 to 15 are specifically for medical students, doctors, their representative bodies and education bodies (including medical schools, medical Royal Colleges and trade unions).

Q12) What factors are the most and least important for a rewarding and satisfying postgraduate medical training pathway?

To note: pay and conditions are not within the scope of the review.

Please submit any evidence to support your response to england.medicaltrainingreview@nhs.net, , quoting your unique survey reference number, which will be generated when you submit your response to this call for evidence.

	Most important [select up to 3]	**Least important [select up to 3]**
Ability to develop and / or deliver effective patient care pathways		
Ability to train and work in one's desired location	x	
Ability to train and work in one's desired specialty		
Access to high quality mentorship and supervision	x	

Being a member of an effective multidisciplinary team		
Confidence in career progression		
Contributing to an effective healthcare service		
Flexible training options		
Leadership, research, quality improvement or teaching opportunities		
Making a difference to the wellbeing of individual patients		
Professional identify and status		x

Professional / technical ‘mastery’ of one’s craft		
Support for personal and professional development		
The opportunity to improve health of a local community at a population level		
Work-life balance and workload	x	
Working conditions		
Other(s) (free text for this option)		

Q13) What are the most and least significant barriers to a rewarding and satisfying postgraduate medical training pathway?

To note: pay and conditions are not within the scope of the review.

	Most important [select up to 3]	**Least important [select up to 3]**
Cost of training (for example, examinations and college membership fees)		
Current rotational training structure		
Inadequate physical and IT infrastructure to support training		
Lack of access to high quality supervision	x	
Lack of access to high quality training opportunities		
Lack of access to simulation, virtual, digital and AI-based education		
Lack of flexibility to gain experience across multiple settings		
Length of training		x
Limited protected time for portfolio development (research, quality improvement, teaching, leadership)		
Burden of portfolio requirements	x	
Relevance of curricula		
Rigidity of training structures / career progression routes		
Service pressures / time to train		
Training bottlenecks at key progression points	x	
Other(s) (free text for this option)		

Q14) Please rank the following options for reforming postgraduate medical education in order of priority.

- Addressing bottlenecks in training progression at key transition points
- **6. Addressing burnout and improving resident doctor wellbeing**
- Balancing general and specialist training opportunities
- Creating formal pathways for doctors to pursue extracurricular interests (for example, informatics, medical entrepreneurship, academic medicine)
- Creating longer-term trainer / resident mentorship structures
- Embedding training to tackle health inequalities and social determinants of health into curricula
- Ensuring access to physical and IT infrastructure required to facilitate training (for example, shared desk space, reliable digital systems)
- Establishing clearer pathways into medical education, with appropriate incentives
- Expanding training in community settings
- Geographically smaller training programmes
- **3. Giving local health systems greater input into shaping postgraduate medical training placements and specialty numbers**
- Greater ability to have capabilities gained in any post counted towards training progression
- Greater access to flexible working patterns
- Making greater use of extended reality, AI and machine learning in the delivery of postgraduate medical education
- More curriculum focus on doctors' competencies in digital health, AI and remote care
- Offering better support for doctors pursing clinical academic careers
- **4. Offering targeted incentives to work in underserved areas**
- **2. Protecting time for educators**
- Providing better career coaching / mentorship / personalised career planning support
- **5. Reducing the frequency of rotations within a programme**
- Reform of the specialty training recruitment processes to support the specialty preferences of candidates
- **1. Reform of the specialty training recruitment processes to support geographical preferences of candidates**

Q15) If you have any further ideas or feedback regarding a model / exemplar design for the delivery of postgraduate medical education, please describe these.

The Royal College of Physicians of Edinburgh would welcome further engagement with this review so that some of our Fellows and Members with particular expertise in this area can contribute to examining some of the solutions that may be put in place.

We would wish to emphasise our support for a system that understands what care people require, what the service to deliver that care looks like, how we staff those services, and how we train and develop colleagues to deliver that care. The national recruitment process needs urgent review and substantial overhaul and we need the most robust workforce plan to avoid bottlenecks and assure realistic opportunities for career progression. Currently we have an unacceptable talent drain and see huge personal losses for those who complete UG/FY and cannot progress with opportunity losses for patient care and financial losses to the UK taxpayer.

If there is any evidence not reflected here that should be considered by the review, please submit this to england.medicaltrainingreview@nhs.net quoting your unique survey reference number, which will be generated when you submit your response to this call for evidence