

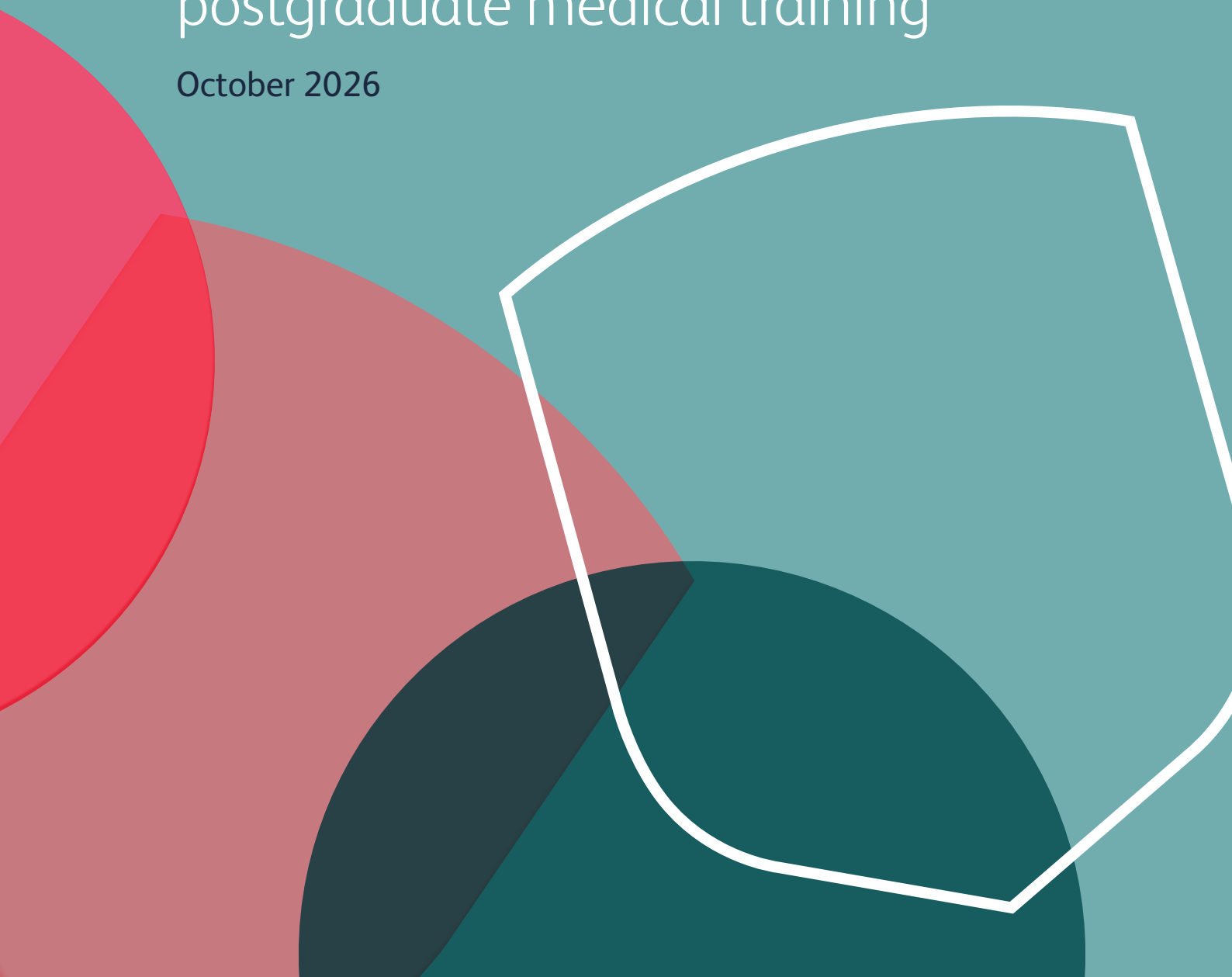


Royal College
of Physicians

Training physicians for the future

A blueprint for reforming
postgraduate medical training

October 2026



The Royal College of Physicians

The Royal College of Physicians (RCP) is a global community of more than 40,000 physicians. As an independent charity, we support doctors across 30 specialties to uphold the highest standards in medicine. Through education and advocacy, we empower our members to lead positive change for patients and help shape better health and care in the UK and around the world.

Together we're shaping the future of medicine.

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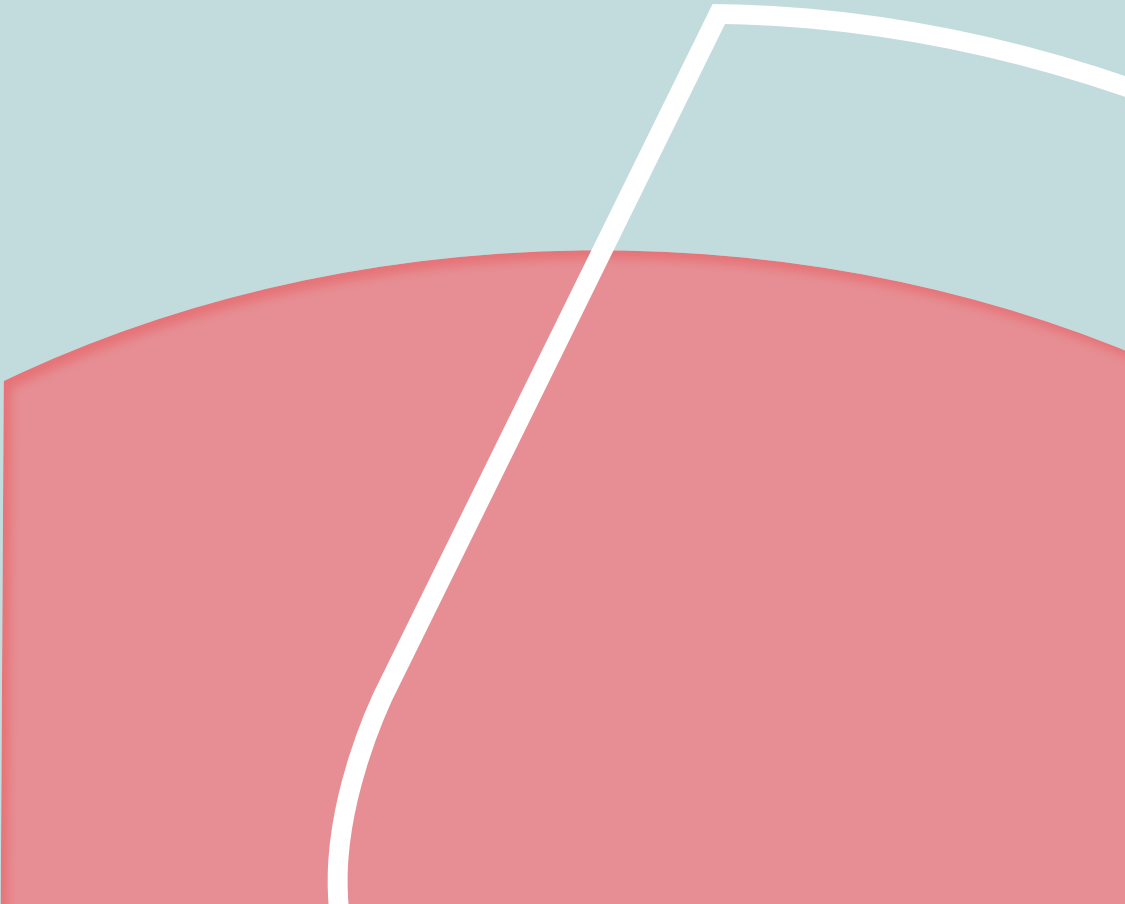
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Royal College of Physicians

11 St Andrews Place	The Spine
Regent's Park	2 Paddington Village
London NW1 4LE	Liverpool L7 3FA

www.rcp.ac.uk

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Foreword from RCP president

Postgraduate medical training is a key pillar underpinning safe, high-quality patient care. Physicians in training today will become the consultants, clinical leaders, educators, researchers and innovators on whom patients and the NHS will depend for decades to come. At the same time, excellence in patient care is central to what we do as physicians. Our responsibility is therefore not simply to improve the current training system, but to ensure that it equips physicians with the skills, experience and adaptability needed to meet future healthcare challenges.

Those future physicians will care for a population that is living longer with multiple long-term conditions, work more seamlessly across hospital and community settings, make use of increasingly sophisticated digital technologies, and lead multidisciplinary teams (MDTs) delivering care in new ways. At the same time, patients will continue to depend on physicians with deep specialist expertise, sound clinical judgement and the confidence to manage complexity, uncertainty and risk.

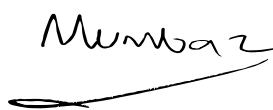
Training must therefore develop both breadth and depth in physicians: the challenge is not to choose between service delivery and education or, indeed, between specialism and generalism, but to ensure that service environments are designed to support both. High-quality training and high-quality patient care are mutually beneficial.

The [medical education and training review](#) (METR) offers a significant opportunity to reshape postgraduate medical training around this vision. Phase one highlighted many of the challenges that resident doctors and trainers have described for years: service pressures crowding out education, inconsistent supervision, inflexible career pathways, and assessment processes that can feel disconnected from professional development. These issues affect not only training experiences, but ultimately the quality of care that patients receive. Phase two of the METR must now focus on delivery of change: making training visible, funded, accountable and protected across every learning environment.

The Royal College of Physicians (RCP) believes that the METR must deliver a training system that is flexible, capability based and accountable. Drawing on evidence from the [RCP next generation campaign](#), member engagement, resident doctor feedback, specialty expertise and previous training reviews, this blueprint sets out the changes required to build a training system that is fit for the future.

The need for reform is reflected in the RCP's [2025 national survey](#) of more than 1,000 resident doctors. Just 26 % felt ready for the next step in their career, while only 17 % believed that postgraduate recruitment processes were fair. Only 65 % expected to remain working in the NHS in 5 years' time, highlighting the risks to both training and workforce retention if reform is not delivered.

Resident doctors should have access to protected learning time, high-quality supervision and progression routes that recognise capability wherever it is developed. Just as importantly, education must be treated as a core function of the health service. Training quality must be visible, educational funding must support education, and organisations must be accountable for delivering the opportunities that they promise. However, while delivering excellent care for patients today, the NHS must also focus on developing the workforce needed for tomorrow. Medical training is an investment whose return is measured over decades. Getting it right matters to today's resident doctors, but above all, it matters to the patients and communities that they will serve throughout their careers.



Professor Mumtaz Patel
President

Foreword from RCP Resident Doctor Committee co-chairs

As resident doctors, we do not need another review to tell us that postgraduate medical training is under pressure – we experience those pressures every day. Many of the concerns highlighted in phase one of the METR will feel familiar to doctors across the UK: service pressures displacing education, inconsistent supervision, inflexible pathways, burdensome assessment processes and difficult career transitions.

Through the RCP's engagement with resident doctors, we have heard remarkably consistent experiences. Clinics are missed because rota pressures make attendance impossible. Training opportunities in routine clinical work have been squeezed to the margins. The pursuit of generalist skills has too often meant time spent covering the acute take, at the expense of both generalist and specialist training. Doctors often rotate before supervisors have had time to get to know them well enough to support their development.

Too often, training quality is determined by where a doctor happens to work, and learning opportunities across all career grades depend more on individual persistence than on being reliably embedded within training. Such struggles have been amplified for resident doctors training less than full time (LTFT), who are often treated as having stepped outside the 'normal' training pathway, despite LTFT work becoming an increasingly common choice in recent years.

None of these concerns are new. The last 20 years have seen several reports into aspects of medical training: *Aspiring to excellence* (Tooke, 2008), *Foundation for excellence* (Collins, 2010), *Time for training* (Temple, 2010) and *Shape of training* (Greenaway, 2013). These reports share several common themes with the phase one report of the METR, yet progress has often been limited over the years, in part because responsibility for training is shared across multiple organisations and accountability for delivering improvement remains fragmented; consequently, there is no effective quality assurance (QA) that ensures a high-quality and equitable standard of training.

The problem is not that we do not know what good training looks like. Rather, we have repeatedly failed to establish the accountability and sustained system-wide action needed to deliver it.

This matters because, aside from the changes that will be required to reflect the direction of travel set out in the [10 Year Health Plan for England](#), what we are asking for does not represent a radical departure from the existing system. Much of what we are calling for is already stated within our curricula and recognised as fundamental to effective training. We are not seeking to reinvent the wheel – we are asking organisations to translate what is already known and agreed into consistent practice. We are asking for resident doctor jobs to be designed with sufficient staffing levels to enable meaningful training through day-to-day clinical practice. We are asking for supervisors with protected time to get to know us, support us and provide honest feedback to help us improve. We are asking for assessments that have genuine educational value. We are asking for a system that recognises and supports flexible working, and progression structures that recognise the skills developed through research, leadership, education and quality improvement (QI).

Most importantly, we want to know that the system values our development as much as it values our service contribution. This matters not only for doctors, but for patients too. Doctors who are properly trained, supported and developed are better equipped to deliver safe, high-quality care.

For the METR to succeed, it must do more than identify the right reforms. It must define the accountability, funding and QA mechanisms needed to ensure that they are finally delivered. The measure of success will not be whether we have identified the right solutions, but whether the system is finally made answerable for putting them into practice, so that these findings are not, 20 years from now, repeated once again.



Dr Ricia Gwenter
RCP Resident Doctor
Committee co-chair



Dr Stephen Joseph
RCP Resident Doctor
Committee co-chair

Introduction: the case for physician training reform

The recent [quality strategy for NHS-funded care in England](#) positions quality as the organising principle for the NHS, defining high-quality care through three interdependent domains:

- > **Safety** – reducing the risk of unintended or unexpected harm to patients arising from the provision of healthcare.
- > **Effectiveness** – delivering evidence-based care that optimises the outcomes that matter to people using services.
- > **Experience** – coordinated, compassionate and responsive care, delivered by staff who are skilled, supported and able to do their job well.

These principles are as important to physicians’ education and training as they are to the delivery of the high-quality, high-value healthcare that they provide.

Good training shapes physicians’ knowledge, skills, judgement, professionalism and ability to deliver safe, effective and compassionate care, and as such must be one of the foundations of the quality agenda. The [quality strategy](#) is also clear that quality and value are inseparable: high-quality care delivers greater value for patients and the NHS by improving outcomes while making the best of NHS resources. Conversely, poor care carries significant human and financial cost.

Investment in physician training should therefore not be viewed as a cost, but as an investment in the capability required to deliver safe care, improve outcomes, reduce unwarranted variation and make best use of finite NHS resources. Poor quality is ultimately expensive and so the question is not whether the NHS can afford to invest in physician training, but whether it can afford the consequences for quality, value, productivity and patient care if it does not.

Mapping good physician training against the three core domains of quality

Good physician training enhances safety	Patient safety is directly influenced by the quality of physician training. Strong clinical knowledge, underpinned by sound diagnostic reasoning, reduces the risk of unintended harm through errors, misdiagnosis, delayed treatment and unnecessary interventions. These can contribute to avoidable harm and poor health outcomes, as well as pressure on NHS resources through longer hospital stays, repeat attendances and increased service use. Investment in resident doctor training is therefore a high-value critical enabler of safe and efficient care.
Good physician training drives clinical effectiveness	In practice, clinical effectiveness means providing timely, appropriate and evidence-based care that improves health outcomes. Well-trained physicians are better able to synthesise complex clinical information, make accurate diagnoses and select appropriate evidence-based interventions. Their expertise, developed through years of medical training, makes them uniquely placed to undertake these responsibilities, particularly when managing uncertainty, complexity and clinical risk. These responsibilities cannot and must not be substituted by others who have not undergone medical training. The need for this expertise is likely to grow as healthcare becomes increasingly complex. Advances in diagnostics, therapeutics and technology continue to expand the volume of information that physicians must interpret, increasing the importance of professional judgement in applying evidence to individual patients. As medical knowledge evolves, the ability to critically appraise and apply new evidence will become an increasingly important determinant of patient outcomes. <i>(continued on next page)</i>

Good physician training drives clinical effectiveness <i>(continued)</i>	Maximising the benefits of medical expertise and improving productivity requires sustained investment in training, enabling doctors to develop competence and exercise greater autonomy as soon as it is safe and appropriate to do so. Through training, doctors should progressively work at the top of their licence, in line with the ambitions of the 10 Year Health Plan for England. By the later stages of training, senior resident doctors should, with appropriate indirect supervision, be able to undertake some clinical activities currently delivered directly by consultants, while consultants retain overall responsibility for patient care. This supports a shift towards care being consultant led rather than consultant delivered, facilitates the transition from supervised to independent practice, ensures that care is delivered by the most appropriate grade of doctor, and allows consultant expertise to be deployed where it adds the greatest value, including managing the most complex clinical problems and developing the next generation of senior decision-makers. Future consultants are developed through deliberate training and the progressive transfer of responsibility between generations of doctors. More effective deployment of finite consultant resource may also offset some of the investment in supervision and training proposed in this report. Investment in physician training should therefore be viewed not as a cost, but as an investment in clinical effectiveness, strengthening both current productivity and the future consultant workforce.
Good physician training improves experience	Patients need compassionate, holistic and responsive care, delivered by physicians who are skilled and supported to do their job well. Good training contributes significantly to patient experience by ensuring that resident doctors have the skills to communicate clearly and support patients through their healthcare journey. Doctors deserve to work in an NHS that recognises high-quality physician training as essential to retention, productivity and workforce sustainability. Yet in an NHS facing unprecedented financial constraints, workforce shortages and productivity pressures, investment in training is too often viewed as competing with the immediate demands of service delivery. This is a false distinction. The greater threat to productivity is not the time invested in training, but burnout and attrition. Doctors who feel competent, confident, supported and in control of their working lives are less likely to burn out, reduce their hours, migrate overseas or leave the profession entirely. The cost of that attrition, in recruitment, locum cover, lost expertise and lost investment, far exceeds the short-term service time that training requires. Training and development are therefore among the most effective levers available to combat burnout and attrition, and investment in them is not a competing priority to service delivery, but necessary for its sustainability.

Core principles for training reform

The RCP believes that the following core principles are essential to delivering high-quality training. They should be read alongside the full report, which provides further context and explains their rationale, interdependencies and implementation considerations.

Core principles	
Resident doctor jobs should be designed for on-the-job learning	Training should be embedded within service delivery and recognised as a fundamental NHS activity, rather than treated as a competing priority. Resident doctors and trainers must have protected time within their job plans for supervision, learning, reflection and professional development, as these are the scaffolding that allows learning through clinical service to occur. Training must be protected to enable effective service delivery; one supports the other. Jobs designed to facilitate training are also more sustainable: they support the competence, confidence and wellbeing that improve retention and productivity.
Educational quality must be visible and accountable	Training quality should be measured, monitored and acted upon, with meaningful consequences where standards are not met. Organisations receiving funding for postgraduate medical education should be able to demonstrate how that funding improves training.
Training must keep pace with a rapidly changing NHS	Curricula and training experiences should reflect the growing importance of neighbourhood health, preventative healthcare, digital healthcare, AI, multidisciplinary working and population health.
The future workforce needs both generalist and specialist expertise	Physicians must be equipped to care holistically for patients with increasing complexity, while also developing deep specialist expertise. Training pathways must provide fair and proportionate opportunities to develop both skillsets, ensuring that neither generalist nor specialist training is allowed to crowd out the other.
Training pathways must become more flexible	Modern medical careers no longer follow a single linear route. Training structures should support different working patterns and career paths, academic pathways, less-than-full-time (LTFT) training, out-of-programme (OOP) experience, and individualised progression without disadvantage.
Progression should be determined by demonstration of defined curricular capabilities, rather than on time served alone	Training should support the progressive development of knowledge, skills, clinical judgement and professional capability, with progression based on robust and reliable evidence that the curriculum-required standard for these domains has been demonstrated, rather than on time served alone. Indicative programme lengths, minimum clinical exposure, examinations and consistent national standards should provide safeguards for patient safety. Capabilities developed outside formal training programmes, including through academic work, leadership, research and locally employed posts, should be recognised.

While some of the recommendations in this report can be taken forward individually, the most significant depend on progress across the wider system. Capability-based progression is a clear example: on its own, it will not deliver the change required. For it to succeed, it needs robust assessment that can reliably judge skills and experience gained inside and outside formal training programmes. It also requires consistent, well-supported supervisory relationships, alongside protected educational time within clinical service to ensure that capability can be developed, observed and assessed in practice. Strong QA of training provision is therefore essential, delivering the oversight needed to identify gaps in implementation and ensure that problems are addressed early. Only by bringing these changes together can the system deliver the training that this report envisions.

Application of recommendations across all UK nations

As this review was commissioned by NHS England, any suggested mechanisms for implementation have been mapped primarily to current NHS England systems and structures. This provides a realistic starting point for considering how the recommendations could be taken forward in practice.

However, the recommendations are intended to be relevant across all four UK nations. While the governance and contractual arrangements for postgraduate medical education differ across the devolved nations, resident doctors are working towards comparable outcomes in terms of training, competence and progression. The NHS England structures and concepts referenced here are therefore intended as illustrative implementation routes. In the devolved nations, the recommendations can be interpreted and applied through the relevant local governance, education and workforce systems. This approach is intended to support consistency in the outcomes and quality of training, while allowing flexibility in how those outcomes are achieved within each nation's distinct system.

A note on implementation and funding

The current landscape presents significant uncertainty about how postgraduate medical training reform might be implemented. The planned abolition of NHS England and the lack of clarity about where responsibility for education and training will sit within the Department of Health

and Social Care (DHSC) creates uncertainty about future governance, implementation and accountability. This uncertainty is compounded by the continued delay in publishing the overdue [10 Year Workforce Plan](#), making it difficult to assess how workforce planning, funding and training reform will align.

This uncertainty extends beyond governance. There has been no indication of what resource, if any, will be available to support training reform. Given the broader financial pressures facing the NHS, significant investment appears unlikely, yet meaningful reform of something as fundamental and complex as medical education cannot credibly be expected to be entirely costless.

These uncertainties create a difficult balance for thinking about training in the future. Aspirational suggestions might be seen as unrealistic, particularly by those grappling with today's challenges, while recommendations that require additional investment are criticised as being impractical or unaffordable. However, if the METR is a genuine opportunity for reform, it is important to articulate the changes that we believe are needed and the direction in which training should develop, despite recognising the current financial climate. Our concern is that, in a constrained financial environment, there is a real risk that sound reforms will be progressively diluted through cost analysis until they no longer improve training or, worse, leave it in a poorer state than before.

The guiding question should not be what training reform costs, but how much failure to reform will cost patients and the future workforce.

The recommendations in this report have been designed to minimise additional cost wherever possible, and many can be delivered through changes to process, culture and the way that existing resources are used. A smaller number of areas, however, will require significant investment to deliver: improved staffing levels, so that resident doctors have time to learn without compromising patient care; sufficient job-planned time for educators and supervisors, whose current allocation for training is frequently insufficient or eroded by service demand; an expansion in the number of training posts, to address the bottlenecks that currently delay progression and waste capability; the resource to support genuine improvement in organisations where training is found to be inadequate; and expanding educational provision to locally employed doctors (LEDs).

Where we do advocate for greater investment, this is not necessarily a call for new money. The proportion of NHS funding allocated for training doctors, and how that funding is used, are ultimately political and system choices. In addition, a clear understanding of how existing funding is being used must be a prerequisite for effective decisions about future investment. At present, that transparency is largely absent.

Organisations must be able to demonstrate that they can trace funding intended for the education and training of doctors to identifiable educational capacity, activity and outcomes. Without this level of financial stewardship, it is impossible to determine whether current investment is sufficient, whether resources are being deployed effectively and appropriately, or where genuine funding gaps exist. Similarly, trusts must demonstrate that they can identify, share and adopt different examples of good practice where necessary to reduce unwarranted variation.

There are many successful models of training delivery across the UK that demonstrate how meaningful change has been achieved, even in financially constrained environments, and show that that barriers to change are not absolute. While successful initiatives may require reprioritisation or adaptation according to local circumstance, they cannot be dismissed as impractical or unaffordable when they have already been successfully implemented elsewhere.

Before additional funding is cited as a prerequisite for local improvement, there should be rigorous scrutiny of whether existing safeguards, proven approaches and opportunities for service redesign have been fully explored. Only when these avenues have been exhausted should funding constraints be accepted as a legitimate barrier to reform.

Where possible, this report proposes practical improvements and implementation routes. In some key areas, however, the uncertainty surrounding future governance arrangements and accountability structures makes it difficult to identify credible mechanisms for delivery. Moreover, many of the proposals rely on the same opaque and multi-agency governance relationships that have not delivered on the promise of previous reforms and have, in part, led to the need for the METR. This raises legitimate questions about whether the broader training system in its current form can deliver the scale of change required, or whether this complex system needs simplifying with clearer responsibilities and more transparent accountability.

Recognising that implementation routes cannot yet be identified for every recommendation, the report is intentionally framed around a set of principles, rather than detailed implementation plans. Defining what good looks like is a necessary first step before determining how it should be delivered within a changing system. The report is not intended to provide an exhaustive review of the specifics of every training stage, specialty or curriculum. Rather, it outlines a set of overarching core principles that should apply across the training continuum and provides a common foundation for reform.

These principles could also be tested in practice. A pilot within a committed trust, or a group of trusts, could evaluate the impact of implementing the recommendations set out in this report. Evaluation should extend beyond traditional measures of training satisfaction to include workforce, operational and patient care outcomes, for example retention rates, sickness rates, locum expenditure, rota gap frequency, productivity, patient experience, continuity of care, and relevant patient safety and quality indicators. Comparison with appropriate control organisations would provide valuable evidence on whether targeted investment in training delivers measurable educational, workforce, organisational and patient benefits.

Implementation must follow at pace. The RCP will use its national, regional and specialty networks to work with resident doctors, educators, employers, other medical royal colleges and system partners to translate these principles into deliverable reform. This should include developing the proposed educational key performance indicators (KPIs), supporting the design of accountability and improvement mechanisms, identifying opportunities to test the recommendations in practice, and monitoring progress as future governance arrangements become clearer.

This report should therefore be viewed as the starting point for a sustained programme of influence and implementation, rather than an endpoint.

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Creating the conditions for high-quality training



Embedding training in service delivery

One of the most consistent messages from resident doctors and trainers is that educational opportunities are too often displaced by service demands, with teaching, supervision and other learning opportunities interrupted, postponed or cancelled because of workforce pressures. Protecting training in service is one of the most important foundations of medical training reform. Unless learning opportunities are consistently protected within everyday clinical practice, wider changes to curricula, assessment and career progression will have limited impact.

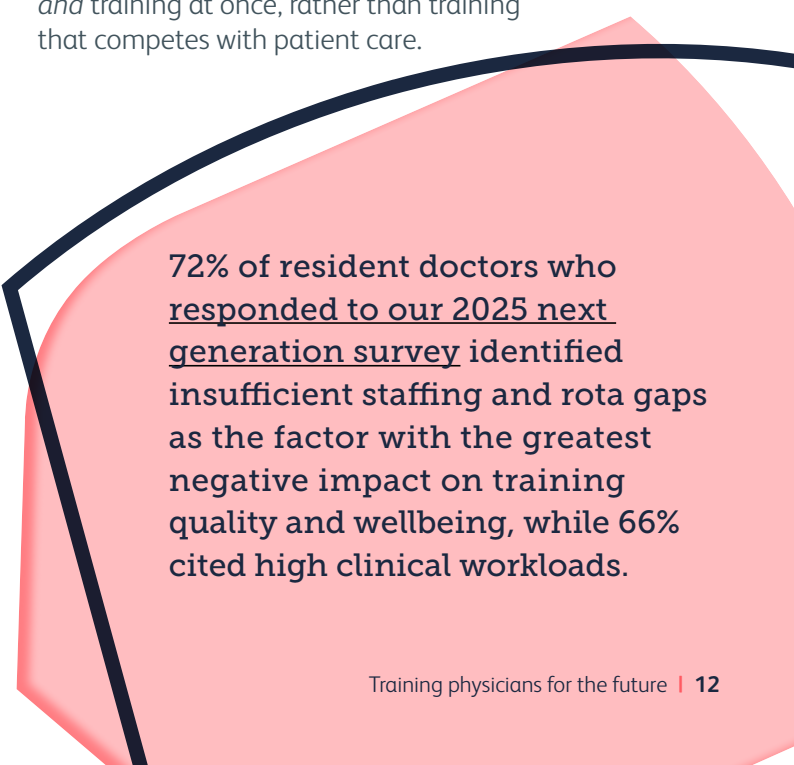
Most postgraduate training takes place through day-to-day clinical work, which is, and should remain, the bedrock of training. Assessing, investigating and managing multiple patient contacts, working alongside experienced colleagues and receiving feedback in real time are central to developing clinical judgement, confidence and capability. However, clinical exposure alone does not automatically translate into effective learning and training. Resident doctors also need the opportunity to reflect on their experience, identify gaps in their knowledge, review relevant guidelines or discuss cases with a senior. It is this 'educational scaffolding' that helps learners consolidate their experience and turns service into training.

However, because the educational potential of routine clinical work is embedded in service, it is difficult to measure, protect and guarantee. Consequently, service pressures often displace this educational scaffolding, leaving training dependent on operational circumstances rather than educational need. This ultimately proves counterproductive by limiting the development of resident doctor capability. Purposeful training cannot be something that happens only when capacity allows, as this reinforces a false distinction between service and education.

Good training supports effective service delivery. Well-designed jobs, with sufficient staffing, appropriate senior support, continuity and feedback, enable resident doctors to develop competence while simultaneously delivering the clinical service required. The focus should therefore be on designing jobs in which learning and service reinforce one another, rather than treating them as competing priorities. To enable this, NHS organisations will need to be funded to provide sufficient staffing levels to deliver quality training, rather than the minimum staffing for safe patient care.

Establishing a defined minimum of protected educational time *within* routine clinical work creates a measurable floor below which training cannot be eroded by service demands. While 'protected' time is not the end goal, it provides a metric that safeguards educational activity, which can then be monitored through QA processes while wider training reforms are developed and embedded. Specifying ringfenced educational time in this context is not intended to suggest that resident doctors are removed from the clinical environment for additional classroom teaching. Rather, it should support structured learning embedded within service, where patient care and education are delivered simultaneously. Many services already demonstrate how this can be achieved through teaching as part of structured ward rounds, reverse ward rounds, dedicated workplace-based assessment (WPBA) sessions, observed clinic consultations, multidisciplinary case reviews and structured debriefs. Every resident doctor should have access to at least two half-day protected training sessions each week. Erosion of this educational time should be monitored through exception reporting (ER), with aggregated data used as an indicator of educational capacity, training quality and organisational commitment to education.

Organisations should reconsider what counts as 'service provision' for resident doctors. Resident doctors rightly contribute to the clinical service of the organisations that employ them, but this contribution does not need to fall solely on inpatient wards and the acute take. Spreading service contribution across domains including outpatient clinics, ambulatory and community settings, can help build the generalist and outpatient capabilities that resident doctors and patients need. Reframed this way, participation in clinics and community services, alongside appropriate educational scaffolding, becomes service *and* training at once, rather than training that competes with patient care.



72% of resident doctors who responded to our 2025 next generation survey identified insufficient staffing and rota gaps as the factor with the greatest negative impact on training quality and wellbeing, while 66% cited high clinical workloads.

Maximising the productivity value of clinical work

The [10 Year Health Plan for England](#) is explicit that NHS staff should be enabled to work at the top of their licence, using the full breadth of their training, skills and experience. The completion of some routine tasks and repeated activities is an essential part of developing competence, but others occupy substantial amounts of physician time while making limited use of their advanced skillset and contributing little to their development.

Physician time should be focused on activities where their expertise adds the greatest value for patients and the NHS, with routine or administrative tasks being digitised or undertaken by other members of the MDT where appropriate. This would improve productivity by enabling physicians to focus on more complex care and apply the expertise and skill developed during their training. Training reform should provide sufficient opportunities for supervised practice and skill consolidation during learning, while reducing low-value activity wherever possible.

One way to simultaneously improve learning and NHS productivity would be to develop key skills early in a placement. Training programmes should identify the skills most valuable to a rotation and deliver training in these skills through structured, intensive learning opportunities at the outset.

For example, a resident doctor in internal medicine training (IMT) starting a gastroenterology placement should receive skills training in ascitic drains at the outset of the rotation, then be timetabled into the setting where day-case paracentesis is performed soon after, for supervised exposure to multiple procedures in a single session. This is far more effective than sporadic opportunities spaced out enough to let skills lapse.

As competence develops, the IMT doctor should be prioritised for further workplace learning opportunities, supported by appropriate supervision. Structured and repeated exposure to key clinical activities accelerates progression through the early stages of learning, building confidence and capability. This, in turn, enables resident doctors to gain more from subsequent clinical experience and contribute more productively to patient care and service delivery.

Promoting continuity, stability and belonging in training environments

High-quality education depends on continuity of working relationships, regular supervision and observation of practice, and a clear sense of educational responsibility for the development of individual doctors. Reintroducing some elements of the traditional ‘firm’ structures could help strengthen these foundations within modern clinical teams.

While European Working Time Directive legislation and changing patterns of work have contributed in part to the erosion of the traditional firm structure, some of its benefits could be reintroduced within current working arrangements through less frequent rotation, longitudinal supervision and intelligent rota design that prioritises training continuity. For example, using block training could reduce disruption caused by frequent movement within training environments. Firm structures would help resident doctors feel valued as individuals rather than interchangeable members of a large system, fostering a stronger sense of belonging within teams.

Ensuring properly resourced educators and supervisors

The effectiveness of stable and supportive training structures, as set out in this chapter, depends on educators having sufficient time. If education is to be delivered well, the full range of educational responsibilities must be protected, resourced and recognised as a core professional activity, with parity of esteem alongside service delivery. The delivery of postgraduate medical education cannot continue to rely on goodwill alone.

Many educators currently either lack adequate job-planned time, or find that service pressures, rota gaps and clinical activity prevent them from using the educational time that they have been allocated. In the [2025 GMC national training survey](#), only 52 % of trainers reported always being able to use their allocated training time for educational purposes, and in a recent [RCP membership survey](#), just 65 % of physicians told us that they have time in their job plan to undertake supervision, with only 61 % of those feeling that this was adequate.

Educational capacity is currently constrained by the finite number and availability of appropriately trained supervisors. To create a sustainable training system, educating and training the next generation of doctors must be recognised as a professional responsibility for doctors at all levels.

Expanding the pool of doctors able to contribute to supervision, including through greater use of specialist, associate specialist and specialty (SAS) doctors in supervisory roles and supporting consultants who are not currently supervisors to take on these responsibilities where they wish to do so, could help increase capacity. To ensure consistency and quality, newly appointed supervisors should be supported through a period of oversight and mentorship by an experienced supervisor as they develop confidence and expertise in the role.

Time is essential for high-quality supervision, but time alone is insufficient. If supervision is to be reliable and high quality rather than dependent on individual aptitude, educators need clear national standards defining what good supervision entails, ongoing professional development to build and maintain their educational skills, and meaningful feedback, including from the resident doctors they supervise, that allows supervision to be improved.

Distinct from supervision, mentoring can play a valuable role in supporting professional development, career planning and wellbeing, particularly across the transitions between training stages, where resident doctors often feel least supported. Mentoring is most effective as a voluntary developmental relationship, and its value depends on genuine rapport between mentor and mentee. For this reason, it cannot simply be mandated or assigned. Organisations can create the conditions in which mentoring flourishes: making it easy for resident doctors to find and access a mentor, allowing them to choose and, where necessary, change who that is, and recognising and valuing the time that senior doctors give as mentors.

In addition to individual educator–resident doctor interactions, educator commitments will extend to other essential activities such as interviewing for recruitment, annual review of competence progression (ARCP) panel participation and educational leadership roles. These require significant time and expertise but, similarly, are not consistently or adequately remunerated. As a result, these activities frequently rely on goodwill, creating capacity constraints. In addition, proposals to strengthen QA processes, such as those in chapter 2 of this report, are likely to require named individuals to oversee,

coordinate and respond to educational concerns. If these responsibilities are to sit with educational leaders, then this work must be formally recognised and resourced.

Many of these reforms will require significant investment, particularly where they depend on protected time being incorporated into job plans and supported by appropriate funding. At a time of financial constraint, workforce shortages and productivity pressures across the NHS, it is understandable that reforms requiring additional investment in training and supervision may be viewed as competing with the immediate demands of service delivery.

These concerns are real. However, they must be weighed against the longer-term consequences of failure to invest in physician training. The expertise and judgement that make today's consultants so valuable to the NHS were themselves developed through investment in their training by previous generations of consultants. There is little reason to believe that the resident doctors of today, who are the consultants of tomorrow, require any less access to consultant expertise during their training than their predecessors had.

Supporting infrastructure

Delivering the training reforms described in this report also depends on adequate educational infrastructure. Some of the recommendations in this report require facilities that are not consistently available: simulation suites, teaching spaces and the digital infrastructure to support modern education. National minimum standards for postgraduate education facilities are needed to ensure that all organisations provide the physical and technical infrastructure that high-quality training requires.

Reduce rotational training to support stable training environments

Training should be organised to maximise continuity of supervision and professional relationships. Frequent or unnecessary rotation can disrupt these relationships, limiting consultants' ability to observe resident doctors' development over time. This does not mean eliminating rotation, or that resident doctors should remain in a single organisation indefinitely. Rather, movement between placements should be purposeful and driven by clear educational need, occurring only where it offers distinct learning opportunities that outweigh any loss of continuity, rather than because rotation is assumed to be beneficial or remains the default model of training.

Geographical rotation remains an important part of training when it provides access to expertise or capabilities that cannot be obtained within a doctor's current placement, or exposure to the different cultures and ways of working across trusts and health boards. There will also be circumstances where doctors request rotation for a range of other legitimate reasons, which should be considered where feasible. However, rotation should be driven by educational need, and every rotation should have a clear educational purpose that is communicated when placements are announced.

Any reduction in rotation must preserve transparent, objective and equitable access to high-quality and specialist training opportunities. Greater continuity must not lead to opportunities being allocated through informal relationships or local patronage, nor should it restrict access for resident doctors based in smaller or less specialised organisations.

One practical approach would be to retain current deaneries, but organise them into smaller 'sub-deanery' geographical training footprints, to ensure a maximum commute of approximately 1 hour. This would allow resident doctors to undertake longer placements within a locality and become more embedded within clinical teams. It would encourage greater organisational investment in development while strengthening continuity of training, supervision and mentorship, and improving resident doctor wellbeing.

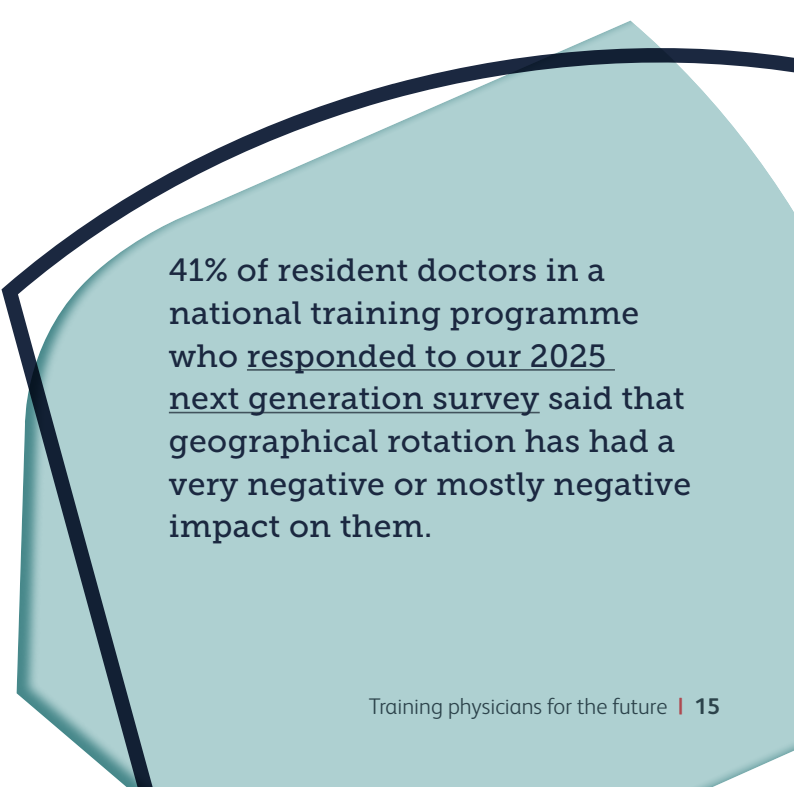
It would also allow resident doctors to develop a better understanding of the communities that they serve. If we are to expect physicians to deliver neighbourhood healthcare, they need opportunities to live in and understand those communities; moving doctors away from the populations that they serve risks losing this valuable local knowledge. Training programmes should be required to demonstrate the educational value of rotations outside these local training footprints, and that such value could not reasonably be accessed close to a resident doctor's base. Where that case cannot clearly be made, rotation should only occur at the resident doctor's request or in exceptional circumstances.

Some training locations have historically been less popular, despite often serving communities with some of the greatest healthcare needs. This proposal must therefore be implemented in a way that does not inadvertently disadvantage organisations in rural, coastal, deprived and other underserved areas. A maximum commute of approximately 1 hour is intended to balance

these considerations. In most parts of England, this would still encompass a sufficiently large geographical area to provide exposure to a range of healthcare settings and patient populations, while reducing unnecessary travel and training disruption. It is also recognised that some locations have historically been less popular because of previous poor training experiences. However, under this model all organisations would remain subject to the same QA processes outlined in chapter 2.

This approach would also require a shift in how educational breadth is achieved, recognising that not all learning objectives require a permanent change in geographical location. Specialist experience can often be delivered through networked models, 'hub-and-spoke' arrangements and short, focused attachments, without requiring frequent relocation.

A more deliberate approach to rotation would also support greater stability and predictability throughout training. Uncertainty about future placements remains a significant source of frustration for many resident doctors. Late notification of rotations, work schedules and rotas creates avoidable disruption and can make flexible working arrangements more difficult to achieve. Resident doctors should receive information about their anticipated geographical placements as early as practicable, ideally across the training programme rather than one placement at a time. Detailed work schedules and rotas should then be provided sufficiently far in advance to enable meaningful personal and professional planning. Training programmes should recognise that predictability is not separate from wellbeing. Stability allows doctors to organise their lives, engage with training opportunities and make career decisions more effectively.



41% of resident doctors in a national training programme who responded to our 2025 next generation survey said that geographical rotation has had a very negative or mostly negative impact on them.

Recommendations

- 1.1 Resource NHS organisations to provide sufficient staffing levels to deliver quality training. This must be an increase on the currently recognised minimum 'safe staffing' levels.
- 1.2 Ensure that protected educational activity is embedded within routine clinical workflows and recognised as a core component of service delivery that cannot be displaced by service pressures. Each resident doctor should have access to at least two half-day protected training experiences each week, which are rooted in clinical work.
- 1.3 Minimise the completion of activities undertaken by resident doctors that provide limited educational value, where alternative workforce models or digital capabilities can safely support delivery.
- 1.4 Identify the key skills most valuable to each placement and deliver training for these through structured, intensive training at the start of each rotation.
- 1.5 Evaluate training programme and rota design to facilitate re-establishing strong team structures based on effective supervision and continuity of relationships.
- 1.6 Ensure that educators and educational leaders have protected, appropriately remunerated time to deliver high-quality training, with erosion of educational activity monitored through exception reporting and used as an indicator of educational capacity and quality.
- 1.7 Support educational supervisors through clear national standards, ongoing professional development and robust feedback mechanisms, including anonymised, aggregated resident feedback to inform improvement and accountability.
- 1.8 Ensure that all resident doctors have access to voluntary mentoring, separate from educational supervision, with organisational support to help them identify mentors who meet their individual needs.
- 1.9 Introduce national minimum standards for postgraduate education facilities, including simulation, teaching space and digital infrastructure.
- 1.10 Reduce unnecessary rotational training by moving towards longer placements in smaller geographical training footprints, while preserving transparent and equitable access to specialist experience and ensuring that rotations occur only where they offer clear educational value.
- 1.11 Provide resident doctors with placement details at least 12 weeks in advance, work schedules 8 weeks in advance and rotas 6 weeks in advance, with compliance monitored as an indicator of training quality.



Making training visible, measurable and accountable



Education must become a core NHS priority

Postgraduate medical training should be recognised as a core NHS function at national, regional and trust levels, with educational quality treated as a corporate governance responsibility rather than delegated to education teams. All organisations involved in training should be expected to demonstrate the same level of accountability for educational outcomes as they do for operational performance, financial stewardship and patient safety objectives, recognising that, in line with the [quality strategy for NHS-funded care in England](#), a high-quality physician workforce is fundamental to the delivery of high-quality patient care.

At present, responsibility for training is distributed across statutory education bodies and their regional teams, royal colleges, regulators and employers. While each has an important role, this shared responsibility and a lack of joined-up working can make it difficult to identify who is accountable when training quality deteriorates.

For example, in [physician training](#), the Joint Royal Colleges of Physicians Training Board (JRCPTB) and General Medical Council (GMC) are responsible for developing/defining and regulating training curricula respectively, yet with limited influence over the delivery of what they set out. Statutory education bodies and their regional teams are responsible for overseeing the delivery of training and QA of how well that training achieves the set curriculum outcomes, but they do not set curricula or directly deliver training. The training curriculum is then delivered in disparate locations by a multitude of autonomous local organisations.

Consequently, no single organisation possesses both the authority to define training standards and the levers to ensure that they are delivered. This fragmentation creates a disconnect between educational ambition and operational responsibility, with a resulting potential for significant differences between the training intended by the curriculum and that delivered to resident doctors. While the governance arrangements appear coherent on paper, they break down when training quality deteriorates. As a result, educational problems have persisted despite being recognised repeatedly at local, regional and national levels.

This report does not propose that responsibility for postgraduate medical training should sit within a single organisation. Instead, we recommend simplifying the

system and establishing clear, unambiguous, transparent lines of collaboration and accountability between the organisations involved. The precise nature of these channels is beyond the scope of this report, particularly given the upcoming abolition of NHS England and a lack of certainty about the DHSC structures that will replace it.

Current quality assurance mechanisms

The [NHS England education quality strategy and framework](#) sets out NHS England's statutory duty to secure continuous improvement in the quality of education and training. This improvement is intended to be reinforced through the [education funding agreement](#), which links educational funding to QA. Training providers are required to demonstrate compliance with these standards through the [Provider Self-Assessment](#) process and wider QA arrangements. In principle, educational funding should therefore be contingent on compliance with agreed quality standards.

In practice, however, this relationship has not been consistently realised, reducing the effectiveness of the framework in driving improvement where standards are not met.

Surveys such as the [GMC national training survey](#) and the NHS England [National Education and Training Survey \(NETS\)](#) are central components of the current QA framework, providing opportunities for resident doctors to give feedback to the system. However, under current QA processes, the threshold for intervention at GMC and NHS England level is still relatively high.



Fewer than half (44%) of resident doctors who [responded to our 2025 next generation survey](#) were satisfied with their clinical training.

The metrics used are not sensitive enough to identify more nuanced but persistent educational deficiencies such as absent supervision, frequently cancelled teaching, late rota publication or repeated loss of protected educational activity before they become embedded within training environments. On their own, these examples of poor educational quality may not individually trigger formal intervention, yet collectively, they can have a substantial impact.

Concerns may also be identified only after resident doctors have rotated, limiting opportunities to improve training for those currently affected. Even if problems are identified, the mechanisms available to drive improvement, despite those outlined in the [education quality strategy](#), are often limited in their effectiveness. As a result, low-quality training environments can persist for prolonged periods without meaningful change. A more effective QA system should therefore place less reliance on annual snapshots, and greater emphasis on continuous transparent monitoring that enables concerns to be identified and addressed before they become entrenched.

Exception reporting (ER) is a potentially powerful mechanism for identifying and addressing deficiencies in training, as it provides a more sensitive means of detecting emerging concerns and patterns, yet it remains significantly underutilised. Although recent contractual reforms in England have led to workplaces increasingly encouraging resident doctors to use ER, translating this into routine practice requires a sustained and supported transition in organisational culture.

ER must be understood not as a failure or an individual grievance, but rather as an essential component of QA and service improvement, giving resident doctors a structured means of identifying systemic problems and contributing to their resolution. ER generates objective data that are harder to dismiss than anecdotes alone and, as such, provides a measurable indication of a problem.

Importantly, the frequency of ER should be interpreted in context: while a high number of reports might initially appear to indicate a poor or deteriorating training environment, it can also indicate that resident doctors feel psychologically safe to raise concerns, and confident that these will be acted upon. Quarterly reports from [guardians of safe working hours](#), submitted to NHS England, should form a key component of any future QA framework.

Future national QA mechanisms

Given the deficiencies in the current QA mechanisms, we recommend the development of a strengthened and updated national QA framework to support training reform. This framework should be more responsive than the current system, identifying concerns at an earlier stage, driving continuous improvement at both local and national levels, and creating meaningful accountability where problems persist.

The current QA framework does, in many cases, already set out quality criteria that describe what good training should look like, and so the strengthened framework should build on, rather than duplicate, these existing standards.

Central to this approach should be the addition of a small set of specialty-specific additional educational key performance indicators (KPIs), intended to provide early warning of a poor or deteriorating training environment. The KPIs should be co-produced with resident doctors and should focus on the things that a functioning training environment can realistically and quickly implement without extra funding, such as access to educational supervision or attendance at protected teaching. The KPIs should be reported every 6 months and sit alongside the current provision for reporting ER data, so that resident doctors see the results of change in a timely fashion.

Crucially, the number of metrics should be kept deliberately small, with a focus on those most closely linked to training quality and outcomes: there should be no more than five KPIs for each specialty grouping, such as medicine, surgery or anaesthetics. This would keep the cost of monitoring low and emphasise that their purpose is to supplement the existing structure, rather than replacing it. KPIs should be sufficiently clear and consistent to support meaningful scrutiny at trust or health board level, while remaining sensitive enough to identify variation between specialties and training environments.

The value of such KPIs lies in what they predict as much as what they measure, as they act as an early warning system: a trust that will not release its resident doctors for regional teaching, for example, is unlikely to be delivering the more demanding and costly aspects of training. Measured frequently, published openly and compared between organisations, they give those responsible for training quality at the local, regional and national levels an immediate and objective picture of the training environment. This in turn makes it possible to identify excellence, reduce unwarranted variation and hold organisations to account.

An updated and improved QA framework must do more than restate expectations: it must measure them often enough to matter, and connect them to improvement and accountability in ways that it currently does not. For example, NHS Education for Scotland's [Scottish Training Survey](#) collects feedback on each training post throughout the year, rather than at a single annual timepoint, providing a practical example of more frequent quality monitoring within an established training system. There is scope to build on and adapt such models across the four nations.

QA at regional level

Statutory education body regional teams should hold responsibility for overseeing organisational performance, coordinating support and agreeing improvement plans where concerns are identified for trusts within each respective region. They should have sufficient independence, expertise and authority to challenge individual providers, while remaining close enough to local services to understand the causes of poor performance and support practical improvement.

QA at departmental and trust level

Every department that employs resident doctors should have a designated education lead with responsibility for the quality of training within that department. While the assurance mechanisms described throughout this chapter provide important oversight and accountability, those closest to training delivery are often best placed to identify both barriers to high-quality training and opportunities for improvement. Departmental education leads should therefore be given sufficient agency to implement solutions that reflect their local circumstances.

The KPIs proposed in this report should be assessed at a departmental level, creating clear accountability for improvement where change is most likely to be effective. As these measures are intended to support change through relatively low resource, they should encourage departments to focus on practical improvements within their own control, rather than relying solely on system-level intervention. This approach promotes local ownership of training quality, while ensuring that performance remains transparent and subject to external scrutiny.

Each education lead should report to a trust medical education faculty. This should be chaired by the director of medical education and include departmental

education leads, resident doctor representatives and medical education managers. The faculty should meet at least every 6 months, oversee local educational KPIs, national survey results and ER data, and be accountable to the trust board for educational performance. To ensure that the training of resident doctors is afforded the same scrutiny and accountability as operational and financial performance, trust and health board leaders should receive regular reports on resident doctor experience, educational outcomes and progress against improvement plans. A named executive and non-executive lead should be responsible for ensuring that identified concerns are addressed or escalated through regional or national avenues.

Ensuring meaningful accountability

A credible QA framework must combine robust monitoring with a clear and proportionate system of intervention that responds both to the severity of concerns and to an organisation's willingness and ability to address them. Where training falls short, the first response should be support and remediation, not the removal of resident doctors or funding.

This is important because withdrawing resident doctors from a struggling organisation can create a downward spiral. Removing doctors reduces workforce capacity, increases service pressures and can further undermine the training environment. This is particularly concerning where poor training environments overlap with rural, coastal, deprived and other underserved areas. Many resident doctors go on to become consultants and senior clinical leaders in the communities where they train. Removing training opportunities therefore risks worsening workforce shortages in areas that already face significant recruitment and retention challenges. While no organisation should be permitted to remain educationally inadequate because of its geographical location, the priority should be supporting and investing in improvement.

To support this approach, the framework should establish a clear escalation pathway, progressing from support and remediation at local level, through enhanced regional oversight and more frequent external review, to sanctions where an organisation persistently fails to address identified concerns. Withdrawal of resident doctors should remain a last resort, used only where the training environment is unsafe or where sustained improvement has not been achieved despite repeated opportunities for remediation.

The hardest case, and the one that the current system handles least effectively, is the organisation where the training is mediocre or poor, but not unsafe enough to justify the withdrawal of resident doctors. Regulatory intervention is typically reserved for the most serious concerns, while financial penalties can be counterproductive, as poor training environments often reflect wider resource constraints, and penalties may further weaken the conditions needed for improvement. There is no single solution, but two mechanisms could help drive improvement in this middle ground.

The first is transparency. Regular publication of a small number of comparable KPIs can create reputational pressure: an organisation that is a visible outlier faces consequences that an invisible outlier does not.

The second is accountability for improvement, rather than performance alone. An organisation should not be penalised simply for having a problem, but for failing to address it. Escalation should therefore be triggered by failure to deliver against an agreed improvement plan, rather than by the existence of the problem itself. This directs pressure towards organisations that fail to improve, while supporting those that are engaging constructively with remediation and support. Throughout, progress should be assessed primarily through the experience of resident doctors themselves, rather than organisational self-assessment. The experience of those receiving training is ultimately the most reliable indicator of whether meaningful improvement has been achieved.

Recognition should sit alongside escalation. One suggestion would be that organisations demonstrating training excellence could be fully accredited, while those meeting minimum standards but with scope for improvement would receive developmental accreditation and targeted support. Where training is excellent, the priority should be to identify, understand and replicate what works. Accreditation would be based on the experience of resident doctors, not organisational size or status. A district general hospital and a teaching hospital would be held to, and be able to demonstrate, the same standard. The details of this approach would require further consideration and engagement with educators, employers and resident doctors, but its core purpose

should be to recognise excellence, support improvement and give resident doctors confidence that training quality is being assessed consistently across the NHS.

Ensuring that educational funding delivers educational outcomes

Educational reform cannot be achieved without confidence that funding designated for training is being used for its intended purpose. Significant public investment is made in postgraduate medical education through educational tariff funding each year, yet there remains limited visibility over how this funding is allocated and spent within individual organisations. Greater transparency is essential to protect educational quality, strengthen accountability and ensure that training investment is translated into high-quality learning environments.

Organisations receiving educational funding should be expected to demonstrate clearly how these resources contribute to training. This should include transparent reporting on the percentage of total educational funding that was invested in supervision, educator time, educational facilities, administration, recruitment, assessment, resident doctor support and protected educational activity. Greater transparency would improve accountability and help identify examples of effective practice that could be replicated elsewhere.

To support this approach, organisations should be prepared to undertake routine educational funding audits each year, requiring them to demonstrate that educational funding is supporting agreed training outcomes and educational standards. The purpose should be to ensure that funding designated for education can be traced to educational activity and that investment in postgraduate training remains protected during periods of financial pressure.

Recommendations

- 2.1 Simplify the governance of postgraduate medical education by defining unambiguous lines of responsibility, accountability and oversight across all organisations involved in training.
- 2.2 Support trusts and health boards to foster a culture in which resident doctors feel safe to raise concerns, repositioning ER as a core QA and improvement tool. ER data should be used proactively to drive improvements in both training and service delivery.
- 2.3 Establish a strengthened national training QA framework, co-developed with resident doctors, with the addition of a low number of specialty-specific KPIs.
- 2.4 Preserve regional QA structures that enable regional teams to provide targeted support and intervention to trusts and health boards where educational outcomes, resident feedback or failure to deliver agreed improvements indicate a need for action.
- 2.5 Appoint a designated education lead in every department that employs resident doctors and ensure that they have the agency to drive departmental improvement.
- 2.6 Support every trust and health board to establish a medical education faculty that reports to the trust board, meets at least every 6 months to review local KPIs, ER and national survey data alongside other concerns, and escalates unresolved issues through regional structures.
- 2.7 Ensure that trust- and health board-level KPI data are reported transparently, reviewed at least every 6 months by named local and regional leads, and supported by a clear regional process for agreeing improvement plans, monitoring delivery, and escalating concerns where organisations fail to demonstrate sustained improvement.
- 2.8 Make postgraduate medical education a standing component of trust and health board governance, with named executive and non-executive responsibility and regular consideration of educational performance alongside workforce, quality, patient safety, operational and financial performance.
- 2.9 Ensure that resident doctor feedback is central to evaluating the effectiveness of local improvement efforts.
- 2.10 Introduce proportionate escalation in trusts and health boards where training concerns persist or agreed improvements are not delivered.
- 2.11 Consider introducing a tiered accreditation framework that recognises excellence in postgraduate medical education, distinguishes organisations meeting expected standards, and identifies those requiring further improvement.
- 2.12 Ensure that trusts receiving educational funding publish transparent information on how resources intended for training are spent.
- 2.13 Be prepared at a trust level to undertake annual audits of educational funding to improve accountability and protection investment in training



Modernising assessment and training progression



A more flexible and capability-based approach to progression

Although training curricula increasingly emphasise capabilities and outcomes rather than time served, much of the training system remains anchored to fixed training durations and annual progression points. While this approach provides consistency, it fails to reflect the reality that doctors develop at different rates, and increasingly follow diverse and non-linear training pathways. Modern postgraduate medical training should therefore adopt a genuinely capability-based model of progression, with advancement determined by demonstrated competence rather than time served alone.

A capability-based model still recognises the importance of time in training to ensure exposure to an adequate breadth and volume of clinical experience. Similarly, it does not remove the requirement for satisfactory completion of postgraduate examinations. Rather, it acknowledges that some resident doctors achieve capabilities more quickly than expected, while others require additional support and experience in certain areas. Neither should be viewed as exceptional.

For capability-based progression to be safe and equitable, it must reliably distinguish between resident doctors who genuinely need additional time to achieve competence, and those who have been denied sufficient training opportunities. Additional time should support the attainment of required capabilities, not compensate for deficiencies in the training provision. Application of the QA systems outlined in chapter 2 is essential in making this distinction. In addition, ongoing analysis should monitor variation in training duration and progression rates, and assess how these relate to training quality and educational outcomes. Such evaluation will be essential for QA of capability-based progression and to identify any unintended consequences.

The case for a greater focus on capability is not simply that a time-based system lacks flexibility. Time served is an imperfect measure of competence, and the current workplace-based assessment and portfolio architecture has not fully addressed this limitation. Despite a substantial increase in assessment and portfolio requirements over the past 2 decades, there is little evidence that these increased requirements have delivered a corresponding improvement in training quality or assessment.

A capability-based model should not mean more assessments or more paperwork. Its purpose is to strengthen the quality of evidence and professional

judgement that inform progression decisions, not to increase the volume of portfolio evidence that resident doctors are required to produce.

Using time in post as a proxy for competence could potentially allow a doctor to progress before they are ready, with implications for patient safety. On the other hand, it could delay the progression of a doctor who has already demonstrated the required capabilities. Neither outcome serves patients, doctors or the NHS. A capability-based model, underpinned by sensible minimum and maximum levels of clinical exposure, would allow timely progression for those who are ready while maintaining appropriate safeguards for patient safety. Retaining indicative programme lengths would continue to provide resident doctors, trainers and employers with the predictability needed for life planning, educational supervision and workforce planning. However, progression itself should be determined by the demonstration of defined curricular capabilities, rather than time served alone.

In addition, it is essential that capability-based progression is not conflated with the idea that medical training can be reduced to the completion of a series of discrete tasks. This distinction is particularly important in the context of the [NHS 10 Year Health Plan for England](#) and its proposed ‘skills escalators’, which suggest a move towards greater autonomy across professional groups.

Capability in the context of physician training is far more than the successful completion of a series of tasks. The current JRCPTB curricula for [stage 1](#) and [stage 2](#) IMT training set out capabilities in practice (CiPs) that describe professional responsibilities requiring clinical judgement, management of uncertainty, synthesis of complex information and accountability for outcomes. Attainment of these broad professional capabilities must remain central to progression decisions.

Capability-based training is not about equipping doctors to perform a range of tasks, but about them developing the expertise to determine when a task or protocol is appropriate, when it is not, and what should happen instead. It is this ability to manage complexity, uncertainty and risk, developed through the breadth and depth of medical training, that distinguishes the physician’s role within the MDT, and must remain central to decisions surrounding progression.

Capability-based progression is therefore not a simple change. Reliably assessing capability is challenging, which is largely why the system has historically leaned on time as a convenient proxy. Done poorly, through inconsistent supervision, superficial assessment or judgements that vary

between assessors, a capability-based model could prove less rigorous and less equitable than the system it replaces. Greater flexibility in progression must not come at the expense of consistency. The standards, processes and evidence used for progression decisions must be applied consistently to minimise unwarranted variation, while still allowing individuals to progress at different rates.

This is why the reforms proposed in this chapter (and throughout this report) on assessment, educational supervision and QA are not adjuncts to capability-based progression, but prerequisites for it. The remainder of this chapter sets out how progression and assessment must change together if demonstrated capability is to become a credible basis for advancement.

The value of good educational supervision

Moving towards a capability-based model requires assessment approaches that are both reliable and valid. This should involve placing greater weight on supervisor professional judgement, longitudinal evidence and meaningful discussion, rather than relying predominantly on individual assessment events. When educational supervision is done well, supervisors are often able to provide a more complete picture of a doctor's development over time. The success of any capability-based system will therefore depend on the quality and consistency of educational supervision. If progression decisions are to rely more heavily on professional judgement and narrative evidence, investment in the capability, training and support of supervisors becomes essential.

Reliability comes not from standardising every individual assessment, but from triangulating multiple sources of evidence: observations from different assessors, gathered over time and considered holistically. Any single judgement may be subjective, but an accumulation of longitudinal evidence provides a more robust and reliable basis for progression decisions.

A system that depends on supervisors knowing resident doctors well, and providing rich, honest developmental feedback, cannot function where supervision is inconsistent, under-resourced or reduced to a portfolio exercise. Nor can it function where resident doctors rotate so frequently between organisations that meaningful educational relationships cannot be established. The reforms to educational supervision and rotational training outlined in chapter 1 are therefore essential prerequisites for assessment reform.

Greater reliance on professional judgement also carries a risk that must be actively managed. Subjective judgement is more vulnerable than standardised metrics to unconscious bias, and there is well-documented evidence of [differential attainment in postgraduate assessment](#), with doctors from ethnic minority backgrounds and those who qualified overseas achieving poorer outcomes at key progression points, even after other factors are accounted for.

A shift towards narrative, judgement-based assessment must not entrench these inequities. The same triangulation that improves reliability is also a safeguard here: judgements drawn from multiple assessors over time are less exposed to the bias of any single individual than a decision resting on one relationship. Assessment and progression processes should be designed, and their outcomes monitored, to identify and reduce differential attainment.

Progression point reviews

The ARCP remains the principal mechanism through which progression decisions are made. However, many resident doctors describe the process as overly administrative, impersonal and lacking transparency. Decisions are often made *in absentia* and can feel distant from day-to-day clinical performance, and variation in processes can contribute to inconsistency.

Historically, in some programmes, progression reviews have operated as a two-stage process: a summative ARCP responsible for determining the progression outcome, followed by a separate developmental discussion focused on feedback, planning and support. Whether progression point reviews are delivered through a single process or a distinct summative and developmental review, the central focus must be the demonstration of capability required for increasingly independent practice or the next stage of responsibility, and not simply whether a resident doctor has completed a set number of forms, assessments or months in training. Crucially, progression decisions must be holistic, but firmly grounded in the available evidence.

Just 29% of resident doctors who [responded to our 2025 next generation survey](#) said that they found the ARCP process useful, while 45% judged it ineffective.

Where competence is not clear, mechanisms must be in place to pause progression and allow resident doctors the support and experience that they need to achieve competence. This would allow programmes to recognise excellence and accelerated development where appropriate, while also supporting doctors who require targeted additional experience.

Resident doctors should have greater visibility of how decisions are reached and more opportunity to contribute to those discussions. While progression panels should retain space to review evidence, and deliberate independently on a progression decision, resident doctors should have a face-to-face or virtual opportunity to discuss the outcome with the panel or within a separate, dedicated post-panel debrief. Resident doctors should be supported to understand the rationale for decisions and contribute to discussions about their subsequent development and support needs, to ensure that there is a focus on looking forward as well as back. This would strengthen confidence in the fairness and consistency of progression outcomes, while improving educational value.

Current progression arrangements are often constrained by annual review cycles that do not always align with individual readiness for progression. Missing a review point can result in unnecessary delays, while doctors who demonstrate capability early may have limited opportunities to progress more quickly. Quarterly ARCP windows should be introduced throughout the year for all specialties, with appropriate extra resourcing and funding.

This change would allow progression decisions to align more closely with evidence of capability, rather than with administrative timetables. Importantly, greater flexibility should not mean lower standards. The purpose is to ensure that progression is determined by demonstrated capability and educational need, rather than by arbitrary dates within the training calendar.

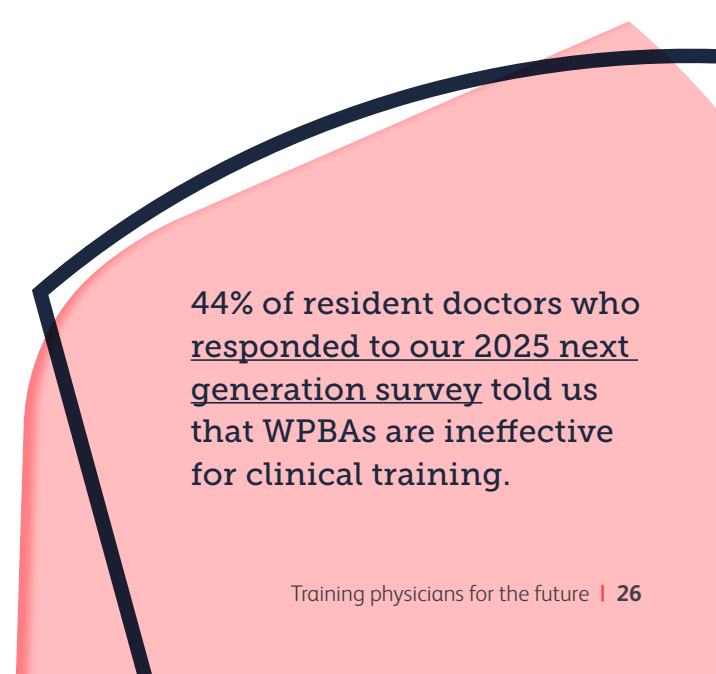
Workplace-based assessment should support learning, not compliance

When used as intended, WPBAs such as case-based discussion (CBD), mini-clinical evaluation exercise (mini-CEX) and acute care assessment tool (ACAT) are evidence-based tools which provide assurance that doctors are developing the knowledge, skills, behaviours and professional judgement required for independent practice. They are designed to support learning, identify areas for development and provide confidence that professional standards are being met.

However, there is a significant gap between how these tools are intended to function and how they are experienced and completed in practice. This is analogous to a drug whose performance in a clinical trial, with a controlled environment and enhanced monitoring, is not fully replicated in the messy reality of a real-world clinic. Many resident doctors report that, like ARCPs, WPBAs are experienced as administrative requirements rather than meaningful educational interventions and, consequently, are viewed as tasks to be completed rather than a process that actively supports professional development. Often, assessments are completed retrospectively and without in-person dialogue, and generate limited developmental feedback. In these circumstances, the quantity of assessments can feel more important than the quality of learning that they support.

While these shortcomings often reflect pressures on educator time, they reinforce a central theme of this report: training must be recognised as a core NHS function and given the time, resource and priority required to deliver it effectively.

WPBAs should remain a core component of physician training, but their educational value must be strengthened if they are to fulfil their intended purpose. If assessments are not being undertaken and utilised in the way that they were designed, the reliability of the evidence used to support decisions must be questioned. WPBAs should be refocused on direct observation where appropriate, followed by meaningful educational dialogue and rich narrative feedback. The objective should be to improve the quality of assessment, not the quantity of completed forms.



44% of resident doctors who responded to our 2025 next generation survey told us that WPBAs are ineffective for clinical training.

This approach would also better support reflective practice, which is an essential component of professional development and one that becomes increasingly crucial as resident doctors progress from supervised to independent practice. The ability to critically reflect on experiences and learn from incidents is fundamental to improving the quality and safety of patient care.

However, reflection within the current [ePortfolio](#), particularly when confined to a formulaic four-box format, does little to replicate the value of a genuinely meaningful reflective conversation. Reflective practice is better developed through structured discussions that enable meaningful learning and inform future practice. Structured, facilitated reflective forums, such as [Balint groups](#) and [Schwartz rounds](#), offer a model for how this could be achieved.

By providing protected time and space to discuss the emotional and professional challenges of clinical work, these forums support the kind of genuine reflection that improves both practice and wellbeing. Opportunities like this should be integrated into training programmes as a core part of how reflective practice is developed and valued, with protected time for participation within job plans and rotas.

Aligning training progression with workforce need

Workforce planning must anticipate and accommodate the increased complexity of rotation design associated with capability-based progression. Training capacity and consultant workforce planning should be more closely aligned, with national education bodies, governments and the NHS planning training posts and consultant roles in parallel. This will help ensure that growth in training capacity keeps pace with increases in medical school places and recent expansion at core training level.

Workforce planning should also be informed by population need at local, regional and national levels, taking account of the growing number of people living with multiple health conditions and frailty, as well as the future balance between hospital- and community-based models of care.

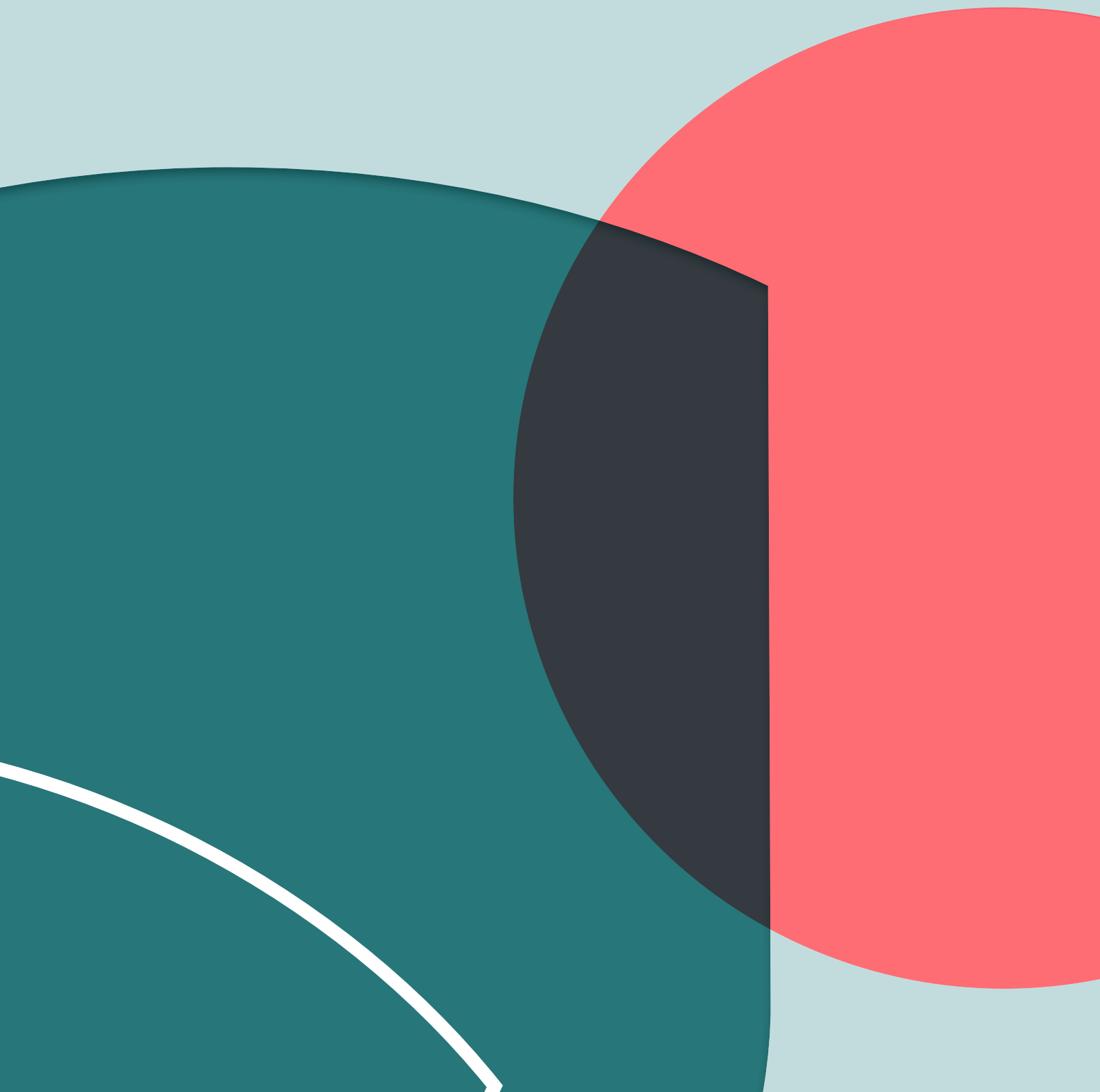
Together, these factors should guide workforce and training expansion, reducing the risk that resident doctors experience avoidable delays in progression because of capacity constraints within the training system or a lack of available consultant posts

Recommendations

- 3.1 Embed a capability-based approach to progression, supported by nationally consistent pathways for accelerated progression, indicative programme lengths, minimum clinical exposure requirements, and safeguards to ensure that additional training time is not used to offset deficiencies in training provision.
- 3.2 Ensure that progression decisions are based on the holistic review of triangulated, longitudinal evidence from multiple assessors, using nationally consistent standards and processes that are monitored to minimise variation and differential attainment.
- 3.3 Reform ARCP processes so that they are transparent, developmental and centred on professional judgement, introducing quarterly review opportunities so that progression can align with demonstrated capability, rather than fixed annual dates.
- 3.4 Refocus WPBA on direct observation, feedback and reflection to ensure that subsequent progression and entrustment decisions are supported by robust evidence of capability.
- 3.5 Integrate structured opportunities for reflective practice, with protected time for participation.
- 3.6 Ensure that workforce and training capacity are planned together, taking account of capability-based progression, population need and future service demand, so that doctors can progress without unnecessary delays caused by capacity constraints or a lack of available consultant posts.



Supporting career flexibility and doctors outside training



Flexible careers require flexible training

Medical careers no longer follow a single, linear pathway. Doctors increasingly pursue diverse training routes, including less-than-full-time (LTFT) training, research, out-of-programme (OOP) opportunities, movement between formal training and locally employed posts, and leadership or educational roles alongside clinical practice. The future of training must reflect this reality.

At the same time, flexibility must be balanced with the operational needs of the NHS. The goal should be to create training pathways that are more adaptable to individual career choices, while retaining sufficient structure to support service planning and high-quality patient care.

A more personalised training system offers significant benefits, but it also risks creating variation and contributing to lack of continuity in care. Doctors in different specialties, regions or organisations should not experience fundamentally different standards of training because flexibility has been implemented inconsistently. National standards must underpin local flexibility. Every doctor should be entitled to a good training experience, regardless of geography, working pattern or employment status.

Less-than-full-time (LTFT) working

LTFT working is now a mainstream feature of the medical workforce, rather than an exception. Consequently, training systems that have been largely designed around traditional full-time career models must adapt.

Flexibility must become a core feature of training design, rather than an accommodation for those whose training pathway differs from the traditional model. Training programmes should make greater use of approaches such as self-rostering, flexible study and development time, job-sharing arrangements and other models that support individual circumstances while maintaining educational standards. These approaches should, wherever possible, preserve continuity in teams, supervision and learning relationships. Longer placements and reduced rotation should help balance flexibility with educational quality.

The growing prevalence of LTFT working should also prompt responsible education bodies to examine why so many resident doctors are choosing to train LTFT. For some, this reflects childcare or other caring responsibilities, and there has also been a wider

generational shift towards more flexible approaches to work. The increase is also likely to reflect the relaxation of the eligibility criteria previously associated with LTFT training. However, it may also indicate that some resident doctors do not believe that full-time training can be undertaken sustainably within the current system, highlighting the importance of creating training environments that are both high quality and compatible with a healthy working life.

While LTFT working can provide an important means of supporting doctors to remain in training and in the workforce, relying on a resident to reduce their working hours to manage burnout places the burden of an unhealthy working environment on the individual. Rising demand for LTFT training should prompt a closer examination of the factors driving this trend, including aspects of the training and working environment that may be contributing to it. LTFT working should be a positive and supported choice rather than, in some cases, a necessary response to an unsustainable working environment.

These trends also have important implications for workforce planning. Unless the growing prevalence of LTFT training is fully reflected in workforce modelling, future workforce capacity will be overestimated. The RCP has long campaigned for the expansion of training posts; however, as working patterns change, increasing the number of funded posts alone will not necessarily deliver a corresponding increase in workforce capacity if a growing proportion of resident doctors train LTFT. Workforce planning must anticipate both growth in training numbers and changes in how doctors choose to train and work.



Nearly half (47%) of resident doctors who responded to our 2025 next generation survey told us that they wanted to work LTFT in the future.

Greater access to LTFT training should therefore be accompanied by workforce planning approaches that account for its impact on whole-time equivalent (WTE) capacity. One potential solution is the routine use of WTE-based recruitment targets. For example, a training programme requiring the equivalent of 10 WTE resident doctors could recruit more than 10 individuals, where a proportion are expected to train LTFT. This would help maintain workforce capacity while preserving access to flexible training arrangements.

Such an approach would require organisations to hold a degree of risk, and may have short-term financial implications if anticipated working patterns change. However, these costs may be offset by improved rota stability, a reduction in rota gaps and reduced reliance on locum cover.

National guidance would help ensure that approaches such as over-recruitment or slot-sharing are applied consistently and equitably across training programmes and regions. Understanding both the drivers of LTFT training and its implications for WTE capacity will be essential to developing a sustainable medical workforce.

Support career development outside formal training

The relationship between training and service roles has evolved to become more integrated. Across the NHS, many doctors develop substantial clinical expertise, leadership skills, teaching experience and specialist capabilities while working outside formal training programmes.

LEDs and SAS doctors are a vital and rapidly growing part of the medical workforce, and their contribution must be better acknowledged through clearer career planning, better recognition of skills and experience, and consistent guidance on progression. Doctors should be able to develop and demonstrate meaningful capabilities regardless of their employment status, and capability gained outside approved training programmes should count towards progression where equivalent standards can be demonstrated. Recognition processes should be transparent, fair and consistently applied. Although mechanisms such as gap analysis exist to support this, their use remains inconsistent. The result is avoidable variation in how prior experience and demonstrated capability are recognised, creating inequity for doctors following different training and employment pathways.

Locally employed roles have a distinct and valuable purpose, with many doctors working within the same

specialty or organisation for extended periods. This can provide greater continuity and institutional memory, stability of location, and opportunities to develop deeper specialist knowledge and experience, while often having fewer out-of-hours commitments. These benefits can support both individual development and high-quality patient care.

National training numbers and national recruitment exist to ensure access to high-quality training, and to prevent the inconsistency and inequity of a purely local recruitment and selection process; these protections must be preserved. Structured training pathways must continue to offer a distinct and straightforward route to certification and consultant practice, or there will be little incentive to enter them. Development opportunities for doctors outside formal training programmes must complement, rather than weaken, the educational protections, supervision and QA associated with postgraduate training.

Our ask is not to blur the distinction between formal training posts and locally employed roles, or to undermine the national training systems that provide a steady pipeline of future consultants equipped to deliver expert patient care. What we are asking for is more nuanced: that doctors working outside formal training are properly supported to develop, and that the capability they build is fairly and transparently recognised, whether they choose to re-enter formal training or not.

Ensuring equitable support outside formal training

Despite the value that LEDs add to the NHS, access to supervision, development opportunities and career support remains inconsistent. Every doctor should have access to meaningful professional development, regardless of whether they are working within a formal training programme. There is no such thing as a non-training doctor.

LEDs should have access to a named supervisor, regular career guidance, and opportunities to identify developmental goals. Appraisal systems should support continuous professional development and be aligned, wherever possible, with broader approaches to career progression and capability development. To be effective, a minimum of quarterly appraisal meetings should be protected in job plans. In addition, minimum national standards for protected and supported learning time and access to study leave should be established, with these being viewed as investments in workforce development rather than optional benefits.

However, enhanced support outside formal training programmes cannot, and should not be expected to, replicate all aspects of postgraduate medical training. Approved training pathways to the certificate of completion of training (CCT) provide specific educational structures, including curriculum oversight, formal progression arrangements and QA, which remain essential to the delivery of specialist training and are not replicable outside formal programmes.

The priority should be to ensure that doctors working outside formal training have equitable access to development opportunities. Phase one of the METR was clear that the educational needs of LEDs must be built into any future model of training, but in a system in which current educational and supervisory capacity is so stretched, it is critical that this is appropriately resourced and funded.

Supporting those new to the NHS

Many LEDs are international medical graduates (IMGs), who make a major contribution to NHS services and form an important part of the future senior doctor workforce. However, IMGs can face additional challenges when first working in the UK, including understanding unfamiliar NHS structures, accessing development opportunities and navigating career pathways.

Greater effort is needed to support doctors who are new to the NHS to understand how its systems operate, and to access the supervision, learning and career development opportunities needed to integrate successfully and progress. There are already many examples of successful local initiatives that support doctors new to the NHS, demonstrating what can be achieved through structured programmes. These approaches should be adopted more widely to ensure that IMGs receive high-quality induction, supervision and career support from the outset, improving their experience, supporting career progression and strengthening future consultant workforce supply.

In the context of legislation that will prioritise UK medical graduates for postgraduate training, and consistent with the wider aim of retaining talented doctors within the NHS workforce, those who wish to pursue training pathways should receive enhanced support to gain the CiPs, experience and protected time required to enter and progress through postgraduate training.

Recording development

Greater flexibility will only succeed if a record of learning can move with the doctor. Current portfolio arrangements often fragment evidence across programmes and career stages. Doctors moving between formal training posts and locally employed posts, undertaking research or OOP experience may find themselves repeatedly recreating evidence or struggling to demonstrate capabilities already achieved.

A single, longitudinal professional portfolio, or ‘training passport’, should be developed to follow doctors throughout their careers. Rather than serving solely as a repository for assessments, it should provide a continuous record of capability, experience and professional development across different roles, employers and learning environments. This would allow learning gained through locally employed posts, research, leadership, education, QI and OOP experiences to be recognised and recorded, supporting a genuinely capability-based approach to progression while reducing duplication and administrative burden.

The passport should also strengthen continuity across training environments and between supervisors. By providing a coherent view of a doctor’s development over time, it would support more meaningful supervision, better mentoring and more informed career development conversations, while reducing the loss of information that can occur as doctors move between roles, organisations and training pathways.

The development of a training passport should be a priority. However, this is not a straightforward technical undertaking, and careful consideration will be needed to bring together the specialty-specific portfolios, while preserving their educational value and distinct requirements.

Today’s resident doctors are increasingly digitally literate and well placed to co-design these solutions. Those with expertise or interest in digital technology, data and system design should be actively involved in the co-production of any future platform. Their contribution should be recognised as a valuable aspect of training and professional development, providing opportunities to demonstrate many of the broader capabilities expected of contemporary physicians.

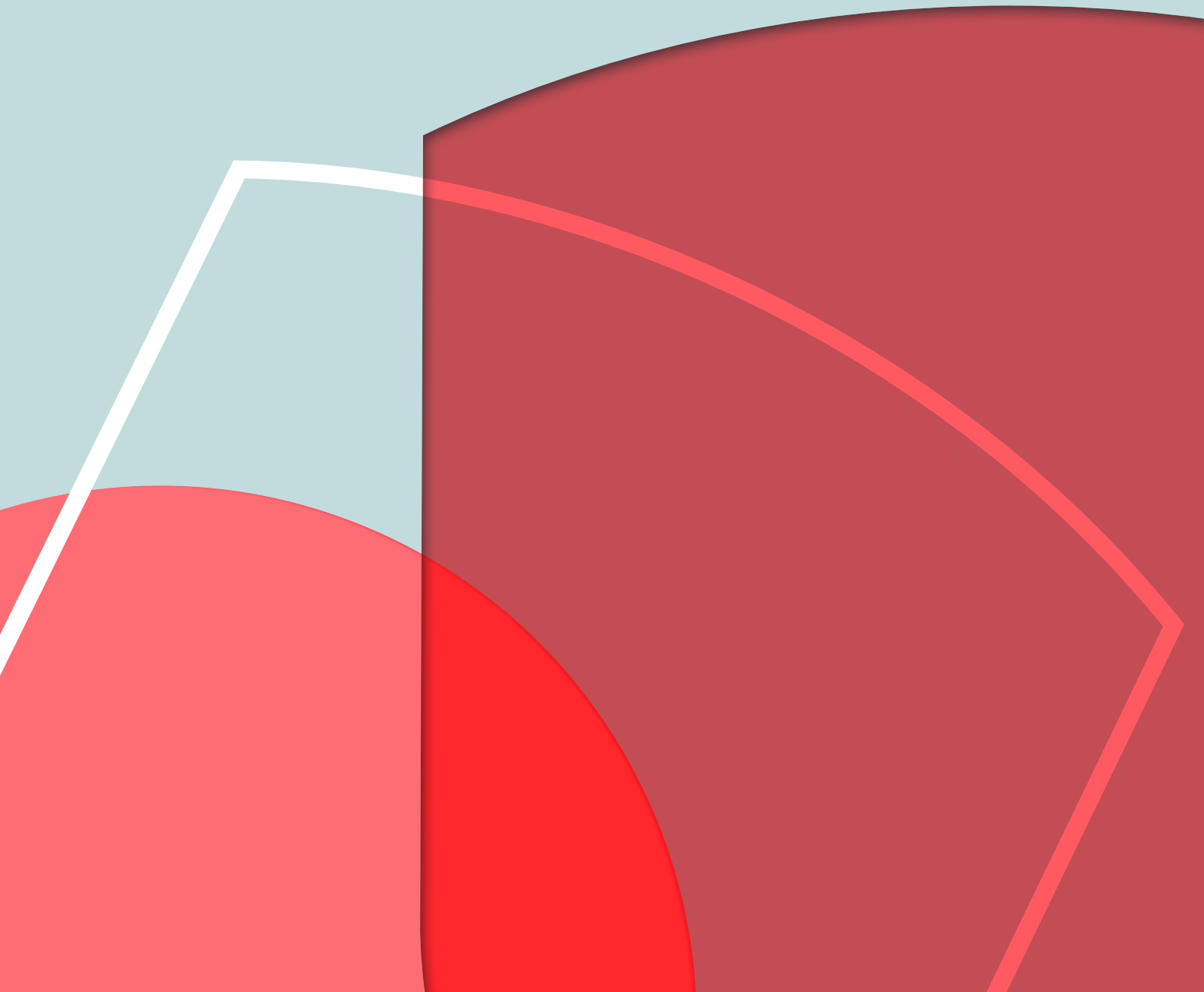
This also illustrates a wider principle: the professional responsibilities described throughout this report should be recognised, valued and capable of being evidenced as part of a doctor’s development, rather than being treated as activities undertaken separately from training.

Recommendations

- 4.1 Protect equitable access to high-quality training, ensuring that flexibility does not create unwarranted variation in educational opportunities or outcomes.
- 4.2 Design training to reflect the modern workforce, supporting greater use of flexible working (including LTFT), self-rostering, job sharing, and flexible study and development time.
- 4.3 Align workforce planning with equivalent WTE capacity to account for increasing LTFT training.
- 4.4 Monitor and address the factors driving the increase in LTFT training, particularly where it is used to mitigate burnout or unsustainable working conditions.
- 4.5 Recognise capability gained outside formal training through transparent, nationally consistent processes based on demonstrated competence, rather than training status or setting.
- 4.6 Provide doctors outside formal training programmes with structured appraisal and nationally consistent recognition of capability that can be transferred between organisations.
- 4.7 Ensure that all LEDs have access to a named educational or professional supervisor, with a minimum of quarterly meetings to support career development, appraisal and progression.
- 4.8 Establish national minimum standards for protected learning time and study leave for LEDs.
- 4.9 Provide doctors new to the NHS, including IMGs, with structured induction and support to understand NHS systems, alongside ongoing support to gain the experience and capabilities to enter formal training programmes, if desired.
- 4.10 Ensure that training and workforce reforms promote fairness and actively reduce barriers faced by internationally trained doctors and other groups at risk of differential attainment.
- 4.11 Develop a single, longitudinal professional portfolio, or 'training passport', that follows doctors across training, employers and career stages, creating a portable record of capability and professional development.



Training doctors for future models of care



The future physician: broad expertise, specialist excellence

Patients are living longer and, increasingly, with multiple long-term conditions. In the years to come, more care will be delivered through outpatient, ambulatory, community and neighbourhood services. Physicians will work across organisational boundaries, lead MDTs, and be at the forefront of growing use of digital technology and AI.

At the same time, medicine will continue to become more specialised, as scientific advances and new technologies expand the range of diagnostic and therapeutic options available. Patients will only benefit from these advances if there are physicians with the specialist clinical, diagnostic and procedural expertise to apply them safely and effectively, underscoring the continuing need for high-quality specialist training.

Future training should build understanding of the entire patient pathway. A physician caring for a person with frailty, heart failure, respiratory disease and diabetes needs to understand how that patient's care moves between acute medicine, specialist clinics, primary care, community services, palliative care and home. Physician training should create opportunities for resident doctors to follow such a care pathway across these settings. Integrated MDT decision making, shared clinics and virtual consultations within neighbourhood teams would help develop the system literacy and leadership skills that future consultants will require, while reducing siloed working.

Communication across pathway transitions is itself a core clinical skill, and one that is frequently undervalued in training. Referrals, clinic letters and discharge summaries underpin the safe coordination and continuity of care across healthcare settings, yet comparatively little time is devoted to teaching resident doctors how to produce them effectively. Poorly constructed clinical communication contributes to delayed follow-up, missed or duplicated investigations, and medication errors. The ability to produce high-quality written clinical correspondence should be explicitly taught and assessed from the foundation programme onwards.

Redefining generalist training

Generalism is sometimes treated as the absence of specialisation. It should instead be understood as a distinct set of expert capabilities that are refined through many years of medical training. For physicians, this involves combining broad medical knowledge with

holistic clinical judgement to manage patients with multiple interacting conditions, navigating complexity, uncertainty and proportionate clinical risk, and being able to make pragmatic, individualised decisions with patients. Generalist physicians coordinate care across conditions, specialties and settings, recognising what they can safely manage themselves, when specialist input is needed, and how to bring that expertise together around the needs of the whole person without fragmenting care.

These capabilities are becoming increasingly important as the population ages, and as growing numbers of people live with multiple health conditions and frailty. Yet despite curriculum changes following the 2013 *Shape of training* review, resident doctors' experience of generalist training often remains narrower than intended. Generalist development is still frequently conflated with, or reduced to, participation in the acute medical take and on-call commitments. While these experiences are important, they are not sufficient on their own to develop the breadth of skills required to deliver high-quality care across inpatient, outpatient and community settings.

The objective should be to develop broad generalist expertise, rather than equating generalist training with time spent on a general medical on-call rota. Doing so is not only educationally restrictive, but increasingly at odds with the vision set out in the *10 Year Health Plan for England*.

Generalist training should begin in medical school and continue through the foundation programme and IMT, providing a strong platform for subsequent specialty development. Training should include outpatient and ambulatory care, management of inpatients with complex conditions whose care involves multiple specialties, multidisciplinary decision making, discharge planning, frailty and transitions of care. These capabilities should continue to be nurtured throughout higher specialist training and into consultant practice, where they remain at the centre of what it means to be a senior decision-maker. The ability to integrate complex information, manage uncertainty, balance risk and make holistic decisions across undifferentiated conditions are defining features of medical training. These capabilities distinguish physicians from other MDT professionals who have not undertaken medical training.

Training should also include experience in areas where physicians increasingly work across the interfaces between acute and general medicine and other specialties. This should include exposure to areas such as surgical liaison, adolescent care and obstetric medicine, where there is currently limited structured exposure for

resident doctors, despite the frequency of interaction with these teams and the significant impact that these interfaces can have on patient pathways. These opportunities are readily available in most, if not all, secondary care settings.

Developing clinical judgement and risk holding

Clinical risk holding should be recognised as a core educational objective throughout training, and developed through supervised decision making, leadership of MDT discussions, management of complexity and uncertainty, and graduated responsibility. The degree of risk holding expected from resident doctors of different grades should be specified in curricula. Assessment systems should place greater emphasis on the demonstration and development of these skills in real-world practice. Resident doctors can learn to better manage risk outside an inpatient environment through outpatient and ambulatory care, hospital at home services, cross-sector MDTs, primary–secondary care collaboration, and follow-up across transitions between hospital and community. However, they must have sufficient exposure to the interface between care environments to do this safely and effectively.

Protecting specialist training

As medicine becomes increasingly specialised, it is essential to maintain an appropriate balance between developing broad generalist capabilities and specialist expertise. Both are essential to high-quality patient care, and training reform must better support their development. Achieving this will require a clearer distinction between training intended to develop broad generalist capability and participation in the general internal medicine (GIM) on-call rota. Although both have value, the educational objectives of training must not be subordinated to service requirements.

The educational requirements of GIM training also need to be more consistently defined and delivered. This could be supported through GIM quality standards at each stage of training, akin to IMT quality criteria, which outline expected educational provision and provide a clear benchmark against which training can be assessed. However, quality standards must achieve more than restating expectations. Compliance against them must be measured, this must be frequently enough to matter, and data collected must be connected to QA, improvement and accountability in ways that they currently are not. This assurance must include where service commitments are routinely exceeding educational need. The updated

QA and ER processes described in chapter 2 must achieve all of this to result in effective improvement.

Current group 1 specialty training programmes incorporate an indicative 12 months of internal medicine stage 2 training within higher specialty training (HST), delivered alongside specialty training through a dual CCT programme. This is intended to encompass a broad range of GIM experience, including inpatient care on specialty wards, participation in GIM clinics, contribution to GIM on-call rotas and involvement in the acute medical take. In practice, however, many resident doctors report that service pressures mean that they are exceeding the indicative 12 months through GIM on-call commitments and acute take involvement alone. This issue is widely recognised across all group 1 HST programmes and is limiting opportunities for resident doctors to develop the specialist capabilities required by their curricula.

The balance between daytime educational activity and out-of-hours service commitments should also be considered explicitly. Out-of-hours work is an important component of training, but excessive commitments can restrict access to the clinics, procedural lists and supervised specialty activities through which many core capabilities are acquired. Training programmes should monitor this balance and demonstrate that resident doctors have fair and proportionate access to both.

In an ideal system, workforce planning would have kept pace with demand, with sufficient doctors to staff GIM on-call rotas while maintaining the intended balance between on-call work and other aspects of generalist and specialty training. This is not the current reality.

One option to establish balance would be more innovative rota design, including periods of ‘block’ training, during which resident doctors undertake dedicated specialty training and dedicated GIM training. In this model, GIM training would not be confined solely to participation in on-call rotas. This would improve continuity in both settings, better protect training opportunities, and help distinguish the GIM experience required for training from the GIM service contribution required by employers.

In addition, any requirement for resident doctors to undertake GIM beyond the current indicative commitment should be justified on educational rather than service grounds. While this may appear ambitious, it reflects the existing curriculum intention. It should also be recognised that the introduction of IMT extended generalist training by a year, reducing the time available for specialty training. Since then, the intended balance has been further eroded by service pressures.

This position is increasingly difficult to sustain. Protecting specialty training while maintaining safe patient care will require a broader pool of doctors to contribute to GIM on-call rotas and a more equitable distribution of these commitments across the medical workforce.

Alongside the urgent expansion of training numbers called for in chapter 1, the system must make better use of the skills of doctors already employed within NHS organisations to relieve pressure on GIM services. The LED workforce has grown rapidly and, where LEDs are not already contributing to GIM rotas, trusts and health boards should consider flexible ways of supporting this. This is not about replacing doctors on training pathways leading to CCT or reducing their exposure to valuable GIM experience. Rather, widening the pool of appropriately skilled doctors contributing to GIM on-call rotas would help distribute workload more evenly across the medical workforce.

Approaches might include employing LEDs at the hospital front door or, where appropriate, incorporating a proportionate GIM commitment into LED job plans. Even modest contributions across such a large group of doctors could provide meaningful additional capacity. This would create greater headroom for doctors in HST to achieve a more appropriate balance between GIM commitments and broader generalist and specialty training. For some LEDs, participation in GIM on-call rotas may also provide valuable opportunities to gain experience, demonstrate equivalent capabilities and strengthen future applications for entry to formal training programmes.

Greater flexibility in how the existing LED workforce is deployed therefore offers a pragmatic short-term response to current pressures. However, it should complement, not substitute for, the longer-term expansion of the medical workforce and the number of posts leading to CCT.

Supporting the transition to senior decision-maker

Doctors in the final year of specialty training should be supported in the transition from supervised resident doctor to senior clinical decision-maker. They should manage clinical risk with increasing autonomy, and gain experience of the wider responsibilities of consultant practice, including clinical governance, educational supervision and service improvement.

This will help ensure that doctors complete training with both the clinical capabilities and the wider professional

skills required for consultant practice. Mentorship could help during this transition, providing senior resident doctors and newly appointed consultants with access to experienced colleagues who can offer guidance, support professional development and facilitate the transition from supervised to independent clinical practice.

Resident doctors dual training in internal medicine who have achieved the required GIM learning outcomes and completed the indicative GIM commitment for their final year of training should have the option of a period of protected specialty training without routine GIM on-call commitments. This would support the development of specialty-specific expertise and better prepare resident doctors for independent consultant practice.

Training for neighbourhood health and integrated care

The shift towards neighbourhood health will change how and where physicians work and, consequently, it follows that it should change how and where physicians are trained too.

There is an important role for physicians in supporting care closer to home, particularly for people with complex needs. Physicians can also contribute to neighbourhood teams in several ways, including direct clinical care for patients who need specialist input, expert advice to primary and community teams, education and upskilling of other colleagues, and contributing to clinical leadership across pathways and organisational boundaries. However, this will only be achievable if physicians are appropriately job planned and funded to undertake this work.

However, consultant job plans have not evolved at the same pace as changes in how and where physicians are expected to contribute to care. Training reforms should define the skills that are needed to work at the hospital–neighbourhood interface and embed them in curricula, supported by appropriate investment.

Expanding training opportunities at this interface will take time, and not every resident doctor will immediately require a traditional community placement. Community physician services are currently unevenly developed, and mandatory placements without sufficient educational infrastructure risk replicating the problems seen elsewhere in training.

In the short term, a reformed curriculum should define the skills needed for competence in working at the hospital–neighbourhood interface, and opportunities for generalist training expansion should be reassessed sequentially and iteratively as the model of healthcare starts to change. As neighbourhood services mature and are quality assured, structured placements should expand, particularly in specialties where future consultant practice will have a substantial community-facing component.

Preparing physicians for the future of digital and AI

Reliable access to basic digital infrastructure needs urgent attention and must be established as a prerequisite to wider digital transformation. These foundations must be in place before more complex technology can be successfully implemented. Digital and AI will increasingly shape how physicians diagnose, communicate, monitor patients and organise care, and should be embedded throughout training. Doctors need to understand not only how to use individual technologies, but how to assess their evidence, limitations, safety, governance, bias and impact on clinical decision making. Training should include virtual consultations, remote monitoring, digital communication and the responsible use of AI. Technology should augment, not replace, clinical experience and educational relationships.

Championing wider professional capabilities: leadership, teaching, research and QI

Physician training must develop capabilities beyond direct clinical care. Leadership, education, research, QI and service development are central to consultant practice, yet opportunities to develop them are often informal and inconsistent. Consultant feedback consistently identifies these activities as sources of purpose, variety and professional fulfilment, as they offer a counterbalance to the intensity of clinical work and may play a crucial role in preventing burnout and improving retention.

Clinical research and academia are an important component of these broader professional capabilities and are discussed in more detail in chapter 7.

QI and service development are increasingly recognised as central to modern consultant practice. The ability to identify opportunities for improvement, build a compelling case to influence change and then deliver it is a core consultant skill. Yet despite being expected to

lead and influence services through their careers, most physicians receive little to no formal education or training in these areas.

Leadership development is equally essential. Clinical leadership has never been more important in delivering safe, effective and compassionate healthcare, and the NHS has repeatedly emphasised the need for skilled, compassionate and inclusive leaders. Physicians are uniquely placed to lead because they combine broad clinical insight with responsibility for complex decision making. Leadership skills should therefore be nurtured early in training. Yet many doctors find themselves expected to assume leadership positions soon after becoming consultants with little formal preparation, limiting their ability to lead effectively, improve services and influence change, while potentially affecting job satisfaction and organisational performance.

Training tomorrow's future educators also deserves greater strategic attention. Developing teaching and training skills is essential both to preparing future educators and to supporting the successful implementation of the METR.

To meaningfully embed these wider professional capabilities, there must be a cultural shift away from the 'firefighting' mentality that dominates clinical environments. These capabilities must be recognised as essential investments in the workforce, supported by protected time and structured development pathways that extend beyond minimal ARCP requirements.

A corresponding change in expectations is needed to ensure that resident doctors are appropriately released from clinical duties and encouraged to seek opportunities outside traditional pathways. Greater use of initiatives such as the flexible training pathway, which provides one protected day a week for resident doctors to undertake a project relating to one of these wider professional capabilities, could ensure that development and use of these skills is properly resourced.

It is also crucial that CiPs gained in this way are assessed holistically as part of capability-based progression, as described in chapter 3. Embedding these skills will not only prepare resident doctors more effectively for the realities of consultant practice, but also ensure that they remain engaged members of the NHS workforce for years to come.

Recommendations

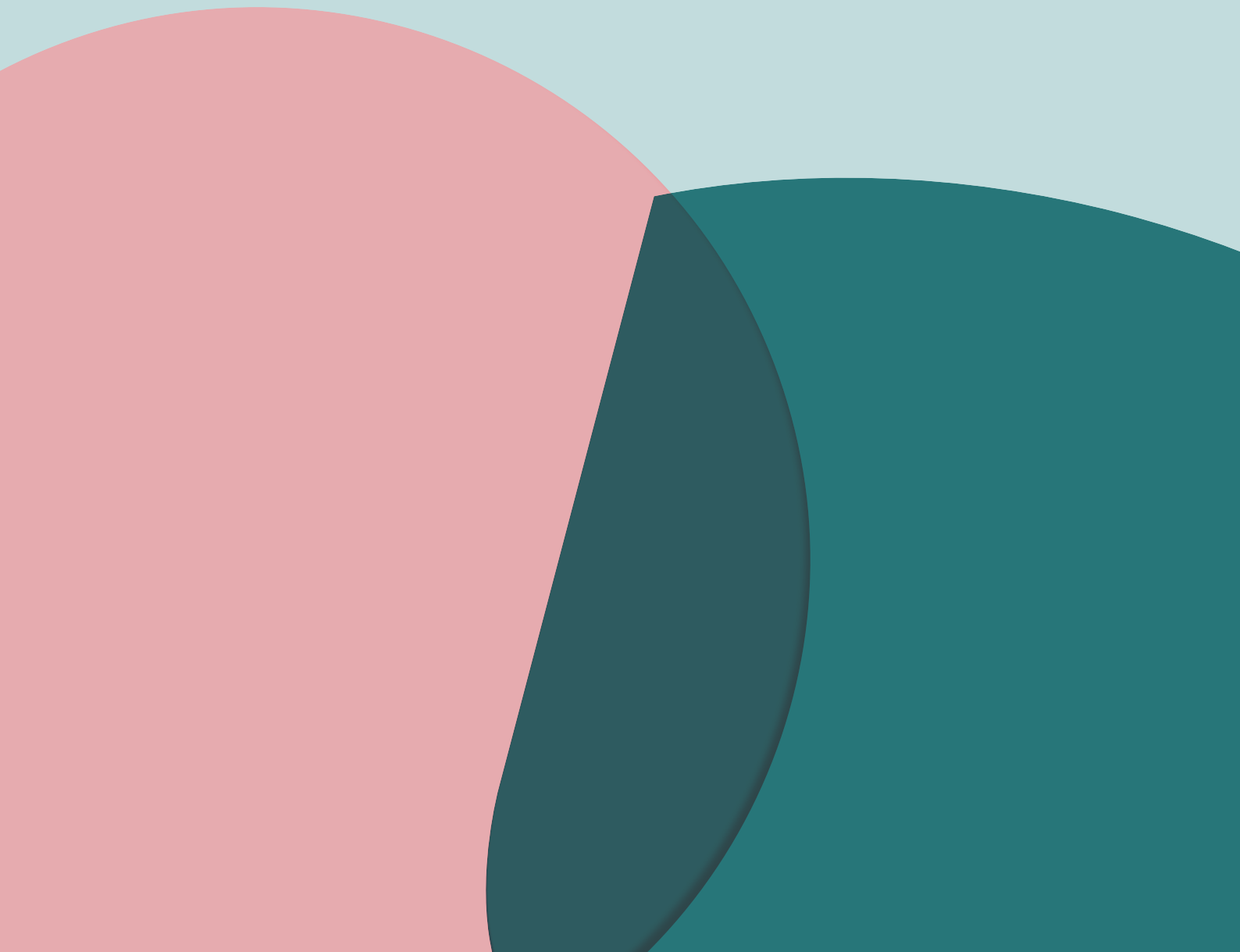
- 5.1 Organise training around patient pathways rather than organisational boundaries, promoting continuity of care, transitions between settings and population health approaches.
- 5.2 Recognise written clinical communication as a core clinical skill by explicitly teaching and assessing referrals, clinic letters and discharge summaries throughout training.
- 5.3 Broaden and standardise GIM training beyond the acute medical take, ensuring that the core generalist capabilities required of future physicians are developed through a balanced range of inpatient and outpatient experiences.
- 5.4 Establish nationally consistent quality standards for GIM training and use QA processes to ensure that service commitments support, rather than exceed, educational need.
- 5.5 Develop clinical risk management and decision making as core capabilities through supervised practice, graduated responsibility and assessment of clinical judgement.
- 5.6 Protect specialty training by maintaining a clear distinction between GIM educational requirements and the GIM service provision required by trusts and health boards, using QA processes to ensure that resident rotas provide a fair and proportionate balance between out-of-hours service and daytime educational activity, without routinely restricting access to clinics, procedures, supervision or specialty-specific training.
- 5.7 Introduce block training models that provide dedicated periods for specialty training and dedicated periods for GIM training, improving continuity of learning and protecting educational opportunities in both areas.
- 5.8 Limit GIM on-call commitments during HST to the 12 months specified in the curriculum, with any additional requirement justified on educational rather than service grounds.
- 5.9 Expand the contribution of the LED workforce to GIM on-call service delivery, reducing reliance on training posts to meet rota demands.
- 5.10 Provide doctors in the final year of specialty training (who have achieved the required GIM curriculum outcomes and completed the expected GIM on-call commitment for that training year) with protected opportunities away from the GIM on-call rota to consolidate specialty-specific expertise and prepare for independent consultant practice.
- 5.11 Support the transition to consultant practice through graduated autonomy, supervised decision making and opportunities to develop leadership, governance and educational capabilities.
- 5.12 Establish structured mentorship programmes for senior resident doctors approaching completion of training, providing access to experienced consultants who can offer support and guidance and facilitate the transition from supervised to independent clinical practice.

Recommendations

- 5.13** Provide structured opportunities to develop neighbourhood health capabilities through integrated, community-based and cross-organisational models of care.
- 5.14** Expand community-based training opportunities, particularly in specialties where future consultant practice will have a substantial community-facing component.
- 5.15** Improve access to reliable basic IT and digital infrastructure, and embed digital and AI capability throughout training, including virtual care, evidence appraisal, safety, ethics, governance and appropriate clinical use.
- 5.16** Recognise leadership, teaching, research, QI and service development as core components of physician training, supported by protected time, structured development opportunities and incorporation into capability-based progression models.



Protecting procedural and craft specialty training



This chapter has been written in response to recommendation 8 of the phase one diagnostic report of the METR. For the purposes of this report, ‘craft’ specialties are those in which consultant practice requires advanced procedural and technical skills developed and maintained through repeated supervised practice.

We do not intend to suggest that craft specialties should be prioritised over others. There are non-procedural capabilities that many specialists develop during training which are equally essential to safe consultant practice, and throughout this report, we make the case for better protection of time to develop specialty-specific expertise across *all* specialties.

However, many procedural specialties provide 24/7 emergency care and rely on skills that depend on regular supervised practice. While all specialties require protected training opportunities, the consequences of inadequate procedural training may become apparent more immediately in acute clinical settings.

Protecting procedural expertise in a changing NHS

The future NHS requires physicians who can manage complexity across systems and settings, but it also depends on physicians with the craft and procedural expertise to deliver advanced diagnostics, interventions and treatments. As generalist capability is strengthened, specialist and procedural training must not be eroded in the process. The NHS will not be able to sustain specialist services, deliver elective recovery, expand diagnostic and treatment capacity and ultimately improve productivity and efficiency without continued investment in the development of future procedural specialists.

For many physician craft specialties, procedural expertise is a central component of consultant practice, underpinning the delivery of high-quality, complex care. Procedural specialties depend on the development of technical proficiency, clinical judgement and procedural confidence through years of dedicated practice. Developing this expertise requires repeated supervised exposure and progressively increasing responsibility over time, which in turn depends on protected training opportunities, with appropriate ringfencing of time, resources and supervision.

In the current training model, there is a fundamental tension between procedural educational requirements and the limited time available to achieve them. This

has been compounded by the reduction in HST time following the introduction of the IMT3 year, alongside the requirement for group 1 specialties to dual train in internal medicine. General medical commitments, acute service pressures, rota requirements and competition for procedural opportunities have further intensified this pressure, making it difficult for resident doctors to obtain sufficient procedural experience within the time available.

In response to the *Shape of training* review (Greenaway, 2013), it was recognised that traditional rota structures for medical craft specialties would need to evolve to accommodate these competing demands. However, no effective mechanisms to mandate, support and monitor implementation of these changes were established. Consequently, the time available for resident doctors to develop procedural competence has reduced, although they are still expected to achieve independent consultant-level practice by the completion of training. As a result, too many report that they feel underprepared for independent consultant practice, despite completion of a recognised training programme.

Procedural training should therefore be explicitly protected within training programmes to ensure that resident doctors have sufficient opportunities to develop the procedural capabilities required for safe and effective consultant practice. This should include the provision of scheduled, ringfenced training lists that are protected from service and operational pressures.

One in four (26%) of resident doctors who responded to our 2025 next generation survey told us that their current role was not preparing them to submit a competitive application for the next stage in their career pathway – and a further 48% said it was only partially preparing them.

More innovative rota scheduling could support this, including 'block' training periods, during which resident doctors spend a defined proportion of their training undertaking specialty or procedural training without competing service commitments. Such approaches would provide greater continuity and volume of procedural experience.

'Immersion' periods of procedural training are designed to maximise early skill acquisition through concentrated and sustained procedural exposure. This approach has been shown to accelerate capability development in endoscopy training and could be adopted more widely across procedural specialties. Concentrated procedural experience would enable resident doctors to develop core CiPs more efficiently and, once competence is achieved, contribute more effectively to service delivery. Robust QA mechanisms, as outlined in chapter 2, would be essential to monitor implementation of protected training time and to ensure that efforts to strengthen generalist skills do not inadvertently erode procedural training opportunities. QA mechanisms must also ensure that service delivery is fair and proportionate, with training opportunities determined by educational need rather than operational pressures, as outlined in chapter 5.

Defining 'generalist' specialist skills

A consistent response to concerns about procedural training has been that the purpose of HST is to develop a broad foundation, including core specialist CiPs, with more advanced subspecialist procedural expertise expected to be acquired through post-CCT training pathways. This position has been reinforced by curricular changes and the shortening of training time. Consequently, within current training programmes, it is recognised that most resident doctors will require further time and development through post-CCT training, fellowship programmes or other structured credentialling pathways to acquire advanced procedural expertise.

However, recognising that advanced subspecialist procedural training may need to continue beyond CCT does not address difficulties in achieving core procedural competence. The concern is not that all resident doctors expect to become advanced subspecialist proceduralists before CCT, but that increasing numbers are struggling to achieve the core procedural CiPs required to achieve CCT in their chosen specialty. These core procedures remain 'generalist' components of the craft specialties and are fundamental to the role of craft physicians.

This distinction is particularly important because the demographic pressures driving the need for greater generalist capability are also driving increased demand for procedures such as echocardiography, coronary angiography, gastroscopy, colonoscopy and bronchoscopy. These procedures are not advanced subspecialist interventions, but core components of contemporary physician practice that are delivered routinely across most hospital settings. The issue is not whether resident doctors should achieve subspecialist expertise before CCT; it is whether doctors training in procedural specialties are leaving HST with the core procedural skills required for consultant practice and to meet current and future service demand.

Emergency procedural training

Craft specialties frequently provide consultant-delivered emergency procedural services for common, and sometimes life-threatening, causes of hospital admission. Resident doctors must therefore complete their training with the confidence, competence and clinical judgement required to undertake these responsibilities independently and safely as consultants.

This requires longitudinal, supervised exposure to emergency and time-critical procedures, including appropriate out-of-hours experience. Such exposure allows resident doctors to progressively develop the technical skills, clinical judgement and decision making required for independent consultant practice. While valuable procedural experience can be gained during daytime procedural lists, out-of-hours decision making and the provision of telephone advice while working off site represent distinct skills that cannot be adequately captured during routine working hours.

Dedicated timetabling is therefore essential to ensure that emergency procedural training is protected from competing service pressures. This should include training blocks, including being on a specialty on-call rota, ensuring that resident doctors gain supervised exposure to the emergency procedural workload that they will be expected to manage as consultants. Achieving independence in emergency procedural practice should remain a core outcome of craft specialty training, and a successful training programme should produce day-one consultants who are able to deliver these services safely, confidently and independently. Greater flexibility in GIM on-call rotas will be key to achieving this, as outlined in chapter 5.

Recommendations

- 6.1** Establish protected procedural training as a core component of craft specialty training, supported by ringfenced training lists, immersive learning experiences and dedicated training blocks.
- 6.2** Ensure that training programmes provide protected access to the opportunities needed to achieve the procedural capabilities required for day-one consultant practice. QA processes should monitor and address service pressures that compromise procedural training capacity.
- 6.3** Ensure that emergency procedural readiness is a core outcome of craft specialty training through longitudinal supervised exposure, graduated responsibility and dedicated emergency procedural training opportunities, including out-of-hours experience.



Strengthening clinical academic career pathways



This chapter has been written in response to recommendation 11 in the phase one diagnostic report of the METR and summarises the ideas and recommendations in the [*RCP view on supporting clinical academic careers*](#), which should be read alongside this report. Although the chapter focuses on clinical academic training pathways leading to research-based clinical academic careers, the principles also apply to clinical academic careers in other areas of medicine.

Clinical academia must be a strategic NHS workforce priority

Clinical academics sit at the intersection of patient care, research, innovation and education. Alongside continuing responsibility for direct patient care, they use their clinical expertise to design and deliver research that informs clinical practice, translating scientific discovery into improvements in diagnosis, treatment and healthcare delivery, and they secure the competitive funding and industry collaborations that grow the UK life sciences sector and help train the next generation of clinicians and researchers.

At a time when healthcare faces increasing challenges from growing numbers of people living with multiple health conditions, rapid technological change and workforce pressures, and the [*10 Year Health Plan for England*](#) promises patients unparalleled access to clinical trials, the NHS needs a strong clinical academic workforce more than ever.

Yet this workforce is in sustained decline, with consultant clinical academics now representing just 3% of the senior clinical workforce, while those aged over 66 now outnumber those under 36 entering the field. The resulting dearth of clinician-led research risks reducing its relevance and practical application. The reasons for this decline are multifactorial, and phase two of the METR provides a critical opportunity to implement the reforms necessary to stabilise and rebuild the clinical academic pipeline.

Creating training pathways that recognise academic careers

Doctors pursuing academic careers continue to encounter training systems designed primarily around conventional clinical pathways. The result is unnecessary complexity, duplication and barriers to progression. Many clinical academics report that progression remains heavily influenced by time spent in clinical service and

fixed numerical thresholds with arbitrary repetition of assessments, despite capability already having been demonstrated and maintained. This framework disadvantages clinical academics and often fails to recognise capabilities that have developed through academic activity.

A capability-based approach (see chapter 3) means that academic work should contribute to progression decisions where it demonstrates relevant curriculum outcomes. Supervisors, training programme directors and ARCP panels should be explicitly empowered and expected to assess and sign off capabilities evidenced through both clinical and research activity and via planned and unplanned learning (ie any activity not declared prospectively but gained organically throughout the year), including OOP activity.

Clinical academics often navigate multiple supervisory relationships simultaneously. While each plays an important role, these arrangements can create fragmented planning processes and competing priorities. They should therefore receive integrated supervision and shared career planning. A single unified personal development plan, agreed jointly between academic and clinical supervisors, would support clearer expectations, better communication and a more coherent approach to progression.

Reforming progression and increasing flexibility

Current ARCP arrangements do not reflect the realities of academic careers. Progression processes are designed around conventional clinical training pathways and may not fully recognise academic achievements or clinical development within academic work. Deaneries should deliver a single, unified ARCP process for clinical academic resident doctors that functions as a joint clinical–academic assessment involving both academic and educational supervisors. There should be an expectation that academic supervisors have input into progression discussions, ensuring that academic expertise informs the process and supports a balanced assessment of clinical academic development.

Successful academic careers rarely follow a standard training timetable. Higher degrees, fellowships and periods of dedicated research are essential components of clinical academic development. Training systems should actively support these opportunities, rather than treating them as interruptions to training. A more flexible OOP framework that allows for multiple, shorter and more

varied placements should be introduced, enabling clinical academic resident doctors to pursue industry placements, international collaborations, and other opportunities essential to building the skills required for successful independent research careers.

Doctors should be able to move between clinical and research environments without unnecessary administrative barriers or concerns that academic activity will disadvantage progression.

Building the future clinical academic workforce

Academic medicine should not be limited to doctors working within established academic centres or those who encounter opportunities through informal networks. Exposure to research and academic careers should begin early in training and be available regardless of geography

or specialty. Access to mentoring, research opportunities, academic events and career advice remains uneven across the UK and contributes to variation in participation. Improving access is essential if the NHS is to benefit from the widest possible pool of future researchers, innovators and clinical leaders.

The future of clinical academia depends on more than training reform alone. Clinical academics frequently report challenges related to funding, employment arrangements and job security. Concerns are particularly evident around posts at clinical lecturer to consultant levels.

Strengthening clinical academia requires coordinated action across universities, funders, NHS organisations and training bodies. Protecting supervisory time, improving alignment between employers and expanding opportunities for academic progression should all be regarded as strategic workforce priorities.

Recommendations

- 7.1** Ensure that every doctor in clinical academic training has a single, unified personal development plan, jointly agreed and regularly reviewed by their clinical and academic supervisors.
- 7.2** Implement a single, unified ARCP process for clinical academic resident doctors that functions as a joint clinical–academic assessment involving academic and educational supervisors, with an expectation that academic supervisors have a strong input into progression discussions.
- 7.3** Produce national standard-setting guidance specifically for clinical academic training to ensure consistent assessment, progression and outcomes.
- 7.4** Ensure that academic training pathways offer greater flexibility, including reform of out-of-programme arrangements allowing for multiple, shorter and more varied placements.
- 7.5** Promote academic opportunities more consistently, with equitable access to mentoring, research experience and career advice across all regions.
- 7.6** Increase investment in clinical academic training, with expansion of the number of academic clinical lecturer (or equivalent) posts and consultant-level clinical academic appointments. These should be funded creatively by collaboration between universities, NHS providers, traditional funders and industry, in order to provide sustainable pathways beyond the fellowship model.
- 7.7** Reduce administrative and employment barriers between NHS and university organisations through greater alignment, standardisation and joint working.

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Defining the purpose and place of medical training in today's NHS



Physicians undergo many years of intensive medical training, which equips them to manage complexity, uncertainty and clinical risk, often based on incomplete information. They make diagnostic and treatment decisions for acutely unwell or medically complex patients, are trained to weigh risks, respond to rapidly changing circumstances, and decide when to escalate, when not to intervene and when to stop treatment altogether. They also hold ultimate responsibility and accountability for medical pathways and for leading MDTs.

The development of these capabilities underpins the rationale for ensuring that physicians develop broad generalist skills. The requirement for dual accreditation in internal medicine in many medical specialties reflects the belief that such capabilities require prolonged and structured training. Resident doctors in the UK therefore undertake one of the longest postgraduate training pathways internationally, comprising 10–15 years of medical education, postgraduate assessment, supervised clinical experience and progressive responsibility.

The expansion of MDTs and the development of new professional roles represent one of the most significant NHS developments in recent years. Members of the MDT make essential contributions to patient care and work most effectively when supported by clear clinical leadership, well-defined roles, clearly articulated scopes and ceilings of practice, appropriate accountability and the right mix of expertise. MDT working must complement rather than substitute medical expertise. However, we have heard concerns from resident doctors about increasing role substitution, including non-medically trained professionals working on doctors' rotas, competition for training opportunities and the prioritisation of training non-rotational staff over resident doctors. These concerns are particularly relevant to the METR because changes in service delivery can reduce, and in some cases have already reduced, access to the supervised clinical experiences through which resident doctors develop the capabilities required for senior decision making and independent consultant practice.

The [10 Year Health Plan for England](#) is explicit that staff should be enabled to work at the top of their licence, using the full breadth of their skills and training. This principle must support effective MDT working and not be used to justify replacing one professional group with another. Inappropriate role substitution risks compromising both the safety of patient care and the quality of training. It is not acceptable practice and must not be considered a solution to workforce pressures.

There should be nationally agreed safeguards to prevent inappropriate role substitution, particularly where operational pressures may incentivise it, and employers should be required to take prompt action to address situations when role misuse is identified. Workforce planning must address workforce shortages urgently by expanding doctor training places at every level, ensuring that there are sufficient physicians to meet service needs while protecting the training opportunities needed to develop the medical workforce.

Fundamental to addressing these workforce planning concerns is establishing a clear definition of the purpose and value of postgraduate medical education. As the METR considers how postgraduate medical training should evolve, including whether greater flexibility is appropriate, it must also define the skills that are unique to being a doctor, and the value and place of these skills within the MDT. This report and its recommendations provide a starting point for that discussion.

If the complexity of the physician role justifies the breadth and duration of training, workforce planning and service design must recognise the added value that this brings to patients and the wider NHS. Conversely, if substantially shorter and narrower training pathways can achieve equivalent outcomes, the structure and duration of physician training should be fundamentally reconsidered.

These two positions are difficult to reconcile: that doctors require 10–15 years of training because of the complexity of their role, and that other members of the MDT can safely undertake comparable responsibilities without it. This contradiction is particularly important given that pressures within the current training system, including competition for opportunities and finite supervisory capacity, have themselves contributed to the workforce and training challenges that have prompted the METR.

Recommendations

- 8.1** Expand medical workforce capacity through robust workforce planning, ensuring sufficient staffing to meet service demand while protecting training quality and educational opportunities.
- 8.2** Develop, implement and enforce nationally agreed standards on scope of practice and role substitution, supporting staff to work at the top of their licence while protecting patient safety, training quality and effective multidisciplinary working.
- 8.3** Define the distinctive capabilities developed through physician training, including why they require prolonged and structured development, and how this expertise will be used within the future workforce.

Conclusion

The METR arrives at a critical moment for the NHS. Workforce shortages, rising demand, increasing patient complexity and changing models of care are placing growing pressure on the health service. At the same time, many of the concerns raised by resident doctors today are the same as those identified in previous reviews: training displaced by service pressures, inconsistent supervision, inflexible pathways and uncertainty about career progression.

Throughout this report, the RCP has set out a vision for postgraduate medical training that is more flexible, more personalised and more clearly focused on capability rather than time served. We have argued for a system that prepares doctors for future models of care, supports clinical academia and procedural excellence, enables diverse career pathways and recognises learning wherever it occurs. At its heart, that system must be built on high-quality supervision, protected learning time and the development of both generalist and specialist expertise.

Previous reviews have proposed many valuable changes, yet implementation has repeatedly faltered, not because the reforms were wrong but because responsibility for delivering them was fragmented and service pressures were allowed to take precedence over education. This is the single most important lesson of the last 20 years, and it demonstrates where the METR should begin.

If only one of our recommendations were to be taken forward, it should be this: training must be made visible, measurable and accountable, because without robust mechanisms to identify where training is falling short and ensure that improvements are made, other reforms risk remaining aspirational, rather than being delivered in practice.

Accountability is the recommendation on which all others depend. It requires three elements working together: QA that makes the reality of training visible, the resource to respond where deficiencies are identified, and clear ownership of delivery. Without all three, improvement is unlikely to follow. Educational quality must become as visible and consequential as the financial, operational and patient safety metrics against which organisations are already held to account.

The future medical workforce will not follow a single pathway. Doctors will increasingly move between clinical practice, research, education and leadership within their careers. Training systems must support this reality while maintaining consistent standards and high-quality patient care. Capability should be recognised wherever it is developed, but formal training programmes must continue to provide the supervision, structure and QA needed to prepare doctors for independent practice.

This matters not only for the quality of training, but for the sustainability of the workforce itself. The pressures that erode training – too little time, too little support, too little continuity – are the same pressures that drive doctors to burn out, reduce their hours or leave. A system that protects and invests in training is therefore not choosing education over service; it is protecting the retention, productivity and expertise on which good patient care depends.

For a system that must deliver care under sustained financial and operational pressure, this is the central point: the cost of training is relatively modest but immediate, while the cost of failing to train is far greater and compounds over time.

The ultimate test of the METR will be whether it creates a system in which training is protected, funded, measured and delivered. Resident doctors do not need another review describing the erosion of training; they need reform which ensures that all organisations responsible for education, training and service delivery are accountable for developing the doctors that patients will depend on in the future.

If implemented, these recommendations offer an opportunity to create a training system that develops confident clinicians, supports innovation, strengthens retention and equips the workforce to meet the challenges ahead. Success will be measured not by the ambition of the recommendations, but by whether the system is finally empowered to put them into practice.



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The RCP's RDC, Student and Foundation Doctor Network, Next Generation Oversight Group, Regional Advisers Committee, Medical Specialties Board, New Consultants Committee and SAS Doctor Network were consulted on the report and its recommendations.

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Contact: policy@rcp.ac.uk

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