



Royal College
of Physicians

Training physicians for the future

A blueprint for reforming
postgraduate medical training

Executive summary and recommendations

October 2026

Executive summary

Postgraduate medical training is one of the foundations of safe, effective and compassionate patient care. The physicians in training today will become the consultants, educators, researchers, innovators and clinical leaders on whom patients and the NHS will depend for decades to come. Yet despite its importance, physician training is not meeting the needs of resident doctors, patients or the NHS. Many of the challenges facing medical training are not new and are well recognised: service pressures crowding out education, inconsistent supervision, inflexible career pathways, burdensome assessment processes and inadequate accountability for training quality.

The medical education and training review (METR) presents an opportunity to move beyond identifying problems and deliver meaningful reform. Drawing on evidence from the RCP's [next generation campaign](#), resident doctor engagement, member consultation and specialty expertise, this report sets out a vision for a postgraduate medical training system that is fit for the future. It argues that training should be viewed as a long-term investment in the quality, productivity and sustainability of healthcare.

The need for reform is urgent. Healthcare is becoming more complex as people live longer with frailty and multiple long-term conditions. At the same time, care is increasingly delivered across organisational boundaries through multidisciplinary teams, community services, digital technologies and emerging neighbourhood health models. Future physicians will require broad generalist skills, deep specialist expertise, strong clinical judgement and the ability to manage complexity, uncertainty and risk. Training systems must evolve to prepare doctors for these realities.

At the heart of this report is a simple principle: high-quality training and high-quality patient care are not competing priorities. Doctors develop through providing patient care, but clinical service alone does not automatically create learning. Training requires protected time, effective supervision, purposeful educational design and accountability. Without these foundations, service pressures will continue to erode the educational opportunities on which the capability of our future physician workforce depends.

The report therefore calls for a fundamental shift in how postgraduate medical education is viewed across

the NHS. Training should be recognised as a core NHS function, rather than an activity that takes place only when service pressures allow. Resident doctor jobs should be designed for learning, educators should have protected and adequately resourced time, and organisations should be expected to demonstrate how educational funding improves training quality and outcomes.

A central theme throughout the report is accountability. Previous reforms have often failed not because the proposed changes were wrong, but because responsibility for delivery was fragmented and ownership of implementation was unclear. Educational quality remains difficult to see, measure and act upon. The report argues that this must change: training quality should become visible, measurable and subject to the same level of scrutiny as operational performance, financial stewardship and patient safety.

A strengthened quality assurance (QA) framework, supported by transparent indicators, meaningful resident doctor feedback and clear escalation processes, is essential. This will require stronger collective accountability across all organisations involved in medical education and training, with clearer responsibilities for monitoring, improvement and action when standards are not being met.

The report also advocates for a more flexible and capability-based approach to training progression. Progression should be determined by demonstrated capability, rather than time served alone. Professional judgement, high-quality supervision and longitudinal evidence should take precedence over administrative compliance and excessive portfolio requirements.

Recognising that modern careers are increasingly diverse, the report argues that training pathways must become more flexible without compromising standards. Less-than-full-time (LTFT) working, academic careers, leadership roles and movement between training and non-training posts are now common features of medical careers. Doctors working outside formal training programmes should receive meaningful support, supervision and development opportunities, and capability acquired in these roles should be recognised transparently.

The report places particular emphasis on the future physician workforce. Future consultants must be

equipped with both broad generalist expertise and specialist excellence. Generalism should not be reduced to participation in acute medical rotas, but understood as a sophisticated set of skills involving holistic patient care, management of complexity and coordination across services. At the same time, specialist and procedural training must be protected. Training reforms that strengthen generalist practice must not inadvertently erode the specialist expertise on which future healthcare depends. The future NHS will also require physicians who can work effectively across pathways and settings, harness digital technologies and AI, lead multidisciplinary teams and contribute to service improvement, research and education. Leadership, teaching, quality improvement (QI) and research should therefore be recognised as core components of physician development rather than optional extras pursued alongside clinical work, with capability developed in these domains recognised and valued throughout training.

Supporting clinical academic careers is another major priority. Clinical academics play a vital role in translating research into patient care, developing innovation and training future generations of healthcare professionals. Training pathways should better accommodate academic careers through more flexible progression arrangements, integrated supervision and improved access to research opportunities.

Whatever reforms are pursued, they must be judged against a simple test: do they protect patient safety, preserve training opportunities and ensure that doctors continue to develop the complex skills, clinical judgement and accountability that underpin consultant practice?

Taken together, the recommendations in this report describe a training system that is more flexible, more personalised and better aligned to future healthcare needs. However, implementation matters more than aspiration. The right solutions have been identified repeatedly over many years, but progress has often been inconsistent and fragmented across the organisations responsible for medical education and training. If the METR is to succeed, it must establish the governance, collective accountability, QA and investment needed to translate reform into practice.

Ultimately, this report argues that the most important recommendation is not a specific curriculum change or training intervention, but the creation of a system in which training is visible, measurable and accountable. Without this foundation, other reforms risk remaining aspirational. With it, there is an opportunity to create a postgraduate medical training system that develops confident clinicians, strengthens workforce retention, supports innovation and equips the physician workforce to meet the challenges of the decades ahead. The success of the METR will not be judged by the ambition of its recommendations, but by whether the health system is finally able and willing to deliver them.

Recommendations

Chapter 1 | Creating the conditions for high-quality training

- 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.

Chapter 2 | Making training visible, measurable and accountable

- 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 exception reporting (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 key performance indicators (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.

Chapter 3 | Modernising assessment and training progression

- 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 annual review of competence progression (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 workplace-based assessments 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.

Chapter 4 | Supporting career flexibility and doctors outside training

- 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 whole-time equivalent 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 locally employed doctors (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 international medical graduates, 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.

Chapter 5 | Training doctors for future models of care

- 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 general internal medicine (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 higher specialty training 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.
- 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.

Chapter 6 | Protecting procedural and craft specialty training

- 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.

Chapter 7 | Strengthening clinical academic career pathways

- 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.

Chapter 8 | Defining the purpose and place of medical training in today's NHS

- 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.



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Published October 2026

This report was developed by a writing group of resident doctors: our thanks go to Dr Ricia Gwenter and Dr Stephen Joseph, RCP Resident Doctor Committee (RDC) co-chairs, and their RDC colleagues Dr Laura Bannon, Dr Alice Cole, Dr Áine Corry, Dr Sacha Moore, Dr Alexandra Pain and Dr Max Thoburn.

The findings and recommendations in this report are based on evidence gathered during the [RCP next generation campaign](#) (including a 2025 [national survey of resident doctors](#)), an internal survey of RCP Council and committee members in February 2026, and five RCP focus groups that specifically considered the themes of phase two of the METR between March and June 2026.

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.

The final document was approved by RCP Council prior to publication.

Read the full [Training physicians for the future](#) report.

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