

UNFINISHED BUSINESS - PROPOSALS FOR REFORM OF THE SENIOR HOUSE OFFICER GRADE SEPTEMBER 2002

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I. OVERVIEW OF REPORT FINDINGS

This report by the Chief Medical Officer for England provides a review of the current status and structure of the Senior Health Officer (SHO) grade, as part of training for doctors in the UK. It considers the case for making changes to the SHO grade and outlines the principal challenges of undertaking such reform, taking into account the needs of trainee doctors and also, the Health Service. The paper puts forward a new framework for SHO training: recommending a programme-based approach to training, it sets out its plans for a two-year foundation programme, followed by a number of broad-based, time-capped basic specialist training programmes, including training for general practice. It proposes a greater emphasis on competency-based assessment for those progressing through training and, at the same time, calls for a review of medical Royal College examinations given their importance in medical assessment. Sir Liam's paper makes suggestions regarding the management, recruitment and delivery of the new programme-based SHO training, which would require strong commitment from Postgraduate Deans, Royal Colleges and the proposed Postgraduate Medical Education and Training Board. Lastly, it speaks of the wider implications of reforming the SHO grade, for example, on doctors in higher specialist training, and considers the possibility of awarding the Certificate of Completion of Specialist Training earlier. This document is presented for consultation, requesting views on all the proposals made and other issues raised.

II. THE CASE FOR CHANGE

The Chief Medical Officer (CMO) report commences by giving some context to the Senior House Officer role. Most young doctors seek SHO posts after the completion of their pre-registration year, prior to continuing on to specialist training either in general practice or in hospital or public health medicine. Hence, the grade represents the phase of training now commonly called *basic specialist training*. The paper underlines the experiential diversity of SHOs; at any one time there will be those in vocational training for general practice, those gaining broader training and experience (before making a career choice), and those choosing to remain in the SHO grade. And the numbers of doctors in SHO appointments is large, representing almost half of all doctors in training in England and Scotland, and over half of those in training in Wales and Northern Ireland.

However, whilst there has been major reform of higher specialist training – including a new specialist registrar grade – and improvements to the education and working conditions of pre-registration posts, the report says “SHOs have been left behind”. It highlights the general consensus that “SHO training requires a radical overhaul”, acknowledging the recommendations of the Department of Health's *"A Health Service of all the talents: Developing the NHS workforce"*¹, as well as the reports of a number of organisations, including the BMA's Junior Doctor Committee, in this regard. This consultation report though speaks of going further than these others, by exploring more radical structural reform of the grade and considering the wider implications of this change on current and future service delivery.

In examining the case for change, then, the paper details the principal challenges of the Senior House Officer grade that this reform should seek to address:

a. Job structure: The document comments on the poor structure of SHO positions, with about half free-standing posts and not part of any training rotation or programme. Furthermore, many SHOs receive limited career guidance and in those posts where training is provided the quality can be indifferent and does not necessarily meet the requirements of a managed training programme. The report alludes to the added burden on the service and on trainees driven by the constant need amongst applicants to secure short-term posts, and thus complete frequent job applications.

b. Planning training: The CMO's report explains that there is currently no defined end point to SHO training. Consequently, the length of time spent by doctors in the grade varies greatly, dependant usually on their ability to secure a specialist or GP registrar post. This, in turn, depends on the number of places available in vocational training programmes and on the requirement to pass medical Royal College examinations before entry to higher specialist training. As a result, many trainees spend considerably longer as SHOs than is required to satisfy training requirements and, although continuing to gain some experience, are effectively repeating training.

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

c. Selection and appointment procedures: Expanding on the previous reference to the burden of frequent job applications, the paper states that selection and appointment procedures are often inefficient and expensive. It adds: appointment procedures for SHO roles have not been standardised as they have for specialist registrar programmes; and selection is not always based upon meeting and assessing the competencies SHOs require to provide good quality care and to progress through training.

d. Supervision, assessment and appraisal: The report emphasises the lack of robust mechanisms for the regular appraisal or formal assessment of SHOs. It suggests that as a consequence poor performance is not being reliably recognised and addressed. In addition, SHO suitability for career progression is often solely measured on success at Royal College exams and on ability to secure further posts.

e. Tension between service and training needs: The paper recognises that tension of this kind is to be expected, given the apprentice-based nature of the SHO system, especially where working and learning are so closely linked. And it contends that the tension is exacerbated by a lack of general understanding of the contribution that SHOs should make to the service. It also laments that there has been no exploration of the potential benefits of SHO “cross-over” to related disciplines or their participation in multi-professional teams.

f. Flexible training: With more women graduating from UK medical schools (41-48% of SHOs in the countries of the UK are women)², the report suggests that there is a greater need for flexible and family-friendly training and working arrangements.

g. Career advice: The consultation paper raises concern over the poor career advice and guidance received by SHOs. But, the report advocates that any improvements in this area should recognise that not every SHO is able or ready to make definitive career decisions early in their postgraduate training. Indeed, it continues that doctors should not be pressed into making premature decisions about careers, this being in neither the interest of the trainee doctor nor of patients. Instead it advocates “exposure to a variety of settings and experiences early in their postgraduate career can help them to make an informed career choice”³.

h. Meeting the needs of non-UK graduates: The paper explains that graduates from overseas and the European Economic Area (EEA) form a significant part of the training workforce in the UK. Their reasons for seeking to train in the UK differ: many come to fulfil a specific training goal and then return to their home country; others come to undertake full postgraduate training in the UK leading to a Certificate of Completion of Specialist Training and then return home; others plan to complete their training and settle in the UK; some may be undecided about their ultimate career aspirations; and some are refugees with particular needs. Non-UK graduates arrive with varying levels of training, qualifications and experience and consequently different training needs. Sir Liam’s report underlines the difficulties faced by this particular group of graduate SHOs in securing initial appointments (particularly in their chosen specialty), and the problems of unemployment they often face when short-term contracts end.

i. Workforce planning: Attention is drawn to the lack of national planning with regard to SHO numbers and to the fact that no account is taken of education goals or of the longer-term needs of the medical workforce. Rather, numbers have been largely influenced by the output of medical graduates and service pressures, and are currently primarily controlled by exercising broad financial constraints (an education levy or equivalent system). In contrast, the report explains, the number of specialist registrar placements is planned to ensure an adequate supply of consultants to the NHS geared to the needs of individual specialties. NHS Trusts, however, continue to seek more SHO posts (or equivalents) because of their excellent value for service and, until the European Working Time Directive begins to take effect, their versatility to cover out of hours work and emergency care. The report notes that trainee preferences also contribute to an imbalance between SHO and specialist registrar training opportunities in different specialties. The excess of SHOs attempting to enter higher specialist training in some specialties means not all doctors can pursue their chosen specialty and have to make alternative training or career choices. With little good career advice, many seek repetitive posts hoping eventually to advance their particular career choice. In other specialties, insufficient trainees wishing to enter higher specialist training or to enter general practice causes a shortfall in applicants for consultant or general practice posts needed to meet service requirements.

j. The role of Royal College examinations: The report outlines the importance of Royal College assessments within the context of the SHO grade, given that entry into higher specialist programmes is commonly determined by success in the relevant Royal College exam⁴. The important function of these examinations in the training continuum is acknowledged, however their role within specialist training varies significantly between Colleges. And neither the timing nor the content of these examinations is clearly linked to the doctor’s progress through training. Indeed, the report suggests that exam failure may lead to

² From the table entitled “Numbers of women doctors in training and proportion in different grades”, “*Unfinished Business -Proposals for reform of the Senior House Officer grade*”, DoH, 2002, p.15

³ Ibid. p.16

⁴ Evidence within the report demonstrates wide variations in both the pass rates and costs across different examinations, but found no particular explanation for these findings other than the differing “traditions, practice and attitudes of Royal Colleges”. Ibid, p.19

“dead time” during training “in which doctors, ready to move on to the next phase of training, cannot do so and mark time until they pass the required examination”.⁵

k. Adapting higher specialist training to changing service demands: The CMO’s paper clarifies that there are around 60 higher specialist training programmes, which doctors can pursue after basic specialist training, varying between two and six years in length according to speciality. Doctors successfully completing these programmes receive a Certificate of Completion of Specialist Training (CCST) and the opportunity to become a consultant. The report indicates a growing view that patient care would be enhanced if delivered by doctors whose training was not so deeply specialised as the current CCST programmes demand. It contends that “if properly grounded in the medical career structure, there could be clear benefits to both the service and the individual doctors in developing new, shorter Certificate programmes designed to produce fully-trained specialists with a wide range of skills more closely attuned to the current needs of the NHS.”⁶ This transition to more broadly-based higher specialist training programmes is contingent on well informed trainees, with the appropriate instruction at the basic specialist stage. The report accepts that current SHO training system is in the main unstructured and would be entirely unsuitable in preparing doctors for new higher specialist training programmes. Thus, it proposes that its reform is essential to establishing the right platform experience and broad specialty training for entry into higher specialist training.

III. A NEW FRAMEWORK FOR TRAINING

Here, the Chief Medical Officer describes the principles on which the proposed new framework for training is to be based and sets out a series of recommendations to reform basic specialist and general practice training. This review of the SHO grade has drawn on the experience of commissioning the previous higher specialist training reform and has taken into account the thinking of a Working Group convened to consider the options for modernising SHO training.⁷

The document comments that in order for the SHO grade reforms to be successful they need to function within the continuum of doctor training, with “clear and effective links to career posts and appointments and pathways leading to clear training goals.”⁸ Furthermore, it underlines the need for flexibility, within these reforms, so that the diverse needs of trainees and changing service demands are accommodated.

Principles for Reform for SHOs

As previously mentioned, Sir Liam’s report puts forward five key principles that underpin the organisation and delivery of its proposed reform of training for SHOs:

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

These principles, it suggests, should in turn be supported by commitments to flexibility for trainees and regular career advice; young doctors should be advised on career planning, recognising the needs and competence of the individual and the likely requirements of the Health Service.

A Programme-Based Approach to Training

The report judges that a programme-based approach to training would substantially address the problems of the SHO grade, ensuring that as many doctors wishing to do so may enter specialist or general practice training. These programmes will be of two types, one a broadly-based programme pursued by all doctors seeking to continue on towards specialisms and the other a more tightly-focused individual programme for a limited number of trainees, who need further supervision and development to achieve their goals.

The CMO’s paper firstly considers the phase of training following graduation, during the first four or five postgraduate years (encompassing what are the current pre-registration house officer and SHO grades). It describes two main building blocks (or programmes) for this phase: a *foundation programme* and a *basic specialist training programmes* (including training for general practice).

Foundation Programme

Under this proposed scheme, all doctors would undertake this integrated, planned two-year *foundation programme*. The first year would equate to the present pre-registration year leading to full registration. The second year would be post-registration and build on the first year by providing further core training. The key purposes of these

⁵ idem

⁶ ibid. p.20

⁷ Annex A of “*Unfinished Business*” lists the members of the Working Group and their provenance. Annex B gives members of the Technical Sub-Group established by the Working Group to inform their deliberations and Annex C of the report records the stakeholders whose contributions informed a series of focus groups sessions convened by the Sub-Group.

⁸ ibid. P.21

foundation years, according to the report, is for trainees to develop the “generic skills essential to all doctors [and] extend and consolidate the knowledge, skills, values and attitudes acquired in medical school and set out in the General Medical Council’s *Good Medical Practice*”⁹. The programme would look also to engender skills, that the report describes as “essential requisites of modern medicine”: for instance, forming effective relationships with patients; appreciating the standards of clinical governance and patient safety; expertise in accessing, appraising and using evidence; competency in communication and team-working; and time management and decision-making skills. Furthermore, these foundation years would look to provide direct experience of different specialties – perhaps those that are not wholly covered in the medical school curriculum – and to gain experience in dealing with the seriously ill. As now, the proposed programme would be undertaken primarily in a service setting, giving graduates a broad experience of medicine and career options in order that they might develop an understanding of the links between different specialties and between primary and secondary care.

Basic Specialist Training Programmes

The report suggests that, having had an opportunity to sample a range of medical practice during the second foundation year, the doctor would decide to compete for entry into one of a number of broadly-based *basic specialist training programmes*. These programmes are intended both to allow doctors to gain experience and develop their clinical skills in a broad specialty grouping and to prepare for entry to higher specialist training or to general practice and post-certification education. These programmes would provide a breadth of education and training yet focus increasingly on basic specialist or discipline-based skills. The report envisages enough places in these basic specialist programmes for all SHOs completing foundation schemes and to accommodate some EEA and overseas graduates. However, it does stipulate that trainees entering *basic specialist training programmes* will not necessarily be successful in obtaining a place in the programme of their first choice, and therefore, it will be important to incorporate support structures into the new system. Whilst the composition, number, content and duration of these basic specialist training programmes is still to be decided, but the model tested by the aforementioned Working Group anticipated eight of them:

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

The paper underlines that an important feature of this process is the time-capping of programmes. Hence, it will not be acceptable for trainees to spend significant periods as SHOs, rather they will be expected to make reasonable progress through to completion of training and then move on.

Individual Training Programmes

Sir Liam’s report foresees a limited number of placements on more tightly-focused *individual programmes* designed to meet the specific training needs of individual doctors. These programmes would be limited to a strict number of placements, which will be closely managed with clear entry criteria and regular assessment of trainees’ progress. The paper emphasises that these programmes, as for the others described, will not provide a temporary “sanctuary” for those requiring more time to study for Royal College exams. A tailored, intensive *individual programme*, according to the document, would be suitable for:

- re-direction of training: for doctors seeking to change career paths who may need additional training – on top of existing “transferable” knowledge and skills from their previous clinical training – to meet the requirements for such a switch.
- return to training: for those doctors seeking to re-enter training from a non-consultant career grades, research or moving to or from general practice, who might find the programme useful preparation for advanced or higher levels of training.
- doctors entering training from elsewhere in the EEA and overseas: again these doctors may find individual programmes a useful preparatory route towards competitive entry for higher level training
- remedial training: for those who have not made the necessary progress through *basic specialist training programmes*

Time-Capping of Programmes

The CMO’s report specifies that all the aforementioned programmes will be time-capped, but at the same time flexible enough to reflect the needs of those training part-time or whose training is interrupted. It advocates time-capping as “an inherent part of sound programme management”¹⁰, enabling trainees to move through appropriate programmes and to make decisions about their future career directions. The paper clarifies that doctors will not be able to remain in training for extended periods, but they will be offered reasonable opportunities to complete programmes or else provided with alternative options (for instance, a placement on an individual programme – see above – or re-training in another programme). Other separate arrangements will be made for those on an agreed career break or leave of absence due to illness, or where a time-capped “period of grace” is granted. This “period of

⁹ *ibid.* p.25, with reference to “Good Medical Practice”, General Medical Council, 2001

¹⁰ *ibid.* p.30.

grace" might be granted to a doctor to enable him or her to organise transition to the next stage of professional development. The report recognises here that time-capping will inevitably mean that there will be a number of doctors who will not be able to progress to higher levels of clinical training, and thereby be obliged to leave the training grades. One suggestion made by the report is that this group may wish to consider posts in a non-consultant career grade, before examining future options within the training continuum.

Assessment and Examination

The proposals in this consultation paper support a greater emphasis on competency-based assessment throughout training and as evidence of its completion. And given the time required to achieve this, progress through training will be informed by success in Royal College exams and increasingly, by the Record of In Training Assessment (RITA) process for SHOs.

However, with the previously acknowledged variations between Royal College exam practice – particularly in setting and quality assuring of exams – the report underlines the exams in their present form are not clear indicators of satisfactory progress through specialist medical training. It highlights the role of the new Postgraduate Medical Education and Training Board¹¹ which is tasked with ensuring that all assessments and examinations – throughout training- are appropriate, valid and reliable. And, in this regard, the report suggests a review of the medical Royal College examinations "would be very valuable"¹². It comments that, unlike other fields of education, there is currently no external quality assurance of exams; it states that "examinations should be "fit for purpose", supporting evidence that a doctor has reached a required standard for clinical practice"¹³, and that greater co-ordination of the timing of examinations with training programmes should be developed.

Managing Training

The CMO's paper suggests that a programme-based approach to SHO training will enable Postgraduate Medical Deans to better supervise and manage its delivery, as elsewhere in the training continuum (namely, in the areas of higher specialist and pre-registration training). This managerial role for the Postgraduate Dean would entail the appointment of trainees, the delivery of the new programme-based training arrangement (as organised by the Programme Director¹⁴) and the support and training of programme trainers.

Postgraduate Deans should be responsible for the recruitment arrangements to all programmes: foundation, basic and higher specialist and individual programmes, as they are now for specialist registrar posts. They and employers will need to ensure that NHS equal opportunities and sound employment practice prevail. Providing some further detail on recruitment, the consultation document proposes that a national system of matching may suit appointment to foundation programmes. Otherwise, there will be competitive entry for basic specialist programmes – though there will need to be provision for those not admitted to their first choice programme – and the arrangements for appointment to the limited placements on individual programmes will need consideration.

Funding Training

The report questions whether 100% of SHO salaries in England should be funded from the education levy, as is the present case for pre-registration house officers and specialist registrars (and all grades in Scotland). Currently, only 50% of the grade's basic salary is met in this way, with the remainder of cost falling to the employing NHS Trust. It suggests that with arguments for and against this proposal, the debate will have to be considered carefully following consultation.

Specific Training Requirements

Sir Liam's report goes on to examine the training requirements of some specific groups and areas of specialism.

General Practice

It considers, firstly, what it terms the "specialty equivalent" of general practice. It states that all doctors, whatever their chosen specialism, should follow some training in general practice. In addition, one of the basic specialist training programmes will provide specific training leading to certification in general practice. It underlines that the minimum period of vocational medical training, by statute, is three years; the paper explains that this legal requirement might be met in the new scheme by some time being spent in the second "foundation" year in general practice, and a subsequent two-year general practice programme. This latter element would see trainees competing for entry to follow, as now, a mixture of hospital and general practice-based training with a period of not less than 12 months in general practice.

Dentistry

In dentistry, the report notes parallels with medicine, in the high standards of practice based upon sound training and clearly defined educational programmes. It refers to the many common core skills between the two and the

¹¹ Postgraduate Medical Education and Training Board is set to replace the existing authorities in the field, the Specialist Training Authority of the Medical Royal Colleges and the Joint Committee on Postgraduate Training for General Practice.

¹² According to the report the Academy of Medical Royal Colleges has already started work in this area.

¹³ Op.cit. *Unfinished Business*, 2002, p.32

¹⁴ The report clarifies that Programme Directors should be part of the postgraduate deanery, accountable to and appointed by the Postgraduate Medical Dean after consultation with the relevant Royal College or Faculty

considerable overlap of the educational and training processes. It makes specific recommendations for the future of the house officer and the senior house officer grades in dentistry in Annex F of the report.

Doctors Qualifying outside the UK

With doctors qualifying outside the UK making up over a third of SHOs in England, the paper is clear that this group must be assured of fair and equal access to high quality training programmes. It outlines a need for an appreciation of the career aspirations of these doctors, a recognition of their overseas training, advice on entry to UK training and career options and equality of opportunity in recruitment practice.

A Single Training Grade

The report seeks to clarify the implications of the programme-based approach to training for the grade system. It asserts that this approach to basic specialist and general practice training unifies “mechanisms for delivery, assessment and appraisal across the training continuum”, effectively creating a single training grade. Thus, a doctor’s progress “may best be defined by advancement through a programme or series of programmes”¹⁵, rather than grades. Within this single grade, the report explains, the various programmes will have specific entry and exit criteria, and workforce planning could determine estimated numbers for each programme. It also suggests that this approach would further enhance the role of competent authorities and medical Royal Colleges in their determining of training programme structure in advance of certification, and the role of the Postgraduate Deans in managing training.

The CMO’s paper emphasises here that the proposal is *not* that the NHS moves immediately to a “run-through” training grade so that all entrants to basic specialist training automatically obtain places at higher specialist level. However, it suggests that the “run through” concept should be actively explored for each specialty. It elucidates further that “provided that appropriately defined entry and exit points for each programme and means of assessing progress through the programme, it could become unnecessary to expect a doctor to change grade during a programme or to link a particular programme to a grade.”¹⁶ It then reiterates the advantages of a programme-based approach to training over a grade-based one, particularly in relation to the Certificate of Completion of Specialist Training (CCST). For example, the approach would allow greater flexibility in planning training, providing opportunities for doctors to change career direction or for shorter programmes leading to a more general CCST; it would allow for programmes of differing duration and structure determined by specialty need; it would re-affirm the importance of basic specialist training within the overall requirements for the CCST and be in keeping with moves to introduce shorter CCST programmes in some specialties.

Links to Higher Specialist Training

With the SHO period forming the initial phase of a doctor’s specialist medical training – the end point being the CCST – the reform of SHO training provides an opportunity to consider UK specialist training as a whole. The proposed reforms to SHO training, according to the report, allow for improved quality of early postgraduate training and provide a better grounding for those wishing to progress on to higher specialist training. And the changes already instigated in this higher specialist area appear to have served both trainees and the NHS well. However, the report details some issues in the *whole* training system that need still to be addressed: for example, the length of specialist training before CCST, the assumption in training that all doctors want to progress to consultant status, the lack of flexibility in training and the growing demand in the NHS for more “generalist” consultants to provide patient care. Once again, the consultation document highlights the advantages of introducing programme-based training in response to these issues. For instance, it asserts that a new range of training programmes could enable doctors in higher specialist training to be awarded a Certificate of Completion of Specialist Training earlier than present. This could be followed by a period of more highly specialised training for those with interest, and for which there was a service need. The paper suggests that “such a model would work best if at the point of completion of the shorter first phase period of higher specialist training, the doctor was eligible for a consultant level post in their chosen specialty. So they would become a consultant in for example: general internal medicine or general paediatrics. This would make a distinction between two categories of specialist: the ‘generalist’ consultant and what some have dubbed the ‘ologists’”.¹⁷ The report notes some further advantages to such a restructuring of specialist training and certification, which might also be considered as part of the consultation, namely:

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

Implications for the Consultant and Non-Consultant Career Grades

Considering the implications of the proposed reforms for these two grades, the paper highlights the particular situation of the non-consultant career grade doctors. It describes the valuable part in the NHS that this band of doctors play, yet indicates that with the current lack of opportunities to leave the grade and return to training, the grade unfairly carries a degree of stigma. The paper recommends that the non-consultant career grade post could and should be transformed; it should be a post in which a doctor gains valuable service experience, but from which it is possible to progress (or move back) into specialist training. Furthermore, if a doctor chooses – for whatever

¹⁵ *ibid.* p.37

¹⁶ *idem*

¹⁷ *ibid.* p.39

reason – to remain in a non-consultant career grade, they should be able to do so with pride, knowing that their experience and expertise in an area of medicine (whether it be for example, emergency medicine, ultrasonography or breast cancer care) was something which the NHS valued and cherished. A review of this role and its opportunities for development is proposed here by the CMO.

Implications for Service Provision

Given its apprenticeship model of training, any reform of SHO training will inevitably have an impact on service provision. Sir Liam's proposals could have an effect on the service output of individual SHOs, due to the greater focus on training. Moreover, improved workforce planning and time-capped programmes might impact on the numbers of SHOs and doctors in non-consultant career grades. However, the paper contends that overall levels of service provision should be maintained: training reforms will deliver fully-trained – and better trained – doctors more quickly (especially coupled with the changes to the CCST mentioned previously); and time-limiting basic specialist training means doctors will not provide service within the SHO grade for long periods as they do now.

Impact of the European Working Time Directive

The report points out that introduction of the proposed new training programmes would coincide with the implementation of the European Working Time Directive within the Health Service. It describes the Directive as an "important challenge" for the healthcare team, which will require the service to explore more creative ways of working and of making better use of the skills within the team. It states that training reform will have an important role to play too, suggesting that the best use of time available for educational benefit will have to be made. The way forward, the paper contends, will be to recognize that "trainees will be available for shorter periods and will be engaged in new working patterns and then to build new approaches to training"¹⁸. The paper adds that with the proposed programme-based system, the service is presented with a way to structure training and make the most of the experiential component of training.

Implementation and Timing

Finally, the CMO's report outlines the various organisations and bodies on whom implementation of these reforms would depend, including the Health Service, postgraduate deaneries, the medical Royal Colleges and the proposed Postgraduate Medical Education and Training Board. The process would need to encompass the design and establishment of the various programmes envisaged and appropriate recruitment procedures for them, the appointment of education and training personnel, and the development of curricula for the programmes. In view of the depth of detail required, the paper proposes two timetable options for implementation to be considered:

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

IV. A CALL FOR VIEWS ON THE PROPOSALS TO REFORM THE SHO GRADE

The report invites comments and ideas on all the issues covered in the document and presents a summary list, as follows, of the central SHO reform proposals on which it would particularly welcome views:

1. The five key principles should be the basis for reform of basic specialist or general practice training.
2. There should be sufficient opportunities for flexible (part-time) training.
3. There should be access to early and regular career advice.
4. After graduating doctors should undertake an integrated, planned two-year *foundation programme* of general training:
 - the first year equating to the current pre-registration house officer year;
 - the second (post registration) year incorporating a generic first year of current SHO training.
5. After completing their *foundation programme*, doctors should enter a *basic specialist training programme* providing a breadth of education and training within certain broad clinical disciplines.
6. A limited number of placements on *individual training programmes* should be provided for those doctors requiring: remedial help; support in changing career direction; or who wish to re-enter training to prepare for competitive entry to higher specialist or general practice training.
7. Following completion of a basic specialist or individual training programme, those trainees to progress directly to higher specialist or general practice training should be allowed a *period of unable grace* before leaving training.
8. Progress through programmes should be determined by assessment.
9. In the longer-term assessment should move towards a competence-based system.
10. The purpose of the Royal College examinations should be reviewed and a system of external accreditation introduced.
11. Programmes should be managed by Programme Directors, appointed by, and accountable to, Postgraduate Medical Deans.
12. Trainers should be supported and trained.

¹⁸ *ibid.* p.42

13. Key information on programmes: the arrangements for appointment and induction; the curriculum to be followed and the procedures for assessment must be made available to all trainees.
14. The appointment arrangements to all programmes should be the responsibility of the postgraduate medical dean. They should meet published nationally agreed standards and practice.
15. The SHO element of general practice training programmes should follow a similar model to those for hospital disciplines.
16. The provisions for basic specialist training should ensure that the needs of non-UK qualified doctors are properly and fairly taken into account.
17. It is proposed that urgent work is undertaken to explore, specialty by specialty, the appropriateness of creating a 'run-through' training grade in which doctors would move seamlessly through training with satisfactory progress checks. This could not be implemented immediately. Given the needs of the service and the availability of training places, the need for application and competition prior to progression should be explored.
18. The arrangements for awarding a Certificate of Completion of Specialist Training (CCST) should be changed. New and shorter higher specialist training programmes should lead to the award of an earlier CCST for those satisfactorily completing training in the 'generalist' elements of a specialty. At that point a doctor should be able to apply for a consultant post in their chosen specialty – say general internal medicine or general paediatrics.
19. A review of the role, educational support, professional development and career opportunities and pathways for non-consultant career grade doctors should begin in the autumn.

The three-month consultation period will close on 22 November 2002; any responses should be sent by post to:

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

or by Email to: andrew.matthewman@doh.gsi.gov.uk

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Copies of the full document are available on the web at:
<http://www.doh.gov.uk/shoconsult/index.htm>