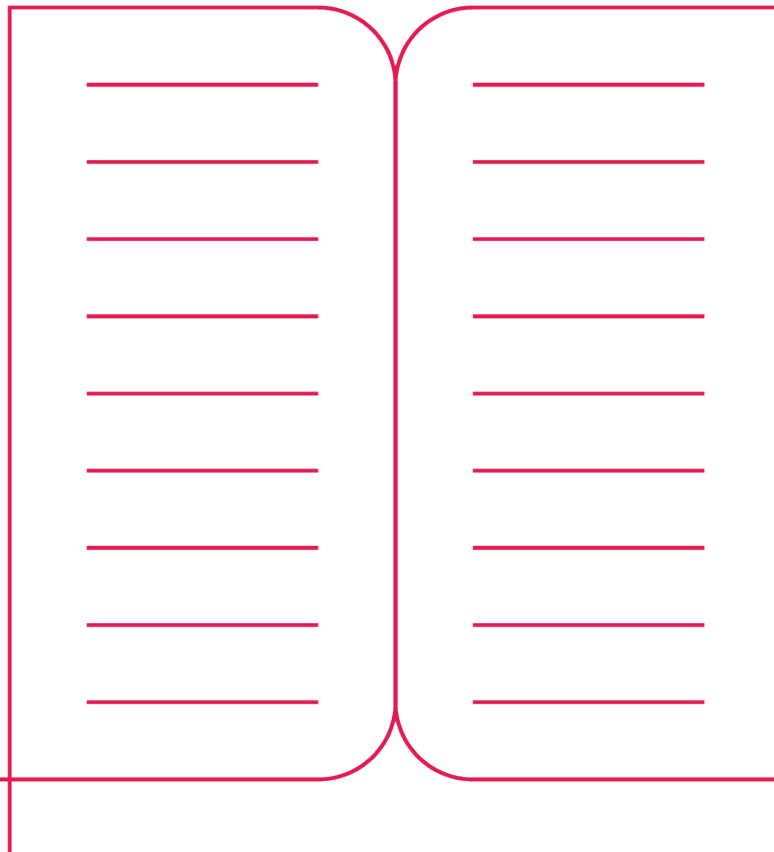


June / 2020

Guidance for flexibility in postgraduate training and changing specialties





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Executive summary

Encouraging and improving flexibility in postgraduate medical training is a key recommendation from the General Medical Council (GMC) report *Adapting for the future* [2017]. The Academy of Medical Royal Colleges [the Academy] *Accreditation of Transferable Competences Framework* (ATCF) in 2014 described how doctors in training could transfer between specialties and obtain recognition of knowledge and skills gained in their original specialty without the need to repeat them.

An Academy and GMC Working Group was convened to review the ATCF in the context of the new standards for curricula and the GMC's 2017 *Generic Professional Capabilities framework*. In addition, the group considered Health Education England's (HEE) developing Out of Programme Pause (OOPP) pilot which would enable doctors in training to 'step off' for a period and to have the opportunity for skills developed during Out of Programme (OOP) recognised when returning to the training programme.

Two scenarios in which flexibility would be appropriate for further consideration for doctors in training were identified:

1. Doctors in training who realise their current programme is not the right one for them and wish to change to train in another specialty
2. Doctors in training who take some time out of their programme for other experience and later return.

A further two aspirational scenarios, in which the principles of flexibility may be applicable for doctors not in training, were also identified:

3. Doctors not in training or trust / health board doctors who may not have decided on their career path but plan to join a training programme
4. Staff Grade, Associate Specialist and Specialty (SAS) doctors working in a particular specialty who wish to enter a training programme.

This guidance describes how doctors in training who wish to train in another specialty can receive recognition towards the Certificate of Completion of Training (CCT) in the new specialty of capabilities gained in their existing specialty. The guidance also suggests how flexibility in training could work in practice for both doctors in training who wish to take time out of training and doctors not in training who wish to join or return to training programmes.

Implementation of this guidance will need to address both general and specialty-specific principles, which individual royal colleges and faculties will need to develop in the context of the new curricula standards. However, it is anticipated that these principles will enhance training not only in terms of the quality of the training experience, but also, crucially, for the safety and quality of care for patients, by maintaining the breadth of professional and clinical capabilities.

The recommendations have been developed in the context of the recent GMC regulatory changes



to support flexible working and training across postgraduate medical education. The GMC remains supportive in principle of trainees 'stepping out' of UK training and for any subsequent skills gained while away to be fully considered upon their return. Results from the ongoing HEE pilots are awaited and the GMC will be looking for the necessary safeguards to be in place to protect both doctors in training and the service.



Section 1 Introduction

The Academy was commissioned by the General Medical Council (GMC) to carry out this review of flexibility within postgraduate medical education as one of the next steps described in their report *Adapting for the Future* [2017]. The report was a response to the issues raised following the Junior Doctors' industrial action against the new contract in England in 2016. It was apparent that there were a number of priorities that needed to be addressed to enhance the quality of training, including a greater emphasis and better balance between training and service provision with more focussed supervision.

In addition, doctors in training strongly advocated approaches to personalised training to enable not only completion of training programmes but also opportunities to develop other interests as well as ensuring a satisfactory work-life balance. Although there are differences in training approaches across the four UK training authorities, the Academy believes that the emphasis on flexibility and movement between specialties is applicable across postgraduate medical education and addresses some of the concerns that have been raised. Both of these principles were highlighted in the recommendations of the *Tooke inquiry* [2008] and David Greenaway's *Shape of Training review* [2013].

For some doctors in training progression in a single specialty to certification works well, but for others the opportunity to gain a breadth of experience in different specialties and posts, working according to their preferences and circumstances, is more appropriate. The introduction of the *Generic Professional Capabilities Framework* (GPC) by the GMC in 2017, has provided a framework for the development of both professional behaviours and the general knowledge and skills expected of all practitioners. This framework underpins practice and helps facilitate both flexibility in training and movement between specialties with the added advantage that common aspects of training will not need to be repeated. An aspirational aim implicit in this work is to improve the retention of doctors in training.

The need for greater flexibility in training has consistently remained one of the strongest themes in feedback received from doctors in training and is also reflected in a significant proportion of trainees taking breaks from training for a variety of reasons.¹ Doctors in training are deeply committed to providing high quality care to patients, but they want training pathways that can adapt to their needs, enhancing and widening their career choices. They want to train in a way that helps them strike the right balance between their professional and personal lives, including training on a less than full time basis. Alongside this, they also want greater opportunities to learn outside their defined training programme, through out of programme training or work experiences. Although there are established routes to gain experience and capabilities out of programme defined within the *Gold Guide [8th Edition 2020]*, there is a desire for doctors in training to develop their own portfolio of skills, which may or may not be considered as part of their formal training towards a CCT.

Finally, doctors who have worked in non-training jobs particularly at early stages of their postgraduate career or have worked overseas before entering training may get none of, or only a portion of, this experience recognised towards specialist certification even if working in the same specialty. This is counterintuitive in the context of GPCs as the doctor in training will be learning and practising professional generic and specialty skills in these roles which should be evaluable.

1. Moberly, T. [2018] Health and wellbeing is the most common reason for doctors to take a break from training BMJ 2018;362:k3097



Advantages of flexibility

Flexibility during a doctor's training has many advantages including:

- The ability to move between specialties
- The ability to take time out of training
- Better cross-specialty understanding
- A more flexible medical workforce with more general training within and across specialties to adapt to patient and health service needs. [This point was emphasised in the report of the [Shape of Training Steering Group](#)]
- Training arrangements that consider how and where doctors train, such as less-than-full-time training and the most appropriate Local Education Provider (LEP) to maximise work-life balance.

With the move to outcomes-based curricula defined in the GMC's [Excellence by design: standards for postgraduate curricula](#) (2017), flexibility needs to be framed in terms of how to provide evidence of capabilities already gained to prevent components of training having to be repeated. It is important that, regardless of the reason for the change, doctors in training are given confidence and assurance that if they move specialty, they will have the capabilities that they have demonstrated recognised and accredited as opposed to the time they have served.

Patient safety

The ability to train flexibly and the option to move between specialties may have significant benefits to patients and the health service, especially in specialties where there is similar or shared content. One potential benefit to the service is expanding career choices, which promotes the retention of a highly skilled work force and acts as a positive contribution towards the improvement of patient safety.

GMC regulations

The governance of the recognition of professional qualifications is primarily contained in the [EU Directive](#), the Medical Act 1983 and the Postgraduate Education and Training Order 2010. These restrict exemptions being granted by the minimum duration of training for Annex V specialties. However, it may be possible for 'capabilities' achieved in a previous programme to be recognised as meeting the outcomes required in a different specialty, provided that the minimum training duration is met. This means that doctors would be able to switch to other training programmes without repeating previous learning. The move to outcomes and shared components in training will help to facilitate this. [cf. [Excellence by Design](#).]

GMC guidance [added to GMC connect in 2018] *Bringing Forward Certificate of Completion of Training Dates* states:

'If a trainee completes the CCT curriculum in a shorter period of time than that stated in the curriculum, in order for us to award a CCT the following minimum criteria must be met:

a) The trainee must have spent at least the EU minimum time in GMC approved training – this varies per specialty recognised in the UK and is often shorter than the time [the GMC] usually expect[s] training to take;

b) The trainee must have demonstrated that all the curriculum competencies have been obtained within GMC approved training.'

The [GPC framework](#) clearly defines the professional attributes of a doctor, which evolve with increasing experience and can be developed in any area of practice. Currently only capabilities achieved within training programmes can be considered as part of training since satisfactory completion of specialty training requires a doctor to have completed all elements of the GMC approved curriculum for the award of a CCT. A key component of increasing flexibility in training is the possible inclusion



of capabilities not gained in training programmes. It is essential that any process of recognition of such capabilities is consistent with GMC regulations and the governance of training towards a CCT as defined in the [Gold Guide](#).

Workforce implications

The GMC report [Adapting for the future](#) states that *'The current training structure results in many doctors narrowing their focus to increasingly specialised areas as they progress. This often limits the capacity of doctors to support rotas outside their specialty, or perhaps more critically, their sub-specialty. Towards the middle to end of their training, many doctors are less able to provide care in broader areas of their specialty.'*

'In many cases they have not continued to hone these general skills after the initial years of training. Many training programmes also have few connections to other areas of practice to which they might link naturally. This approach reduces the exposure of trainees to caring for patients whose needs cross-specialty boundaries.'

In practice, however, doctors are still caring for patients with cross-specialty needs even if their main focus is on one aspect. The key aspect is that they are able to recognise and take account of those other conditions and maintain a holistic view of the patient's needs.

Families of specialties

In [Adapting for the Future](#) the GMC also states that *'Different specialties focus on particular patient and service needs. As a result of this, there are some inherent differences in training requirements between specialties. But there are also many professional and to some extent specialty attributes that could be shared between curricula. These opportunities have not been fully realised in the way training is developed.'*

There are a number of examples of 'families of specialties', such as the group within the Acute Care Common Stem (anaesthetics, intensive care medicine, emergency medicine and internal medicine) and Broad Based Training. More specialties want to support flexibility, with the potential for sharing of training opportunities across related specialties. (Some exemplars are shown in Appendix 1).



Updating the Accreditation of Transferable Competences Framework (ATCF)

A key commitment from the GMC's *Adapting for the Future* report was, with the Academy, to review and refine as needed, the ATCF, while reflecting the shift in emphasis from competences to high level outcomes and capabilities. This also included the identification of common outcomes and shared components of training across groups or families of specialties.

A Working Group between the Academy and the GMC was convened with representation from the medical royal colleges and faculties, the GMC, CoPMeD, the Academy Trainee Doctors' Group and the Academy Patient and Lay Committee, with papers circulated to NHS Employers, and the Medical Education Reference Group (see Acknowledgements). The Working Group has taken steps to achieve four country engagement via the Joint Academy Training Forum to ensure that the proposals are applicable to all UK postgraduate medical education jurisdictions, while acknowledging that differences exist between the nations regarding the requirements of the workforce.

The ATCF recommended that doctors in training should be able to move easily between programmes in a way that is proportionate to the demand for movement, the impact on doctors in training and the impact on service delivery.

It was also recommended that capabilities gained by a doctor in one specialty training programme should be recognised and count towards the capabilities, which are required in training in another specialty. Without this, a doctor would have to go back to Year 1 of the specialty to which they are moving and repeat some elements of their training, thus increasing the overall length of training. Equivalent training between related specialties should also be recognised, with clear indications about what further training would be necessary in the new specialty. As stated below, the option of seeking recognition of previously achieved capabilities is a matter of choice for the doctor in training and some may not wish to do so.

This guidance builds on the original ATCF and is intended to provide practical advice for training providers and doctors in training. The Working Group concluded that the original ATCF did not fully cover the breadth of flexibility including the option to change specialties and was now no longer relevant in the context of changes to training described in *Excellence by design: standards for postgraduate curricula*. Therefore, the focus of what follows is on the principles of flexibility within training and moving between specialties rather than going into any specific detail of individual specialties that might be involved. It is acknowledged that introducing greater flexibility would have speciality-specific implications, which would be best addressed by individual colleges and faculties in their curricula revisions and by the statutory Education bodies.

This guidance will be implemented as a staged process with appropriate evaluation and monitoring undertaken jointly between the Academy and the GMC with a review date of January 2022.

Change in terminology – competences to capabilities

Two recent changes by the GMC have introduced use of the word 'capabilities' rather than competences. The GPC framework makes this explicit in its title and includes this definition: *'High level, complex professional capabilities are flexible and adaptive in a wide range of contexts. Many of the qualities of effective professionals, such as clinicians, leaders and educators, can be characterised by such professional capabilities. This includes the kinds of outcomes and descriptors outlined in [the] framework that are integral to their professional practice.'* Secondly, the new standards and



requirements for medical curricula *Excellence by design: standards for postgraduate curricula* require colleges and faculties to state how they will ‘*set out specialty-specific capabilities, including scope of practice and the levels of performance expected of those completing training*’.



Section 2

Principles and practicalities of flexibility and changing specialties

It is strongly recommended that the option to train flexibly should be open to all doctors in training. The opportunities to train flexibly and / or to move between specialties are intended to promote capability-based training. For an individual this may shorten training or equally could extend the duration in order to ensure satisfactory acquisition of capabilities. The option of seeking recognition of previously achieved capabilities is a matter of choice for the doctor in training and some may not wish to do so.

All elements of the GMC approved curriculum must be completed for specialist certification and are expected to be demonstrated in an approved training programme or a prospectively approved Out of Programme (OOP) opportunity.

Specialty curriculum defined skills and capabilities gained during time before appointment to a programme, time out of programme and / or time in a previous programme need to be demonstrated on return / entry to programme using a provisional gap analysis (see Section 3), which would be formally considered by the Annual Review of Competency Progression (ARCP) panel. The gap analysis is defined as the method of identifying the difference between current knowledge, skills and / or practices and those required in the next stage of training. This can be appropriately modified for any of the scenarios described below.

The GMC is currently reviewing its guidance on the recognition of capabilities gained outside training in unapproved posts. This will be tested in the Health Education England (HEE) Out of Programme Pause (OOPP) pilot (see below). The GMC is supportive in principle of doctors in training 'stepping out' of UK training and for any subsequent skills gained while away to be fully considered upon their return.

The results from ongoing pilots will be evaluated to ensure the necessary safeguards are in place that protect both the doctor in training and the service.

In the latest version of the *Gold Guide – 8th edition [Section 1.11-1.12]*, the need for flexibility and discretion to make derogations reflecting innovations in specialty training is recognised.

Different types of flexibility and changing specialty

Two scenarios where flexibility and changing specialty* within postgraduate medical education may be appropriate for doctors in training have been identified:

1. **Doctors in training who realise that their current programme is not the right one for them and wish to change to train in another specialty**
2. **Doctors in training who take some time out of their programme for other experience and later return.**

* For brevity in the following sections the term 'flexibility' will be deemed to include changing specialty



There are also two aspirational scenarios in which the principles of flexibility may be applicable for doctors not in training:**

3. **Doctors not in training or trust / health board doctors who may not have decided on their career path but plan to join a training programme**
4. **Staff Grade, Associate Specialist and Specialty [SAS] doctors working in a particular specialty who wish to enter a training programme.**

Figure 1 on the following page, outlines of routes for each of the four possible scenarios with responsibilities for each step. It is strongly recommended that colleges and faculties should be closely involved in all phases of the processes.

**It is recognised these two scenarios need further consideration and are currently aspirational

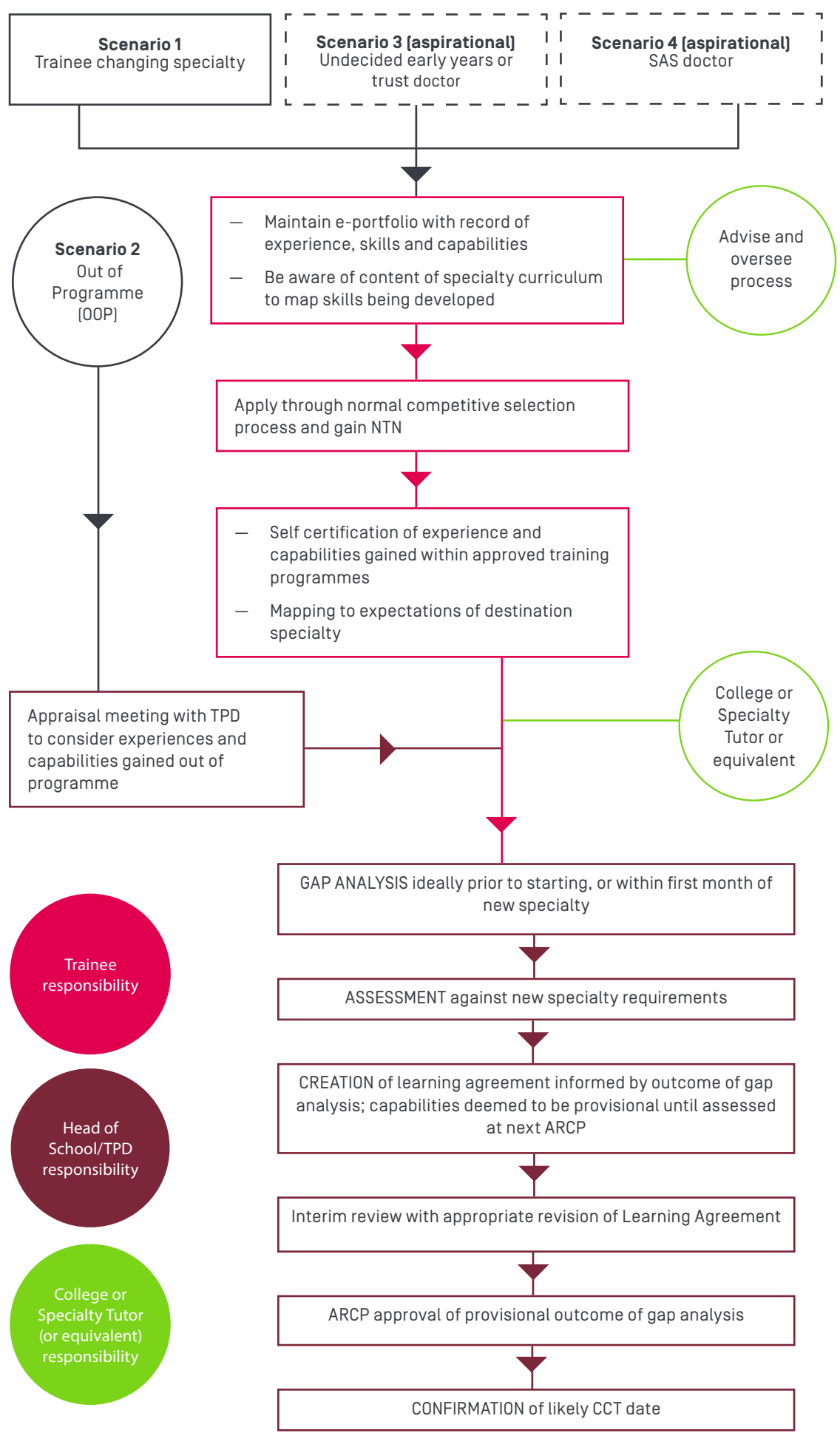


Figure 1. Different routes for flexibility, with responsibilities



Scenario 1

Doctors in training who realise that their current programme is not the right one for them and wish to change to train in another specialty

Principles

Doctors wishing to join training programmes are required to identify their career specialty at an early stage. For some this decision is well made and successful, but for others there needs to be the option to change this decision.

Doctors in training who wish to change to train in another specialty should have the option to have relevant knowledge and skills that have been acquired in a different programme recognised in a transparent process upon joining the preferred specialty.

They will need to be appointed by the appropriate competitive selection process to the new specialty. This is intended to ensure not only consistency with the established governance for specialty recruitment, including fairness for all doctors in training, but also to align with workforce requirements.

Each doctor in training will be expected to include self-assessment of their prior experience, mapping this against the expectations of the destination specialty. They should demonstrate the generic and specialty-specific capabilities achieved in their original training programme. If a doctor in training has not passed the examinations required for their original specialty this will not prevent recognition of transferable capabilities.

If successful in gaining a training number in the destination specialty, a process of gap analysis (Section 3) will be required before entry, or at least within the first month of work in the destination specialty. This will also need to ensure that prior experience included in the application equates to valid experience required for the new specialty. When the move is between linked specialties, the common curriculum content of these specialties should enable recognition of those capabilities already achieved to enable the doctor in training to be placed at the appropriate stage of training as defined in the specialty curriculum. Alternatively, identifying an accelerated training pathway may be appropriate if capabilities already achieved do not align to the initial stages of the new programme.

The doctor in training and Training Programme Director [TPD] will agree the provisional outcome of the gap analysis, which will inform the learning agreement to be developed with the Educational Supervisor. At the end of the training year all evidence from the doctor in training's portfolio including the provisional outcome of the gap analysis will be reviewed at the ARCP to determine satisfactory progression and changes, if any, to the likely CCT date.

Practicalities

The ability to move from one specialty to another should be available to all doctors seeking to attain entry to the Specialist Register. This should include recognition of capabilities gained in the original specialty although there are likely to be specialty-specific variations in what constitutes acceptability of those capabilities gained in the other specialty (this particularly applies to General Practice).

The doctor will need to:

- Discuss the possibility of changing with their current specialty TPD and / or Postgraduate Dean, not only to seek advice but also support for the change



- Have a letter from the Postgraduate Dean at the time of application if there is any deficit within their training for which a corrective strategy is in place. Such support must be clearly defined in order to continue to correct the deficit and bridge the move, particularly if to a new region. This would also include pastoral support e.g. health, caring commitments or disability
- Ensure that they have knowledge of relevant capabilities and expectations required in the destination specialty curriculum
- Make sure that they gain and record relevant experience prior to applying
- Ensure that they are eligible or can become eligible following appointment to the new specialty for examinations in the destination curriculum, and have the expected time needed to pass the required examinations
- Apply for a destination specialty as part of the normal selection process, normally in the national recruitment round or equivalent — if unsuccessful, they will normally continue with their existing programme retaining their original National Training Number (NTN) as appropriate.

The person specification for the destination specialty will need to state explicitly that doctors in training would be welcomed from other specialties. These person specifications should promote a proactive approach including the expectation that documented capabilities will be considered emphasising the need for evidence to ensure quality and patient safety.

Risks

It will be necessary:

- To ensure workforce planning allows for doctors in training changing specialties — probably a largely theoretical risk as to-date the numbers changing specialties are not high
- To develop a robust gap analysis to ensure previously gained specialty-specific and generic capabilities can contribute to the award of a CCT — again largely theoretical as the ARCP process would work to approve the provisional outcome of the gap analysis
- To ensure that doctors in training meet the minimum training time for the new specialty.



Scenario 2

Doctors in training who take some time out of their programme for other experience and later return

Principles

The purpose of taking time out of programme and the required processes are clearly defined in the *Gold Guide*. In addition, there is a definition of those circumstances — out of programme [training] and out of programme [research] [OOPT, OOPR] — under which capabilities gained out of programme can be recognised towards certification and those where capabilities are not recognised — out of programme [experience] [OOPE].

The Statutory Education Bodies across the UK have developed approaches to taking time out of postgraduate training in the context of their local programmes. Each is adapting these approaches to reflect the inclusion of flexibility to facilitate choice in training location, the pace of progression through specialty training, the opportunity to take breaks from training and the opportunity to work and train less than full time.

HEE is developing a programme, Out of Programme Pause [OOPP], which is currently being piloted to evaluate opportunities for doctors in training who wish to 'pause' their training to undertake an NHS non-training post, gain further experience, take stock of their training, work in another related specialty etc. This will not only include clinical patient facing roles but also non-clinical activities such as leadership, management and informatics. Out of Programme Pause differs from OOPE in that experiences or capabilities gained while out of programme are likely to be counted toward CCT if they are demonstrated and assessed once back in training. [Details of the planned OOPP pilot are included in Appendix 2].

NHS Education for Scotland [NES] is working to find ways to ensure that capabilities gained by doctors out of structured and managed training pathways are not 'wasted' and that the skills and experience gained in such posts are taken into account when planning and managing subsequent training. NES see clear opportunities to support Postgraduate Deans in taking account of capabilities gained in 'non-training' posts within the UK NHS system, when making judgements about a doctor's progression through a training pathway.

It is however, essential that not only standards of training are maintained but also a balance is struck which supports a more flexible approach, while ensuring that those responsible and accountable have the tools to ensure the supply of an appropriately trained and experienced medical workforce.

As a result, any initiative needs to be piloted and evaluated before being introduced more widely. There must be a focus on patient safety and safeguards in place to ensure that doctors in training can enhance their experience in an appropriate environment.

The GMC has given its support to the principle that capabilities gained outside training programmes may be recognised towards a CCT. Building on the existing OOP arrangements established across the four nations and learning from the current OOPP pilots being tested by HEE, the GMC will need to be satisfied that any future arrangements have safeguards that protect both doctors in training and training programmes.

In response to concerns about OOPP, the GMC has confirmed that no doctor in training should be disadvantaged as a result of participating in HEE's pilot scheme. If doctors in training have 'stepped off'



training to undertake out of programme opportunities through OOPP, the expectation is that they will return to a UK training programme leading to the award of a CCT. Postgraduate Deans will play a pivotal role in supporting these doctors in training and ensuring that they know what to expect.

Practicalities

This will require:

- Doctors in training to discuss their plans, with clear aims, for their time OOPP with their Educational Supervisor, TPD and their Postgraduate Dean. In the OOPP these opportunities will be relevant to UK healthcare delivery and / or the capabilities within the respective doctor in training's curriculum
- Doctors in training to have successfully completed at least one year of training and given (normally) a minimum of six months' notice to ensure that there is time to apply for prospective approval
- Out of programme opportunities to be subject to balancing the needs of the individual doctor in training against the educational and service requirements of the programme in which they are enrolled. Approval will be entirely at the Postgraduate Dean's discretion
- Continuing contact with their Postgraduate Dean via their specialty training programme faculty with regular and timely feedback from the doctor in training to their TPD on their progress during the OOPP
- An appraisal undertaken within the employing trust / health board when the OOPP is a clinical post under the normal governance of the trust / health board medical director (or equivalent)
- Deciding whether the Postgraduate Dean remains Responsible Officer for the doctor in training (in liaison with the employing host organisation), or if this transfers to the employer for the duration of the OOPP. This decision is at the discretion of the Postgraduate Dean, in line with the Responsible Officer regulations for the relevant nation
- A robust process of assessment of the capabilities acquired during OOPP (Section 3) with a clear focus on patient safety as the doctor in training rejoins training
- Such capabilities to be demonstrated in the context of the learning agreement and approved once back in training within the ARCP process.

Risks

- Potential to destabilise the doctor in training workforce and the service associated with a programme if large numbers wish to 'step off'
- Additional administrative work for Deanery / Local Education Training Board (LETB) offices to manage applications and programmes
- Increased number of applications for approval by TPDs and Postgraduate Deans
- Additional workload for TPDs / Educational Supervisors assessing capabilities
- Approval of capabilities gained outside training programmes being included in portfolios for certification
- Potential loss of the network of information / communication that supports a Responsible Officer when a doctor in training is working within a paired service area
- Currently there is greater availability for OOPP in more popular and larger specialties and more popular geographies simply because the programmes are better staffed. This disadvantages less popular and smaller specialties and geographies. This situation could be worsened by expansion of and greater expectation of OOPP opportunities
- Potential adverse consequences on the training experience for doctors in training who do not take OOPP as the options for backfilling staffing vacancies are limited



- Potential consequences for doctors in training taking time out of programme in relation to length of continuous service (which may impact on pension and employment rights), revalidation and those taking on unsuitable roles while out of programme.

Mitigation of risks

- Approval of time out of programme will be given by the Postgraduate Dean in consultation with the TPD, taking into consideration the stage and progress of the doctor in training, the requirements of their programme in terms of post allocation for the service and the anticipated benefits of the OOP
- Controlling the numbers of doctors in training on OOPP will facilitate the administration load on the deaneries / local offices
- The doctor in training will keep a contemporaneous record of their experience / capabilities during the OOPP including procedures and clinical encounters as well as evidence of the GPCs with supporting reports from senior colleagues with whom they are working
- This record will be assessed on return by the TPD and a provisional outcome agreed with the doctor in training to inform the learning agreement for the forthcoming period of training in their GMC approved training programme
- This learning agreement should ensure that the returning doctor in training is able to demonstrate the capabilities that they wish to be counted toward certification
- Appropriate encouragement should be considered for geographies and specialties which are less easy to fill, to develop posts which provide attractive opportunities for the OOPP experience
- Conditions of employment risks are little different from the risks of many of the current forms of OOP and therefore are well known. Guidance around suitable roles for doctors in training undertaking OOPP will be developed as the programme progresses
- The outcome of the pilot phase of OOPP should be carefully evaluated to determine what has worked, what has not and where improvements can be made.



Scenarios 3 and 4 [Aspirational]

Doctors not in training

The following scenarios have also been considered in which flexibility may be applicable to doctors not in training or those in SAS posts. It is however, recognised that further work is required to determine if these aspirational approaches are practical and are consistent with regulatory requirements.

Scenario 3 [Aspirational]: Doctors not in training or trust/health board doctors who may not have decided on their career path but plan to join a training programme

Scenario 3a

Early years doctors not in training (within three years of completing F2) — Principles

Since the introduction of the Foundation Programme there has been a steady decline in the number of doctors progressing to Specialty Training straight after Foundation — in 2018 only 38% did so. However, the majority do return to training within three years. During that time these doctors work overseas or undertake a service job for further experience. Although this is time that does not include formal training, the available experience does provide professional development as well as providing the opportunity to gain insight into different specialties. Many of these doctors continue to record their experience in continuity with their Foundation ePortfolio (e.g. using the Horus system).

It should be possible for this experience to be recognised once the doctor decides to join a training programme. Implementation of this approach should be encouraging to doctors in the early years of their career — they are developing within the context of the GPCs and it could also help to reduce assessments (in relation to the GPCs) when they enter specialty or GP training.

The GMC has recently reviewed its guidance on recognition of capabilities gained outside training as well as the criteria for combined training programmes and recommended that on completion, where eligible, trainees should be awarded a CCT.

Practicalities

- This scenario would include doctors who are working in service posts at a Core level often in parallel with doctors in training of similar experience
- They should be encouraged to record generic and specialty-specific capabilities in a portfolio as part of their appraisal / revalidation (facilitated by the GPCs)
- Should such a doctor successfully be appointed to a training programme, it is proposed that these capabilities would be reviewed to determine if they can contribute to their training via an equivalent gap analysis
- It is recommended that up to three years' experience is considered.



Scenario 3b

Doctors not in training or trust / health board doctors who may not have decided on their career path but plan to join a training programme — Principles

These doctors would be likely to be working in Trust (or equivalent) service posts. In order to meet patient needs and address rota gaps, employers have created non-training grade jobs in parallel with training posts. Doctors in these roles sometimes have the same opportunities and support as doctors in training and can achieve the same outcomes as the equivalent approved programme.

During the different posts the doctor would be encouraged to keep a record of their experience, skills and capabilities using an ePortfolio or their own record, which would contribute to their appraisal documents. The regular recording of this evidence is important and would be essential for the purposes of providing evidence and identifying skills and capabilities to be taken into consideration should they be appointed into a training post. It is recommended that a maximum of three years' experience is considered.

Doctors should have knowledge of the content for the curriculum of the specialties in which they are working and for the specialty in which they may wish to train, to map the skills that they are developing.

Practicalities

- If a doctor in such a post were planning to join a training programme it is recommended that they seek the support of the employer Director of Medical Education (DME) to oversee their development with direct supervision by the relevant specialty tutor where available. The DME with appropriate College and / or Specialty advice from within the LEP would be best placed to advise on career development within the context of annual appraisals
- The appraisals would identify professional development requirements, which for these doctors would be the development of skills in the specialty in which they were working and would be recorded as part of the appraisal record
- Following successful appointment to a specialty training programme by the appropriate competitive selection process, the Head of School or nominated deputy such as the TPD, would review the portfolio to determine what skills and capabilities have been achieved and how these map against the new specialty curriculum
- The doctor in training and TPD would then agree the outcome of the gap analysis. This evaluation of capabilities and experience already achieved should be made in accordance with the stage of training into which the doctor is starting against the requirements of the specialty curriculum. This is intended to minimise repeating skills and allow progression with new capabilities
- The doctor in training and their Educational Supervisor would develop a learning agreement based on the gap analysis, which would be reviewed as defined in the *Gold Guide* and against the trajectory defined in the specialty curriculum
- At the end of the training year all evidence from the doctor in training's portfolio including the outcome of the gap analysis would be reviewed at the ARCP with determination of a likely certification date.

Risks

- Since these capabilities have been developed outside the existing governance of postgraduate training, should doctors not in training who have joined an approved programme wish to be considered for entry to the Specialist Register it is envisaged that they will need to apply using the combined programme route for a CCT, if eligible
- The possibility of double standards and a consequent effect on patient safety, although Trusts will have a vested interest in patient safety and the ability to quality control a doctor's professional development
- Workforce planning would be complicated although this source of doctors may help such planning.



Scenario 4 [Aspirational] Staff Grade, Associate Specialist and Specialty [SAS]doctors working in a particular specialty who wish to enter a training programme

Principles

The principles described in Scenario 3 would also apply to SAS doctors wishing to join a specialty training programme. Each LEP which employs SAS Doctors would be encouraged to identify an SAS Tutor. The SAS Tutor would be the first point of contact for all SAS Doctors to support and offer advice and guidance on career related issues, education and development.

Access to portfolios for SAS doctors is available in some Colleges with increased access being considered by others. In addition to helping with the certification application process, access to ePortfolios can be beneficial for doctors collecting evidence to inform appraisal and revalidation.

Entry to a training programme would require an SAS doctor to be appointed by the appropriate competitive selection process to the new specialty. This is intended to ensure not only consistency with the established governance for specialty recruitment, but also to align with workforce requirements.

Practicalities

- The approach described in Scenario 3 could be applicable to SAS doctors who wished to join a training programme. However, there would need to be further consideration in the context of the [Charter for SAS Doctors](#) (Academy, BMA, HEE & NHS Employers 2014) and SAS contract reform
- Many SAS doctors develop specialty-specific capabilities which can be assessed for equivalence to specialist training via the CESR / CEGPR route to the specialist register. The most significant barrier SAS doctors face when looking to enter a formal training programme is gaining recognition for the experience and competence they have developed while out of training
- SAS doctors may choose to use a specialist portfolio, which may require respective College membership. If they wish to join a training programme, their portfolio would be reviewed with a gap analysis (Section 3). Their subsequent progress route to the specialist register would be assessed with ARCP as appropriate. As long as the doctor meets the criteria for the combined training programme they would be recommended on completion and where eligible, to be awarded a CCT.



Section 3

Gap analysis

A gap analysis in this context means an evaluation of the gap between the capabilities already obtained either under training in the previous curriculum or from working in non-training posts and the requirements imposed by the new curriculum to which the doctor has moved.

For all four scenarios, a gap analysis will be required to identify the difference between current knowledge, skills, and / or practices and those required in the next stage of training. This will be necessary very early in the process of joining a new programme or returning to an original programme, not only for the essential assurance of patient safety, but also for the benefit of the doctor in training / doctor and the supervising team / department. For those moving to a new specialty this should ideally be done prior to starting in the destination specialty, but otherwise should be completed during the induction process, or within the first month in the new specialty. For those returning to training it should be completed in the context of deciding the learning agreement for the forthcoming period of training i.e. within the first two weeks with clear guidance that capabilities apparently achieved while out of programme are not practised until the learning agreement has been determined.

The gap analysis will be under the jurisdiction of the Postgraduate Dean with external advice as appropriate from the relevant medical royal college or faculty. It will be undertaken within the required time frame by the Head of School or nominated deputy, such as the TPD, who will have a broad unbiased overview of the doctor in training or doctor's evidenced capabilities.

The evidence for the gap analysis will be provided by the doctor in training / doctor according to criteria defined for each scenario (see Appendix 3) and will be mapped against the requirements of the specialty curriculum expected of the doctor when returning to or joining a programme. This will ensure that training progression can be determined in the context of an individual trajectory towards the capabilities required to achieve specialist certification. It is emphasised that the 'gap' should be defined as the differences in learning between the changing specialties / returning doctor's capabilities and the expected level for the year that they are joining. This may mean that capabilities can be achieved in a shorter time frame or if in a longer time the doctor may need to have their date of specialist certification extended.

There may be specialty-specific variations such that what constitutes acceptability of capabilities gained in one specialty is not acceptable / relevant in the new specialty. This is likely to be an issue particularly for general practice where the generalist approach is more appropriate when compared to hospital-based specialties. In such circumstances, specific capabilities and behaviours already learnt may need to be actively reduced in emphasis in the context of the new learning priorities.

The template will be recorded in the ePortfolio either as a PDF or as a digital entry. The gap analysis templates have been designed to cover the key components to which specific specialty requirements can be added as required (Appendix 3).

The outcome of the gap analysis will be provisional and used to define the learning agreement as the process is considered to be formative and not summative. The outcome will be discussed by the TPD and the doctor's Educational Supervisor, who will be responsible for deciding the detail of the Learning Agreement. When technical skills gained while out of programme are included in the evidence for the gap analysis, these will need to be assessed in the first three months of the new post in the programme. The outcome of the gap analysis will be considered for final approval at the next appropriate ARCP with allowance for specific specialty requirements. This will ensure training



progression is within the context of the established governance of the ARCP process.

The responsibility lies with the doctor to provide evidence from their ePortfolio that will inform the learning agreement. Counting prior experience must be a doctor led process with guidance from their trainer to ensure that the experience is acceptable to the relevant specialty curriculum. However, there will be some who are not keen to count previous experience. For example, it is already difficult to complete all the requirements for General Practice in three years and doctors would need to have very clear expectations about any possible effect on the duration of training. The timing of when this decision is made will depend on the level of training at which the transfer takes place and be confirmed at the ARCP. However, in the context of outcomes-based curricula, particularly with respect to GPCs, previous experience will influence where the doctor is relative to the requirements of the relevant training year and their trajectory to the endpoint of training.

Quality assurance of the gap analysis process and in possible cases of disagreement between trainee and TPD about outcome leading to an appeal

The outcome of the gap analysis will be provisional and is intended to inform the Learning Agreement which can be modified at the first review. Therefore, the usual ARCP quality assurance processes will apply as the provisional gap analysis outcome will be formally approved at the ARCP sign-off.



Scenario 1

Doctors in training who realise that their current programme is not the right one for them and wish to change to train in another specialty

The gap analysis will include:

- Which previous capabilities are applicable
- How previous capabilities relate to the requirements for certification in the new specialty
- What gaps there are in training and the requirements for successful completion of training which are clearly described in the Learning Agreement
- Confirmation that the decisions made during the gap analysis are provisional and will be subject to the definitive assessment and review at the first ARCP.

Following the gap analysis, a learning agreement will:

- Take into consideration learning already achieved which meets the requirements of the new specialty and does not need to be repeated
- Define important areas of training or capabilities that must be achieved within the timescale in the destination specialty
- Identify any extra support that will be needed to achieve these capabilities, or any extra supervision that will be provided
- Note any workplace-based assessments or examinations that must be achieved in the destination specialty
- Clearly state when these capabilities must be achieved
- Consider the context in which the capabilities are achieved
- Help doctors in training ensure that they have sufficient time in the destination specialty to complete mandatory examination requirements
- Be agreed before or within one month of entry into the destination specialty. It is only reasonable, for example, to allow a doctor in training to enter the destination specialty at Year 3 if they will be able to achieve other requirements for progress in the destination specialty, such as examinations, or mandatory periods of sub-specialty training.



Scenario 2

Doctors in training who take some time out of their programme for other experience and later return

The gap analysis will include:

- Review of the capabilities achieved in programme before going out of programme, including planned trajectory for completion of training
- Review of all evidence recorded during time out of programme including clinical skills and knowledge and technical skills, nature of experience and any senior colleague / supervisor reports with particular reference to degree of supervision
- Assessment of the OOPP experience in the context of the training trajectory to determine if the doctor in training has progressed to or beyond the expected capabilities or has not progressed
- Agreement of the content of the Learning Agreement for the coming period of training, which will be formally assessed at the next ARCP.

Following the gap analysis, a Learning Agreement will:

- Define the generic and specialty specific capabilities which need to be achieved in the coming period before the next ARCP, including mandatory training
- Identify those capabilities provisionally approved by the gap analysis which have been achieved OOPP and define how and where these are assessed by the Clinical Supervisor / Educational Supervisor (CS / ES) in the coming period of training
- Ensure that the provisional outcomes defined by the gap analysis are completed for review at the next ARCP.



Scenarios 3 (a & b) and 4 (Aspirational)

Doctors not in training or trust/health board doctors who may not have decided on their career path but plan to join a training programme

SAS doctors working in a particular specialty who wish to enter a training programme

The gap analysis will:

- Review the capabilities already achieved to enable planning a trajectory for completion of training
- Review all of the evidence recorded including GPCs, clinical skills and knowledge and technical skills, nature of experience / working environment and any senior colleague / supervisor reports with particular reference to degree of supervision
- Agree the content of a Learning Agreement for the coming period of training, which will be formally assessed at the first ARCP.

Following the gap analysis, a Learning Agreement will:

- Define important areas of training or capabilities that must be achieved within a defined timescale
- Identify any extra support that will be needed to achieve these capabilities, or any extra supervision that will be required
- Note any workplace-based assessments or examinations that must be achieved
- Clearly state when these capabilities must be achieved
- Consider the context in which the capabilities are achieved
- Help ensure that the doctor has sufficient time to complete mandatory examination requirements.



Section 4

Implications for curricula, patients and employers

Curriculum content

The GMC has indicated that every college should identify areas of common capabilities (GPCs) as part of *Excellence by design: standards for postgraduate curricula* which will be documented within new curricula as they are approved and published as well as clarifying which elements are specialty-specific. This should highlight both content and assessment to ensure consistency between and across specialties.

The original ATCF described the close interrelationship and interdependencies between general practice, paediatrics, internal medicine, emergency medicine and psychiatry. It is proposed that the principles described in this guidance can be applied to other areas of practice where there are shared commonalities and interdependencies both in core and higher professional training.

Implications for employers

The *Gold Guide* states that doctors in training have an employment relationship with their employer and are subject to their employing organisation's policies and procedures. It is important therefore that employers are fully aware of the performance and progress of all doctors, including doctors in training, in their employment.

There is an established process between TPDs and the employers with respect to the provision of doctors in training as part of the workforce. This includes the standard arrangements for doctors in training taking approved time out of programme.

The same principles apply to OOPP as for other time out of programme, with due recognition of the needs of the service to minimise any effects on staffing rotas.

Individual employers also have established processes to support the professional development of those doctors in early years' posts, which are not training posts and those in career posts outside of training.

These doctors should be actively encouraged to develop their portfolios with appropriate supervision and appraisal in order to facilitate flexibility of their career development.

Implications for terms of employment

Doctors in training should be aware that any time spent out of programme in a non-NHS setting will have an effect on both their cumulative NHS service and their continuous employment. This has practical implications for employment rights such as pay, pension entitlement, maternity leave and pay, parental leave and other entitlements. Doctors in training considering going out of programme can speak to their employer and if they are a member, the BMA, for further advice on these issues.



SAS Doctors

The 2014 [SAS Charter](#) and the 2019, NHSE/I [Maximising potential: essential measure to support SAS doctors](#) guidance both include sections for each of the devolved nations. The SAS tutor / SAS Educational Advisor, when available, is the first point of contact for all SAS doctors and is there to support and offer advice and guidance on career related issues, education and development as well as the use of SAS funding.

The key responsibilities of the SAS tutor are to:

- Develop effective working relationships within the LEP
- Develop communication mechanisms with the LETB, particularly the Lead Associate Dean for SAS doctors
- Provide support and guidance for all SAS doctors within the LEP
- Provide advice to LEPs on the most effective use of educational resources
- Be aware of both local and national policies and processes relating to SAS doctors.

When there is no SAS tutor / SAS Educational Advisor, the consultant with whom the doctor is working, or their appraiser should be able to fulfil these responsibilities.

Doctors from other countries

It is likely that doctors who have undertaken some or all of their training outside the UK may be able to have some of their existing capabilities counted towards an application for entry to the Specialist Register. For example, a large number of doctors in training in the first year of IMT have come into programme on the Certificate of Readiness to enter Specialty Training [CREST], which will need to be assessed by a gap analysis of their skills to address issues around differential attainment. However, this is an area that is under active consideration at the time of publication and will be addressed in future updates.



Section 5

Proposals for implementation

The aim of this work is to make training more flexible for doctors and there are understandable concerns about possible impacts on patient safety, training and service provision. These have been addressed as far as it is currently possible to do so, but some of the issues are only likely to surface once the proposals are put into practice.

There are still areas under discussion, such as the GMC's standing on the legal aspects, and HEE's finalisation of the OOPP changes. In order to allow as smooth a transition, it is proposed that there will be a staged implementation of Scenarios 1 and 2, along with further work to assess the potential of Scenarios 3 and 4.

All proposals will be reviewed at the end of 2022.



Appendix 1

Exemplars cited from the GMC's Adapting for the future

The **Combined Infection Training programme** was jointly developed with the JRCPTB and the Royal College of Pathologists to develop a common pathway and more closely align training in the infection disciplines of infectious diseases, topical medicine, medical microbiology and medical virology.

The **Clinical Oncology curriculum** allows for accredited transferable capabilities to be brought in from medical oncology training. The specialties are exploring the possibility of more commonality of oncology training. There is also now closer integration of clinical radiology and nuclear medicine, with a common recruitment process and the first three years of training.

The **Acute Care Common Stem programme** is an example of effective consensual working across four specialties — acute medicine, intensive care medicine, emergency medicine and anaesthesia. Its purpose is to provide doctors in training with a broad range of knowledge, skills and attitudes in order to be able to:

- Assess any acutely ill patient and commence resuscitation if necessary
- Diagnose the most likely underlying problem
- Initiate appropriate investigations
- Commence appropriate immediate treatment
- Identify and liaise with the inpatient teams to ensure appropriate definitive care.

Doctors in training enter the programme through a parent specialty. They usually work in these specialties for up to six months each before progressing to their chosen area of practice. This gives them experience in related fields and provides them with a broader and complementary clinical base.

Transferring into GP training

The Royal College of General Practitioners Curriculum Development Group has undertaken an assessment of the specialty curricula and identified where there is significant commonality and where there are gaps. There are currently seven specialties approved for transfer into general practice:

- Anaesthetics
- General medicine
- Obstetrics and gynaecology
- Paediatrics
- Psychiatry
- Emergency medicine
- Acute Care Common Stem



Broad Based Training

Broad Based Training (BBT) is a two year, structured core training programme providing six-month placements in Internal Medical Training, General Practice, Paediatrics and Psychiatry. Initially running in England from 2013, funding from HEE ceased in 2015 and recruitment could no longer continue. The BBT curriculum was approved by the GMC in 2016 and programmes are now running in Scotland and commenced in Northern Ireland from August 2019.

In each post, doctors in training have the opportunity to experience aspects of one of the other three specialties involved in the programme for 10% of the allocated post time. For example, while undertaking a post in paediatrics, doctors in training will be released from their rotation for 10% of the time to gain experience of managing psychiatric conditions pertinent to paediatrics.

At the end of the two years, BBT trainees gain direct entry to CT / ST2 level training, subject to satisfactory progression and completion of the programme, in one of the four specialties involved in BBT without the need for further competitive interview.



Appendix 2

Health Education England Out of Programme Pause proposal

Although existing out of programme mechanisms (time out of programme for clinical experience [OOPE], time out of programme for research [OOPR], time out of programme for a career break [OOPC] and time out of programme for approved clinical training [OOPT]) provided a degree of flexibility, none of these mechanisms recognise that doctors in training sometimes wish to 'pause' their training to undertake an NHS non-training post, gain further experience, take stock of their training, work in another related specialty etc.

Equally, doctors in training have also told Health Education England (HEE) that they felt frustrated about the inability to count capabilities or time in non-training posts, when they had left and at a later stage returned to training. Furthermore, doctors in training stated that they felt they were on a 'production line' and were discouraged from 'pausing' training, despite feeling that this would have positive benefits for their personal development and / or well-being.

The commitment to increase flexibility in training for Junior Doctors has been built upon in the NHS in England in the Long-Term plan, which committed to accelerate the introduction of measures to allow doctors to 'step in and out' of training. The proposal for Out of Programme Pause (OOPP) is intended as a significant step towards meeting this commitment and engagement with NHS Employers has confirmed that this would be a proposal supported by provider organisations.

The HEE OOPP proposal allows doctors in training to 'pause' their training and 'step off' their programme for up to two years. It would allow doctors in training who have had at least one year's specialty training and are normally progressing satisfactorily on their training trajectory, to apply for an OOPP to undertake work in a patient-facing role with a UK based organisation, or non-clinical activities such as leadership, management and informatics. As with existing OOP options, doctors in training would normally be required to give a minimum of six months' notice of their intention to take an OOPP post. Out of Programme Pause would be subject to exigencies of the service and educational sufficiency of the training programmes they are attached to and so it may be necessary to limit or introduce a waiting list should demand for OOPP be high in a particular area.

Doctors in training returning to training after 'stepping off' should discuss their return to programme with their TPD, applying the principles of the HEE [Supported Return to Training](#) guidance. The TPD and the doctor in training should review the experience gained and determine how that experience fits with the training in the context of the relevant specialty curriculum and its defined capabilities. This should allow the TPD and the doctor in training to determine if they can progress on their current trajectory, or if none of the experience gained would contribute to the programme, or if new capabilities were demonstrated and how these experiences might be demonstrated once back within the programme.

It is possible that a doctor in training has progressed against all or only some of the curriculum defined capabilities, or indeed, may have remained at the same level as before 'stepping off', or even lost some capabilities. Once the initial educational appraisal meeting has taken place that informs the education plan of the returning doctor in training, they should then have an opportunity to demonstrate these skills and capabilities once returned to their prospectively approved training programme. This should ideally be undertaken in the first three months following return to training, to allow the doctor in training and educational supervisor to ensure that the training plan is appropriate and properly satisfies the learning objectives in advance of the next ARCP.



If the return from OOPP is on or around the normal programme progression point, the doctor in training's experience should be reviewed at the nearest ARCP, providing this gives them enough time to demonstrate agreed capabilities gained while OOPP once back within the prospectively approved programme. If the return is mid-year, the OOPP experience should be approved at the next ARCP.

At the ARCP, a formal determination of outcome would be made with an adjustment to the CCT in the light of the demonstration of capabilities evidenced following return to training and the Educational Supervisor's report. This would be in accordance with Gold Guide and GMC guidance. If the doctor in training and their educational supervisor did not feel an adjustment to the CCT date would be appropriate, then there would be no requirement to do so.



Appendix 3

Gap analysis templates

Doctor changing specialty [Scenario 1]

SECTION 1: PERSONAL DETAILS

Name

GMC number

GMC licence to practise renewal date

Revalidation date

Are you up to date with revalidation requirements?

SECTION 2: DOCTOR CHANGING SPECIALTY

National Training Number (original specialty)

Original specialty

Original programme

Current level of training

National Training Number (New Specialty)

New specialty

New programme

Exams: [1] completed, with date of completion

Exams: [2] planned, with anticipated date

Date of most recent ARCP

Outcome of most recent ARCP

Plan for next training year

Log book of clinical skills, technical skills

Describe level of skill and competence achieved in training to-date (within old curriculum)

Describe how these map to new specialty

OR

Describe level of capabilities (in context of new curriculum format) achieved in original specialty with evidence

Demonstrate how these high level learning outcomes are applicable to new specialty

Identify any support required to achieve new specialty requirements in appropriate timescale



SECTION 3: OUTCOME OF GAP ANALYSIS

Components of Learning Agreement:

- a) Mandatory training requirements
- b) Identify any exam requirements in new specialty
- c) Determine appropriate capabilities to be achieved according to level of training
- d) In work assessment of skills gained in original specialty

Provisional level of training based on gap analysis [ahead of ARCP]

Join at a stage requiring further supervision

Consider for accelerated progress based on previous progression



SECTION 1: PERSONAL DETAILS

Name
GMC number
GMC licence to practise renewal date

Revalidation date
Are you up to date with revalidation requirements?

SECTION 2: TRAINING TO DATE

National Training Number
Specialty
Programme
Current stage / year of training
Exams: [1] completed, with date of completion
Exams: [2] planned, with anticipated date

Required mandatory capabilities:
Most recent update of ALS / ATLS / APLS (choose appropriate training course)
Date of update

Date of most recent ARCP
Outcome of most recent ARCP
Plan for next training year

SECTION 3: TIME OUT OF PROGRAMME

Level / year of training at beginning of OOPP
Duration planned for OOPP

Reason for OOPP:
(1) Professional (includes clinical experience, leadership and management)
Goals for professional OOPP

Reason for OOPP:
(2) Non-professional
Goals for non-professional OOPP

Experience gained during OOPP

Description of activity undertaken — general
Description of activity undertaken — specialty-specific
GPCs achieved
Degree of supervision

Name of supervisor(s) — (equivalent to ES)
Position of supervisor
Qualifications of supervisor
Workplace-based assessments or high level learning outcomes (new curriculum) undertaken with outcomes

Goals of OOPP achieved?



Planned stage / year of training on return

Expected CCT date

Requirements identified by gap analysis to support stage planned on return (SuppoRTT)

CPD undertaken during time out of programme

Use of activities enabling 'keep in touch' / maintaining competence in context

Date of appraisal during OOPP

Outcome of appraisal (if applicable) during OOPP

Mandatory training required once back in programme

SECTION 4: OUTCOME OF GAP ANALYSIS

Components of Learning Agreement required on return:

- a) Mandatory training requirements
- b) Determine appropriate capabilities to be achieved according to stage of training
- c) In work assessment of skills gained on OOPP

Provisional level of training based on gap analysis (ahead of ARCP)

Rejoin at a level requiring further supervision

Rejoin at the same level at which the OOPP was started (no progress)

Rejoin at the level the doctor in training would have progressed to if performance had been satisfactory and if they had not gone OOPP (chronological progress made)

Rejoin at a higher level than that which the doctor in training would have progressed to if performance had been satisfactory and if they had not gone OOPP (accelerated progress made)



Doctors not in training joining a programme [Scenarios 3 & 4]***

SECTION 1: PERSONAL DETAILS

Name
GMC number
GMC licence to practise renewal date

Revalidation date
Are you up to date with revalidation requirements?

SECTION 2: DOCTORS NOT IN TRAINING / SAS DOCTORS JOINING A PROGRAMME

Current post and time in post

Review of CV
Review of portfolio (if available)
Review of CPD

Exams: [1] completed, with date of completion
Exams: [2] planned, with anticipated date

Date of most recent appraisal
PDP from most recent appraisal

Description of activity undertaken in previous posts — general
Description of activity undertaken in previous posts — specialty-specific
Log book of clinical skills, technical skills
Degree of supervision — overall

Describe level of skill and competence achieved to date

Identify any support required to achieve new specialty requirements in appropriate timescale

OUTCOME OF GAP ANALYSIS

Components of Learning Agreement in first year of training:
a) Mandatory training requirements
b) Identify any exam requirements in new specialty
c) Appropriate capabilities according to level of training
d) Assessment of capabilities gained in previous experience

Provisional level of training based on gap analysis [ahead of ARCP]

Determine trajectory of training
Consider for accelerated progress based on previous experience / capabilities

***Currently aspirational scenarios only



Glossary

ACCS	Acute Care Common Stem
ARCP	Annual Review of Competence Progression
ATCF	Accreditation of Transferable Competencies Framework
BBT	Broad Based Training
Capability	High level, complex professional capabilities which are flexible and adaptive in a wide range of contexts. Many of the qualities of effective professionals, such as clinicians, leaders and educators, can be characterised by such professional capabilities. This includes the kinds of outcomes and descriptors outlined in [the] framework that are integral to their professional practice.
CCT	Certificate of Completion of Training
CESR	Certificate of Eligibility for Specialist Registration
COGPEd	Committee of General Practice Education Directors
Competence	Specific measurable ability of knowledge skills and behaviour that a learner has to demonstrate at a defined stage of medical education or practice
CS	Clinical Supervisor
DME	Director of Medical Education
ES	Educational Supervisor
Gap Analysis	The method of identifying the difference between current knowledge, skills, and / or practices and those required in the next stage of training.
GPC	Generic Professional Capabilities
GMC	General Medical Council
HEE	Health Education England
LEP	Local Education Provider
LETB	Local Education Training Board
LTFT	Less than full time training
NES	NHS Education for Scotland
NIMDTA	Northern Ireland Medical and Dental Training Agency
NTN	National Training Number
OOPE	Out of programme [experience]
OOPC	Out of programme [career break]
OOPP	Out of programme [pause]
OOPT	Out of programme [training]
OOPR	Out of programme [research]
SAS	Staff Grade, Associate Specialists and Specialty doctors
TPD	Training Programme Director



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