Medical training review

1. Are you responding on behalf of a committee, department or organisation?
    a. Yes
    b. No
2. If you answered yes, which of the following categories best describes your committee, department or organisation?
    a. Body representing a non-medical clinical profession
    b. Body representing doctors
    c. Charity or body representing patients and/or the public
    d. Government / arm's length body
    e. Independent service provider
    f. Medical Royal College
    g. Medical School
    h. NHS Service provider
    i. Regulatory body
    j. Research funding body
    k. Other (please state)
3. If you answered yes, what is the name of your organisation?
    a. British Geriatrics Society
4. What is your profession / role? (please tick all that apply)
    a. Doctor – locally employed doctor
    b. Doctor – on the Specialist Register or GP Register
    c. Doctor – specialty / specialist grade
    d. Doctor in postgraduate training (Core)
    e. Doctor in postgraduate training (Foundation)
    f. Doctor in postgraduate training (Higher Specialty / Run through / GP Specialty Trainee)
    g. Medical degree student
    h. Senior training faculty (director of medical education, associate or deputy dean, postgraduate dean)
    i. Trainer / educator (training programme director, college tutor, head of school, educational or clinical supervisor or clinical trainer)
    j. Other clinical professional
    k. Employer / service manager
    l. Patient
    m. Policy-maker
    n. Other (please state) British Geriatrics Society
    o. Prefer not to say
5. Which NHS region are you based in?
    a. East of England

b. London
c. Midlands
d. North East and Yorkshire
e. North West
f. South East
g. South West
h. Northern Ireland
i. Scotland
j. Wales
k. National organisation

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

Subtheme 1.1 – Workforce distribution

1. To what extent do you agree or disagree with the following statement: The current system of recruitment to and distribution of training posts meets the health needs of patients and the population.
   a. Strongly disagree
   b. Disagree
   c. Neither agree nor disagree
   d. Agree
   e. Strongly agree
   f. Don't know
2. If you disagree, what changes are needed to better align the distribution of training posts with local health needs?

Older people use health and social care services more than any other population group and this trend will continue as the population continues to age. Recruitment into geriatric medicine therefore should be a priority to ensure that the future medical workforce has the skills required to provide high quality care to older people. As highlighted in the Chief Medical Officer's 2023 report, Health in an ageing society, the distribution of older people is centred around rural and coastal communities. While urban areas have large numbers of older people (because they have large numbers of all people), rural and coastal areas have greater proportions of older people. This must be taken into account when distributing training posts with more geriatric medicine training posts allocated to areas where there is a greater proportion of older people.

In 2024 there were 281 applications for 161 ST4 geriatric medicine posts, a competition ratio of 1.75. However, despite this competition for posts at a national level, at a regional level, systems often struggle to fill the roles available. In 2024, three regions (Kent Surrey and Sussex; Thames Valley; and Wessex) all filled fewer than half of the posts available

at ST4 level. More needs to be done to promote geriatric medicine as a specialism and to encourage doctors in training to accept posts in regions where there is a greater need.

Training doctors to lead the care of our older population outside a hospital setting is imperative to enable the NHS to meet the important 'left shift' from acute hospital to community. Geriatricians currently work in both community and hospital settings but there is considerable geographic disparity in the ability of trainees to access community-based experience during their training. Delivering care for older people in the community is likely to be a key skill for geriatricians in the future so it is crucial that this is addressed.

3. To what extent do you agree or disagree with the following statement: The current distribution of training posts meets the needs of healthcare service providers in delivering healthcare and developing their future medical workforce.
    a. Strongly disagree
    b. Disagree
    c. Neither agree nor disagree
    d. Agree
    e. Strongly agree
    f. Don't know
4. If you disagree, what changes would better align training post distribution with service and workforce needs?

The current system does not allow for timely information to be made available to Trusts about how many registrars have been allocated to join a hospital before a rotation begins. This means that services are unable to plan sufficiently. For instance, if not all of the posts available have been filled for each rotation, the service may need to recruit a locum doctor to ensure they are able to provide an adequate service to patients. However, the lateness of information about whether posts have been filled makes it impossible to recruit a locum in the time available.

Most trainees stay in the region where they trained for their initial consultant post. For this reason, training post allocation by region needs to map to patient need, demographics and the subsequent workforce requirements. This review provides an opportunity to ensure that these ratios are fit for purpose. At the BGS we would be happy to help ensure that the multiprofessional older people's healthcare workforce meets the needs of the ageing population, now and into the future.

Healthcare service providers have to make choices about the services they can provide, based on the workforce they have available to them. The British Geriatrics Society recommends a ratio of one consultant geriatrician for every 500 people aged over 85, as set out in our report 'The case for more geriatricians' (www.bgs.org.uk/moregeriatricians). In parts of the country where this ratio is achieved

systems are able to provide services such as perioperative care, oncogeriatrics or hospital at home, in addition to core clinical services. Areas where this ratio is not achieved are less able to provide these services.

Geriatricians have specific skills in helping to coordinate care for older patients across the spectrum of their healthcare and across a range of clinical settings. Research shows that the involvement of geriatricians helps to improve mortality, reduce length of stay and improve quality in ever increasing areas of healthcare including orthopaedic surgery, general surgery, vascular surgery, oncology, haematology and renal medicine. As the population ages and more people are living for longer with multiple long-term conditions, this ability to work collaboratively with other specialties will be increasingly important. However, it will only be possible at scale if the distribution of training posts is evened out.

Subtheme 1.2 – Experience of being a resident doctor

1. To what extent do you agree or disagree with the following statement: The current model of postgraduate medical training meets the personal and professional needs of most doctors.
    a. Strongly disagree
    b. Disagree
    c. Neither agree nor disagree
    d. Agree
    e. Strongly agree
    f. Don't know
2. If you disagree, what changes would have greater impact in supporting the personal and professional needs of doctors in training?

The current system means that doctors in training do not know where they will be posted from one grade to another and from one rotation to another. When they are allocated a training post, they do not know how long they will be in that post or where their next post will be. This makes it difficult for doctors in training to plan their own training and careers as well as their personal lives including maintaining relationships and family lives.

Doctors in training report that the current system of postgraduate medical training does not support a work/life balance. This has a big impact on many doctors in training, especially as they are typically in training roles at times in their lives when they may also be considering other life changes such as starting a family. Less than full time training and late CCT dates may also mean that doctors in training have caring responsibilities for older family members while training. The postgraduate medical training programme is not conducive to family commitments.

It may be useful to consider a competency-based training programme to enable doctors in training to have experience from outside the formal training programme recognised as part of their training. The current system is not flexible enough for experience from before an individual starts formal training to be considered. This particularly affects international medical graduates (IMGs) who may have experience from their home countries which is currently not considered towards their training. IMGs are increasingly making up a significant proportion of the geriatric medicine workforce and this will continue to be the case as the population continues to age.

Subtheme 1.3 – Flexibility in training

1. To what extent do you agree or disagree with the following statement: Current training processes are flexible enough to meet the needs of most doctors.
   a. Strongly disagree
   b. Disagree
   c. Neither agree nor disagree
   d. Agree
   e. Strongly agree
   f. Don't know
2. If you disagree, which areas of flexibility need improvement?

While there have been improvements in flexibility in training in recent years, more needs to be done to support doctors in training to work flexibly throughout their training. BGS has published a position statement about flexible working in geriatric medicine. We are currently in the process of updating this document to make it inclusive of the full multiprofessional team involved in older people's healthcare.

While Flexible Working Champions are in existence in all Trusts, many of our doctors in training (including those working flexibly) report being unaware of this role or the support available. Flexible Working Champions should ensure that all doctors in training are provided with information about this role and the availability of support.

Increasing numbers of doctors in training are working less than full time (LTFT) for various reasons including caring for children or ageing parents and non-clinical commitments. This provides benefits for both the trainee and the employer, reducing the risk of burnout and fatigue and providing a richer career journey that includes research or out of programme experience. The training programme needs to evolve to meet the needs of trainees to ensure that the future workforce is adequately resourced. BGS recommends an ongoing review of flexibility in training to ensure that training is meeting the needs of those being trained. As previously stated, a move to competency-based training and the ability to count previous experience towards training would help to ensure that doctors in training have the flexibility that they need.

Theme 2: training capacity, delivery and quality

Subtheme 2.1 – Preparation for future practice

1. To what extent do you agree or disagree with the following statement: The current postgraduate medical training adequately prepares doctors for the professional and clinical demands of their future roles.
    a. Strongly disagree
    b. Disagree
    c. Neither agree nor disagree
    d. Agree
    e. Strongly agree
    f. Don't know
2. If you disagree, which of the areas contributing to preparedness require the most improvement?

In addition to the clinical demands of medicine, doctors in training need more training to prepare them for the leadership and management aspects of their roles. This may include training on finance, complaints, writing business cases and developing strategy. This will help them to play a leadership role once they are appointed as consultants.

This could be achieved through mentoring programmes and shadowing of senior leaders and managements being built into postgraduate training programmes. This training should be shared across professions including general practice, ambulance services, pharmacy, nursing and allied health professions as well as across specialties. This would help to avoid professional silos developing.

The current postgraduate training programme is not preparing doctors in training for the environment in which they will be working in the future, in particular the three shifts from hospital to community, illness to prevention and analogue to digital. Current availability of community based experience is patchy at best for trainees which is concerning given the shift of older people's healthcare out of hospitals and into the community.

In addition, there is a need for greater numbers of generalists and specialists from other specialities to care for older people, alongside geriatric medicine specialists. This will support geriatric medicine teams to straddle care from acute into the community. Older people should always have access to the care they need in the most appropriate setting and this will involve the ability to be able to seamlessly move from hospital into the community. Continuity of care is a key tenet of good quality care and is currently hugely lacking in the current system. Continuity of care will be crucial to supporting the shift from hospital to community. The doctors of the future need to have skills in rapid diagnostics, intense acute management as well as how to manage patients out of hospital, including managing and holding risk.

The system is currently set up as an illness-treatment system and doctors are not necessarily trained with the skills and knowledge to promote a healthy society and

healthy lifestyles throughout the life course. It is never too late to prevent ill health and geriatricians must be trained to ensure that they are supporting their patients to be as healthy as possible as they age. This will enable more older people to live independently for longer and will delay or prevent the need for hospital treatment.

The delivery of healthcare is becoming more virtual with technology playing an increasingly important role in care, including virtual patient consultations, wearable technologies supporting patients at home and the use of artificial intelligence in care. Training must adapt to this new environment of care to ensure that the doctors of the future have the necessary skills.

Subtheme 2.2 – Quality of the learning environment

1. To what extent do you agree or disagree with the following statement: The current system of postgraduate medical education provides doctors with a high quality learning environment.
    a. Strongly disagree
    b. Disagree
    c. Neither agree nor disagree
    d. Agree
    e. Strongly agree
    f. Don't know
2. If you disagree, which of the areas contributing to preparedness require the most improvement?

The current system requires doctors in training to undertake on-call work and night shifts. This can mean that they do not have the opportunity to provide continuity of care to their patients. Continuity of care is highly valued by patients, especially older people who may be experiencing cognitive impairment and may feel reassured by a familiar face in hospital. Research has shown continuity of care to improve patient satisfaction, which impacts upon a patient's likelihood to continue with the treatment regimen proposed. (https://pmc.ncbi.nlm.nih.gov/articles/PMC1490082/) Providing continuity of care is also a valuable learning opportunity for doctors in training to follow a patient throughout their time in hospital. Continuity of care leads to a much richer learning environment where trainees can see the impact of the care they deliver and see patients across the healthcare spectrum from home to acute care and rehabilitation. Research from the Health Foundation shows that greater continuity of care in the community leads to fewer secondary care presentations. (https://www.health.org.uk/funding-and-fellowships/journal-articles/association-between-continuity-of-care-in-general-0)

The current system also means that doctors in training have less contact time with their supervisors than would be ideal.

Subtheme 2.3 – Education capacity

1. To what extent do you agree or disagree with the following statement: trainers in postgraduate medical education have sufficient time, support and resources to deliver quality supervision and training.
    a. Strongly disagree
    b. Disagree
    c. Neither agree nor disagree
    d. Agree
    e. Strongly agree
    f. Don't know
2. If you disagree, which factors could better support medical educators?

As detailed previously, the current system requires doctors in training to undertake on-call work and night shifts. Because of this working pattern, there is often a mismatch between when they are available and when their trainers are available to support them.

Subtheme 2.4 – Equality, diversity and inclusion

1. To what extent do you agree or disagree with the following statement: Postgraduate medical training creates an equitable and inclusive environment for doctors from diverse backgrounds, including those from minority ethnic groups and those with disabilities?
    a. Strongly disagree
    b. Disagree
    c. Neither agree nor disagree
    d. Agree
    e. Strongly agree
    f. Don't know
2. If you disagree, how can things be done differently to address differential attainment, sexism and microaggressions for doctors from diverse backgrounds?

Despite some progress, evidence still shows differential attainment in qualifications such as the MRCP across all specialties. In addition, doctors who trained outside of the UK are less likely to be successful in applying for Higher Specialty Trainee posts. Diversity across the workforce is to be encouraged and celebrated with microaggressions aimed at anyone from diverse backgrounds to be called out and acted upon. BGS has published a position statement about calling out sexual misconduct in healthcare and we have established an Equality, Diversity and Inclusion working group which aims to address some of these issues.

Specifically regarding inclusivity for people with disabilities, there has been an increase in recent years of doctors in training with neurodiversity. As such, it is important for

Trusts and deaneries to ensure that Training Programme Directors have the necessary skills and knowledge to support individuals with neurodiversity.

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

Subtheme 3.1 – Hospital to community

1. To what extent do you agree or disagree with the following statement: Postgraduate medical training should include more opportunities in community-based settings to better align with patient and community needs.
    a. Strongly disagree
    b. Disagree
    c. Neither agree nor disagree
    d. Agree
    e. Strongly agree
    f. Don't know
2. If you disagree, please explain why you believe postgraduate education should not provide more community-based opportunities.

Our doctors in training often report limited time spent in the community during their training. This is especially the case for those who train less than full time – of which there are increasing numbers of trainees in geriatric medicine and thus the speciality will be affected disproportionately. In older people's healthcare, experience in the community is essential as most older people are not in hospital and do not want to be in hospital. While hospital admission should always be available to older people who can benefit from it (for rapid diagnostics and acute care management for significant treatable illnesses), for many older people, hospital causes more harm than good. If treatment can be provided in the community then this should be considered. Having more doctors with community-based experience will help to provide care nearer to where older people are, giving better patient outcomes. As a specialty we have worked to redevelop community resources and have been leading exponents of the virtual ward programme (https://www.bgs.org.uk/ImplementingVirtualWards) However, despite the development of these services, trainees do not gain universal exposure to patient care in this manner. Training is needed in the delivery of virtual healthcare, working with MDTs in the community and how to integrate patients seamlessly with acute secondary care.

Subtheme 3.2 – Treatment to prevention

1. To what extent do you agree or disagree with the following statement: Postgraduate medical training curricula should include a stronger focus on addressing health inequalities, social determinants of health and population health.
    a. Strongly disagree

b. Disagree
c. Neither agree nor disagree
d. Agree
e. Strongly agree
f. Don't know
2. If you disagree please give your reasons.

It is estimated that healthcare only accounts for around 10% of a population's health with the remaining 90% determined by socioeconomic and demographic factors. With this in mind, it is important that doctors in training have knowledge about these issues with a particular focus on reducing inequalities, alongside their skills in the delivery of healthcare. Greater training is needed to ensure the doctors of tomorrow are able to educate patients on the things they can do to prevent / delay sarcopenia, frailty and dementia as there are significant benefits which can be obtained in the prevention of these conditions.

Subtheme 3.3 – Analogue to digital

1. To what extent do you agree or disagree with the following statement: Postgraduate medical training should incorporate more content on digital health, AI and remote care, including the use of technologies such as extended reality, AI and machine learning, to enhance learning experiences and improve trainer capacity.
   a. Strongly disagree
   b. Disagree
   c. Neither agree nor disagree
   d. Agree
   e. Strongly agree
   f. Don't know
2. If you disagree, please explain your reasons.

While we agree with this statement, it is our view that AI and machine learning play a smaller role in older people's healthcare than they might in some other specialties. In addition, while remote care is playing an important role for some people, in geriatric medicine it is unlikely to replace hands-on care. Many older people lack confidence in using technology and still prefer face to face appointments in many circumstances.

Career expectations and system gaps / issues impacting on satisfaction

1. What factors are the most and least important for a rewarding and satisfying postgraduate medical training pathway? [note: pay and conditions are not within scope]

	Most important (select up to 3)	**Least important (select up to 3)**

Ability to develop and / or deliver effective patient care pathways		x
Ability to train and work in one's desired location		
Ability to train and work in one's desired specialty		
Access to high quality mentorship and supervision		
Being a member of an effective multidisciplinary team		
Confidence in career progression		
Contributing to an effective healthcare service		
Flexible training options	x	
Leadership, research, quality improvement or teaching opportunities		
Making a difference to the wellbeing of individual patients		
Professional identity and status		x
Professional / technical 'mastery' of one's craft	x	
Support for personal and professional development		
The opportunity to improve health of a local community at population level		
Work-life balance and workload	x	
Working conditions		
Other(s) – free text		

2. What are the most and least significant barriers to a rewarding and satisfying postgraduate medical training pathway? [note: pay and conditions not within scope]

	Most important (select up to 3)	**Least important (select up to 3)**
Cost of training (for example, examinations and college membership fees)		
Current rotational training structure		
Inadequate physical and IT infrastructure to support training		
Lack of access to high quality supervision		
Lack of access to high quality training opportunities		
Lack of access to simulation, virtual, digital and AI-based education		x
Lack of flexibility to gain experience across multiple settings		

Length of training		x
Limited protected time for portfolio development (research, quality improvement, teaching, leadership)		
Burden of portfolio requirements		x
Relevance of curricula		
Rigidity of training structures / career progression routes	x	
Service pressures / time to train	x	
Training bottlenecks at key progression points	x	
Other(s) – free text		

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

1. Addressing bottlenecks in training progression at key transition points
2. Greater access to flexible working patterns
3. Balancing general and specialist training opportunities
4. Creating longer-term trainer / resident mentorship schemes
5. Reform of the specialty training recruitment processes to support the specialty preferences of candidates
6. Reform of the specialty training recruitment processes to support geographical preferences of candidates
7. Addressing burnout and improving resident doctor wellbeing
8. Ensuring access to physical and IT infrastructure required to facilitate training (for example, shared desk space, reliable digital systems)
9. Expanding training in community settings
10. Reducing the frequency of rotations within a programme
11. Greater ability to have capabilities gained in any post counted towards training progression
12. Offering better support for doctors pursuing clinical academic careers
13. Embedding training to tackle health inequalities and social determinants of health into curricula
14. Establishing clearer pathways into medical education, with appropriate incentives
15. Geographically smaller training programmes
16. Giving local health systems greater input into shaping postgraduate medical training placements and specialty numbers
17. More curriculum focus on doctors' competencies in digital health, AI and remote care
18. Offering targeted incentives to work in underserved areas

19. Creating formal pathways for doctors to pursue extracurricular interests (for examples, informatics, medical entrepreneurship, academic medicine)
20. Protecting time for educators
21. Providing better career coaching / mentorship / personalised career planning support
22. Making greater use of extended reality, AI and machine learning in the delivery of postgraduate medical education

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

The introduction of community geriatrics training posts would ensure that more doctors in training have the skills needed to care for older people in their own homes or in care homes. These specialist community posts have been introduced in paediatric medicine and have been successful as they require less hospital based work and do not require an on-call commitment. This is more popular with doctors in training trying to achieve a work life balance. This would also help to address workforce shortages in rural and coastal communities. The introduction of this post would need to be accompanied by an investment in the future workforce to deliver significant levels of care in the community.

A training model where doctors in training are employed by a single employer for the duration of their training has the potential to make training less bureaucratic and complicated. This has been introduced in the East Midlands where doctors in training are employed by one hospital during their training and seconded to other hospitals for rotations. This makes taking maternity leave, for example, less complicated.

Doctors in training would also appreciate a model where they know all of their rotations at the beginning of their training. To achieve this, roles should be advertised by rotation rather than by deanery. This would enable doctors in training to apply for roles at a rotation that suits them, rather than applying to a deanery and risk being posted to hospitals far away from their home.