The King's Fund breakfast meeting: Medical Education and Training Review - 22 October 2026

This breakfast engagement session was convened to inform the Medical Education and Training Review (METR) by testing four tensions emerging from its work: individual geographic choice and reducing health inequalities; flexibility alongside structure and predictability; formal and non-traditional training routes; and specialist depth and broader medical capability. It was attended by over 30 stakeholders representing views from primary care, secondary care, Royal Colleges and national NHS bodies.

In the first table conversation, participants explored how each tension appears in practice and what helps or hinders a workable balance. The second conversation focused on what METR should learn and what successful management of the tension would look like.

The summary below brings together both rounds. Participants consistently argued that reform should not select one side of each tension, but create clear expectations, credible routes and practical conditions in which legitimate priorities can coexist.

A. Individual geographic choice and reducing health inequalities

Location choices reflect relationships, caring responsibilities, housing, partners' careers, childcare, community and predictability and not simply preference. Broad, frequently changing rotations can undermine wellbeing and retention. Narrower, more predictable geographies and locally rooted programmes could help doctors establish lives, feel part of teams and remain after training.

Underserved coastal, rural and deprived areas require deliberate intervention. Medical schools and training placements can attract staff, research and investment, and people often remain near where they train. Participants proposed aligning training distribution with population need, improving placements, and offering incentives such as health-equity fellowships, career development, childcare and transport. A compelling offer was considered more sustainable than compulsion.

Education should build understanding of population health and inequality through direct experience with patients and communities. Extending structured education to LEDs and SAS doctors could also strengthen local workforces where formal trainee recruitment is difficult.

Implications for METR

- Balance autonomy with population need through predictable regional footprints, attractive incentives and high-quality local training, recognising that belonging, reputation and lived experience shape choices as much as formal policy.
- Plan the placement of medical schools and training capacity jointly across education, health and workforce policy, with local institutions and communities able to shape a credible offer.
- Embed population-health equity and local-context learning throughout education, reinforcing professional norms that value contribution in underserved settings without relying mainly on compulsion.

B. Flexibility and structure/predictability

Participants reframed flexibility as autonomy: control over geography, working hours, pace, experiences and career destination. For many it means stability in one place with adaptable arrangements, not frequent movement. Frustration often arises from rigid administration rather than structure itself.

Structure remains important. Learners need clear standards, dependable rotations, honest information about competition and jobs, and an understanding that choices carry trade-offs. Participants rejected any implied guarantee of a preferred consultant post, location or working pattern. Flexibility may need to vary by career stage and circumstance.

Local employment and flexible progression routes could offer continuity and tailored careers alongside the national training-number route. However, decentralisation risks inconsistency, favouritism and wider inequality unless educators are prepared, assessment is transparent and external oversight remains. Workable flexibility depends on strong trainer relationships, employer ownership and protected resources.

Implications for METR

- Define clearly what flexibility means, what remains standardised and which trade-offs must be accepted, while giving local leaders sufficient discretion to respond constructively to individual circumstances.
- Create navigable routes with honest career information, portable recognition of competence and credible movement between pathways, so that informal networks or local sponsorship are not prerequisites for progression.
- Test flexible models against deliverability, equity and patient-service requirements, including whether local decision-making, incentives and established working practices support consistent access in reality.

C. Formal training routes and recognition of “non-traditional” pathways

Participants described SAS and locally employed doctors (LEDs) as a large, diverse and often undervalued workforce. Their progression depends too heavily on local champions: some organisations offer strong development programmes, mentoring and portfolios, while others provide little supervision or career guidance. A consistent, portable way to record capability was strongly supported, combining common professional capabilities with specialty-specific evidence. Supervised service delivery should be recognised as learning.

Formal training remains valued for national standards, quality assurance and confidence that doctors are ready for consultant or GP roles. Rather than erasing distinctions, participants wanted routes with equal esteem, transparent endpoints, opportunities to move between them and proportionate external assurance. The language of “alternative” pathways was seen as potentially reinforcing hierarchy; “career progression” or “flexible” pathways may better reflect legitimate choices, including SAS careers.

Employers must understand workforce skills, provide mentorship, fund supervision, create specialist posts and recognise prior competence. Expansion will fail without educational capacity, protected trainer time and realistic workforce planning.

Implications for METR

- Decide the purpose, endpoints and transfer points of each route, while retaining proportionate national quality assurance and addressing the signals that currently confer greater status on some routes than others.
- Set a consistent, portable framework for recognising prior learning, workplace capability and service-based learning, supported by trusted judgements across employers and specialties.
- Align accountability, incentives and everyday leadership so that protected education, career progression and parity of esteem become normal organisational practice rather than depending on individual champions.
- Seek to align with existing work being undertaken by NHS England and the GMC.

D. Specialist depth and generalist capability

“Generalism” was considered ambiguous. Participants distinguished specialty breadth from common medical capabilities: managing complexity and uncertainty, coordinating care, navigating systems, leading teams, communicating risk and understanding patient journeys. These are essential across specialties but learned inconsistently and poorly evidenced.

Participants cautioned against diluting specialist expertise or reducing capability to a checklist. Medicine is increasingly complex, and safe practice still requires sufficient clinical exposure, technical depth and readiness for the realities of a consultant or GP role. General professional capabilities should therefore be developed within authentic specialty practice, not as detached classroom modules.

The strongest proposed mechanism was protected educational relationships. Teams, mentorship, case discussion and timely reflection convert service into learning and develop judgement. Reliance on portfolios and brief, remote reviews can displace feedback. Technology could reduce documentation burdens and connect cases to curricula but should support supervision, not replace it. A supervised pre-consultant phase could help doctors practise clinical and non-clinical leadership.

Implications for METR

- Define a common set of medical professional capabilities, while allowing specialties to translate them into credible practice and modelling them through senior clinical leadership.
- Protect and account for trainer time, funding and regular direct feedback, with organisational expectations that make teaching and reflective discussion part of routine work rather than an optional extra.
- Ensure progression balances qualitative judgement, clinical exposure and specialty competence, while creating enough continuity and trust for honest feedback and avoiding both crude counts and tick-box portfolios.

Attending to the recurring theme of culture

Across the discussions, participants repeatedly returned to the gap between formal policy and day-to-day experience. Geographic incentives will work best where doctors encounter good training, predictable rotations, practical support and a genuine sense of belonging. Greater flexibility will depend on how educators and managers exercise discretion, while transparent safeguards prevent informal networks or local custom from determining

opportunity. Non-traditional routes will gain credibility only if senior clinicians, colleges and employers visibly recognise them and if progression does not depend on local champions. Broader medical capabilities will be developed through trusted teams, protected conversations and supervised responsibility rather than not portfolios alone.

For the Medical Education and Training Review, this means treating reform as cultural as well as technical change: new structures, standards and funding will need to be reinforced by professional signals, relationships, routines and accountability that reshape what is valued and what happens in practice.