NHS
Health Education England

Review Body on Doctors' and Dentists' Remuneration

Health Education England's written evidence for 2022/23

1. Introduction

1.1. Health Education England (HEE) welcomes the opportunity to submit evidence to the Review Body on Doctors' and Dentists' Remuneration (DDRB) as part of its national process of gathering evidence from interested parties to inform the recommendations for 2022/23.

1.2. HEE's evidence provides an update on our key areas of responsibility, namely the education and training of doctors and dentists and our range of initiatives to drive reform in postgraduate medical and dental education. We have also included updated information on the impact of COVID-19 and the resultant, associated financial challenges, and a section on the dental workforce.

1.3. Our evidence has been provided in the light of the broad strategy outlined in the *NHS Long Term Plan* and *We are the NHS: People Plan for 2020/21*. Our June 2020 publication, *The Future Doctor* report, sets out HEE's co-created vision for the reforms of medical education and training in the next stage of this strategy[1]. HEE's recently published *Advancing Dental Care (ADC) Review Report*[2] sets out recommendations on developing a future dental education and training infrastructure which can best support patient and population needs within the NHS.

1.4. In July 2021, HEE was commissioned to work with our partners to review long term strategic trends for the health and social care workforce. The Long-Term Strategic Framework for Health and Social Care Workforce Planning will help ensure we have the right numbers, skills, values and behaviours to deliver world leading clinical services and continued high standards of patient care. This includes the medical and entire multi-professional workforce across health and social care.

2. Health Education England

2.1. The Government announced on 22 November an intention for Health Education England (HEE) and NHS England (NHSE) to come together to form a new organisation, subject to the passage of the necessary legislation. This is designed to create a stronger organisation that aligns workforce, financial and service planning with education and training, COVID-19 recovery, the People Plan, and a robust workforce reform programme for the benefit of patients and the public.

2.2. Until the new organisation is formally created, HEE will continue to be a statutory Arm's Length Body of the Department of Health and Social Care (DHSC). HEE is the NHS body that works with others to plan, educate and train the health workforce. To deliver this purpose, HEE:

[1] Health Education England: Future Doctor report (2020). https://www.hee.nhs.uk/our-work/future-doctor

[2] https://www.hee.nhs.uk/our-work/advancing-dental-care

- seeks out, invests in and quality assures the best education and training for trainees, new roles and current professionals; intervening where quality, environment or supply are not meeting the needs of learners or the NHS;

- ensures new evidence-based science, digital technology, skills and knowledge enhance both individual staff and multi-professional teams;

- co-operates and collaborates with partners across health and education, respecting each other's roles, expertise and responsibilities. HEE brings workforce data, intelligence and analysis, policy proposals, practical transformation and development tools and resources, both financial and people, to shared issues.

2.3. HEE has identified its core roles as:

- Workforce design and analysis

- Medical and Dental education

- Clinical education and training

- Quality of education and training

- Workforce transformation and skills development

- Developing global partnerships

2.4. While HEE will continue to deliver its statutory responsibilities to secure sufficient and high-quality education and training for the NHS workforce, HEE recognises the importance of working collaboratively with the DHSC, NHSE/I, and other health system stakeholders to tackle the issues facing the NHS and its workforce.

2.5. This closer alignment will be formalised through the forthcoming integration which, subject to legislative changes, is scheduled for completion by April 2023. Work is in progress to outline key areas such as the purpose, culture, strategy, and governance of the new organisation. Dr Navina Evans, Chief Executive of HEE is joining the Senior Leadership Team of NHSE/I to help closer working to deliver business and prepare the ground for the new organisation.

2.6. In the meantime, we will continue to work collaboratively to ensure the NHS has the workforce it needs to deliver the service ambitions for patients set out in the NHS Long Term Plan and the NHS People Plan, including:

- **make the NHS the best place to work,** improving staff experience and retention

- **improve the leadership culture**, with an emphasis on compassionate, inclusive and collaborative leadership behaviours

- **transform and grow the workforce** ('more staff, working differently') in support of NHS Long Term Plan service priorities by:

- **releasing more time for care**, supported by systematic use of digital technology

- **supporting and enabling workforce redesign** through better use of clinical and non-clinical roles to support registered professions, extended and advanced roles, and helping established professions work in multidisciplinary teams across different settings including primary care

- **growing the future workforce** and **reforming education and training** to ensure the right number and mix of staff – with the right skills are able to join the NHS workforce in the short, medium and longer term

- **implement a new operating model for workforce issues,** with a much stronger role for integrated care systems**.**

3. The Medical Workforce

Workforce Context.

3.1. The most recent systematic and comprehensive collection was conducted jointly by NHSEI and HEE, relating to the end of March 2019: nearly three years ago, and pre-pandemic. Whilst the response was extremely good, with the data collected covering 99% of consultant staff in post, there has not been any agreement to undertake a further data collection because of the burden on employers.

3.2. After some data cleansing, and conversion of all data to a standard measure of staff in post (the number in ESR at March 2019) the data indicate the vacancy rates in Table 1 below. This summarises the data collected on shortfall from establishment for consultants, in identified specialties and grouped specialties. The data indicated that, at that point, there were approximately 4,600 vacant consultant posts - an overall rate of 10% of establishment. Within this overall rate

- emergency medicine and the psychiatry specialties were in the shortest supply, the 'acute take' specialties were also in significant shortage – the data mask notable variations between specialties in this grouping. Wider medicine also indicates considerable shortages, and again the aggregate masks variation
- Histopathology, clinical radiology – both central to diagnostics and the treatment of cancer - exhibit marked shortage as do the oncology specialties
- Specialties where there was at the time less concern were surgery (which is ten specialties, again with variation between them), anaesthetics (although intensive care medicine or ICM, a small but rapidly growing specialty, exhibited significant shortage), obstetrics and gynaecology, and paediatrics.

Shortfall from consultant establishment at March 2019									
	North East & Yorkshire	North West	Midlands	East of England	London	South East	South West	All	Aggregate shortfall all England
Emergency Medicine	20%	7%	32%	18%	20%	38%	-	19.7%	375
Psychiatry	31%	35%	18%	6%	9%	10%	13%	17.4%	747
Acute take	16%	16%	22%	14%	14%	15%	10%	15.6%	891
Pathology	15%	16%	10%	10%	9%	15%	11%	12.6%	175
Clinical Radiology	13%	13%	13%	16%	12%	6%	5%	11.3%	357
Wider medical	10%	14%	10%	15%	6%	10%	6%	9.4%	565
Oncology	15%	16%	9%	2%	2%	12%	5%	8.5%	101
Ophthalmology	15%	9%	8%	11%	3%	12%	1%	8.5%	112
Infectious diseases	5%	13%	19%	3%	5%	-	13%	7.1%	44
Surgery	11%	6%	5%	9%	5%	8%	6%	7.1%	604
Anaesthetics and ICM	6%	4%	6%	9%	6%	5%	1%	5.3%	389
Obstetrics & Gynaecology+CSRH	12%	0%	4%	6%	3%	6%	1%	4.6%	122
Paediatrics	6%	2%	6%	6%	5%	2%	-	3.9%	138
Aggregate across specialties	13%	11%	11%	10%	8%	10%	5%	10%	
Shortfall from establishment	996	696	894	477	679	641	237	4,620	
Source: HEE/NHSI Joint Collection, analysed by HEE*									

Table 1: Shortfall from consultant establishment at March 2019[3]

Table 1 data rationale - 'Funded establishment' is the term used for the number of posts, expressed in 'full-time equivalent' (FTE) or 'programmed activities sessions' (PAs) that an employer has planned and budgeted for to deliver the services of the organisation. It follows that, in principle:

- funded establishment is the most appropriate measure of current demand as that is the workforce which the NHS is funded for and prepared to employ;
- shortfall from that establishment is the most appropriate measure of current shortage; and
- it is not possible to conduct a robust supply and demand assessment without granular data at specialty level: supply into a given specialty comes from a given training route as that is what defines a specialty.

There is no long-standing routine and standardised collection of workforce establishment at the level of medical specialty. Consequently, the current system relies one-off data collections.

Recruitment into specialty at CT/ST1

3.3. The data in Appendix A shows that recruitment to CT1/ST1 in 2020/21 was successful with an overall fill rate of 99%, with 15/16 programmes reaching a 100% fill rate. Particularly noteworthy was the record number of 4,000 applicants that accepted General Practice training, in line with the Government's manifesto target.

3.4. Applications have closed for 2022 recruitment and Rounds 1 and 2 have received over 38,000 applications compared to 35,000 in 2021. The main driver for the increase continues to be applications from international medical graduates.

4. The Medical Education Reform Programme

[3] Source: HEE/NHSI Joint Collection, analysed by HEE*

4.1. HEE's Medical Education Reform Programme (MERP) covers a range of aligned initiatives to enhance the structure and delivery of postgraduate medical training. The programme was established in response to several drivers including:

- Issues around recruitment and retention of doctors in training;
- The expectations of doctors in training, both in terms of their careers in medicine and in where, when and how their training is delivered;
- Societal, demographic and workforce changes, placing changing demands upon the medical workforce of the future and offering new challenges and opportunities.

4.2. The programmes within MERP will see radical changes in how medical education is delivered. To ensure successful delivery, the programme is therefore designed to work in partnership with national stakeholders, including system and professional regulators, the British Medical Association (BMA), medical Royal Colleges, provider organisations and most importantly educators and doctors in training. This approach aims to facilitate system wide ownership and delivery of change. The following section outlines some of the key strands and outcomes of the programme.

4.3. HEE's medical education reforms are focused on a number of key and aligned initiatives to produce doctors that better meet the needs of patients and service, address health inequalities and improve the experience of doctors in training. These key initiatives are drawn from *The Future Doctor*. This co-created vision sets out what is required of the doctors of the future. It sets a clear direction for the next phase of our reforms for medical education and training, so our future doctors are equipped with the right skills to deliver care in an evolving environment. This is focused around six reform pillars set out below:

1. **Enhanced generalism** – ensuring doctors across primary and secondary care can care for patients with multimorbidities and disease clusters through enhanced generalist training.
2. **Equality, diversity and inclusion** – widening participation / access, opening new undergraduate routes including development of a Medical doctor (degree) Apprenticeship.
3. **Accelerating undergraduate supply** – getting doctors into the NHS workforce quicker through testing the potential of a 6-month undergraduate internships based on the success of the Foundation Interim Year 1.
4. **Address health inequalities** by ensuring a more even distribution of HEE funded training posts across the country meaning we better support NHS service priorities across England – this will also tackle remote and rural healthcare challenges.
5. Improve the **wellbeing and experience of doctors** in training through flexible training opportunities, portfolio careers and other initiatives through the Enhancing Junior Doctors' Working Lives Programme, and through the implementation of the HEE NHS Staff and Learners Wellbeing Commission, not least during the pandemic.

6. **Boosting multi-professional team working alongside producing more generalist doctors (point 1 above) we will support service provision to be more efficient through** normalising generalism, skill mix and multi-disciplinary team (MDT) innovations e.g., supporting new roles, Anaesthesia Associates, Physician Associates and Advanced Clinical Practitioners.

Specific initiatives relevant to DDRB

4.4. Below we highlight specific HEE initiatives that should link to the DDRB’s consideration of the appropriate reward structure to support their delivery.

Future workforce - Enhancing Generalist Skills

4.5. HEE’s Future Doctor report defines the generalist skills needed by all doctors to enable them to:

- support ‘whole person’ care for complex patients with multiple chronic conditions;
- manage the trade-offs and potential conflict of multiple medications or treatments in the care for complex or acutely ill patients;
- understand the population health, health promotion and care needs of the communities they serve; and
- apply their knowledge and learning to reduce health inequalities and address local health priorities.

4.6. By embedding augmented generalist skills early in training, we will develop doctors who can confidently deploy a broader range of generalist skills confidently and early in their careers.

4.7. This will be delivered by developing and delivering a wraparound professional educational offer to augment training using innovative educational methods. This wraparound offer is based upon an outcomes-based framework through which the GMC Generic professional capabilities are woven and includes capabilities focused on person- centered practice, complex multimorbidity, population health, systems working, social justice and health equity and environmental sustainability. Delivery of the enhance offer will be undertaken on a local level where HEE will work closely with Integrated Care Systems to organise and deliver training activities and work with local health and care systems to develop training and career pathways within local health and care systems that enable doctors to learn and apply these skills confidently.

4.8. HEE’s trailblazer programme will drive this change where there are the best opportunities in the system. It will produce a cohort of trainee doctors with enhanced generalist skills, recognised by a generalist certification. Seven trailblazers are in place within each of HEE’s seven regions, with the first cohort of learners due to commence the programme in August 2022. Further expansion is planned for 2023 and beyond.

Addressing Health Inequalities – distribution of training places

4.9. The NHS Long Term Plan committed to meaningful action to tackle health inequalities. With this fundamental principle in mind, HEE has worked with NHSE/I to develop a robust model for guiding the distribution of HEE-funded training posts, being piloted in three high-fill specialties (Haematology, Cardiology and Obstetrics and Gynaecology) to better align with patient need. This follows evidence from NHS Improvement showing a correlation between Summary Hospital Mortality Indices and doctors per head of population, together with the realisation that specialty trainees form a crucial component of the junior doctor workforce up until they complete their training.

4.10. Furthermore, upon completion of training most doctors settle to practice permanently throughout their careers. Further evidence of the difficulty in attracting permanent medical staff and trainees to coastal areas as an example of this geographical misalignment of staff to patient need has been highlighted in the Chief Medical Officer's 2021 annual report. In short, trainees tend to remain where they are to become the permanent NHS staff resource for an area and currently the geographies that appear unattractive to train in for junior doctors suffer worse health outcomes with greater disease prevalence and yet with recourse to fewer trainees and trained senior staff.

4.11. The first training posts within these three specialties will move in time for trainees to commence in post in August 2022. Work is now commencing to model a further tranche of specialties as part of a commitment to review the distribution of all foundation and specialty training posts.

4.12. The programme also seeks to address long-term challenges with attracting, recruiting and retaining trainees in remote, rural and smaller health systems. There is an opportunity to highlight and promote the educational value of remote and rural clinical placements and to develop guidance for creating and supporting training posts in these locations. Postgraduate Deans have also been asked to look at distribution of doctors within their own footprints, with remote and rural systems in mind.

4.13. The proposed direction would address short-term service needs; improve training quality by providing trainees with greater exposure to conditions related to their specialty; and support long-term benefits for populations with current geographical and specialty shortages. This follows evidence that specialists are likely to settle and practice near to where they train. GMC data shows that 48.57% of specialists who gained their CCT between 2012-2019 are based within 10 miles of their specialty training postcode, and 80% within 50 miles.

4.14. HEE has recommended a range of methods to transition the distribution of training to the future recommended position, while maintaining continuity of care and patient quality and safety at the same time.

Flexible Pay

4.15. We note the DDRB would welcome evidence or proposals that look at extending the range of pay premia to cover difficult to recruit to specialties and geographies. We suggest this

debate should link to HEE's work around the geographical distribution of training places described above, given the potential scope for a complementary approach.

4.16. In terms of providing evidence, HEE's experience of introducing flexible pay premia is limited to the General Practice Targeted Enhanced Recruitment Scheme (TERS) and a small number of non-GP training posts in the North East region. The TERS is an initiative that offers a one-off taxable payment of £20,000 to GP trainees committed to working in a select number of training places in England that have been hard to recruit to. The scheme has been running since 2016. The sum is repayable if trainees leave the programme during the training period and is taxable.

4.17. The 20/21 data appears to show this has been successful (see Appendix C), and HEE is therefore considering whether flexible pay premia should also be considered in psychiatry where there is a similar pressing need to increase recruitment to the training grades. However, HEE believes caution should be exercised in extrapolating the TERS results in considering the evidence for flexible pay premia more generally as GP (and psychiatry) trainee recruitment present specific issues and other factors may also have influenced the results. Furthermore, longitudinal tracking is required to ascertain if TERS trainees remain in an area post CCT. Allocation of TERS places for 2022/23 round have increased to 800 in line with the GP contract and funded by NHSEI.

4.18. It should also be noted that following its review of the UK Foundation Programme, HEE announced that from August 2019 it would launch a range of Foundation Priority Programmes to support specific areas of the UK that have historically found it difficult to attract and retain trainees through the foundation and specialty recruitment processes. The main aim is to maximise the opportunity for applicants who wish to be in less popular areas and therefore improve supply for specialty training and beyond.

4.19. To date, priority programmes have been introduced and evaluated, including the following local financial incentives:

- Trent Foundation School are offering an enhanced salary package in the second year of the programme;

- Northern Foundation School are offering eighty-five priority programmes with an offering of £7,500 per training year taxable incentive. These programmes also include additional educational support for all F1 and F2 doctors through the F-Docs online education package;

- Wessex Foundation School are offering three programmes, which are located on the Isle of Wight in the second year. Trainees will be given £8,750 (taxable) in their F2 year to spend on whatever they like.

- All Foundation Schools are offering programmes which include a fellowship with the Royal College of Psychiatry with the intention of supporting recruitment to Core Psychiatry programmes.

SAS Doctors

4.19 HEE acknowledges many doctors choose a career as a SAS doctor, but that some SAS doctors report concerns with a lack of support in the workplace. Given this career choice and their significant contribution to patient care and service delivery, HEE is committed to addressing such concerns by increasing opportunities for, and enhancing the development, of SAS doctors. To support this, HEE administered a fund of £4.5m in 2019/20 and £5m in both 2020/21 and 2021/22 for the development of SAS doctors.

4.20 However, it is equally important that SAS doctor roles are seen as a viable career choice. HEE has engaged with colleagues from DHSC and NHS Employers on the development of the 'Specialist Grade' doctor role introduced in 2021. This is designed to offer career progression and professional development opportunities whilst also ensuring that this is aligned to employer and service need.

5. Enhancing Junior Doctors Working Lives

5.1 The Enhancing Junior Doctors' Working Lives (EJDWL) programme was established in 2016 to address the concerns and improve the working lives of doctors in training. The programme includes initiatives such as, reforming study budgets, study leave and delivering greater flexibility in medical training.

5.2 Enhancing Junior Doctors' Working Lives continues to be an important focus of HEE's work. The EJDWL programme aims to enable doctors to progress in their training and longer-term medical careers whilst maintaining a healthy and balanced personal life.

5.3 HEE's annual report on the programme[4] details the progress we have made to enhance junior doctors' working lives during 2020- 2021. Progress in key areas includes -

- expanding the availability of Less Than Full Time (LTFT) training (category 3) to all doctors in specialty training, meaning eligibility criteria will no longer be required if seeking to work flexibly;
- extending the Out of Programme Pause (OOPP) offer, allowing trainees to 'step in step out' of training without unnecessary burden;
- embedding the Supported Return to Training (SuppoRTT) programmes which support trainees return onto programme after a period of absence – regardless of the specialty.

5.4 HEE is committed to increasing flexibility in postgraduate medical training to support trainees work more equally across all specialties. A key initiative is HEE's work to provide trainees across all specialties with the opportunity to undertake a period of Less Than Full Time training for personal choice (known as Category 3 Less Than Full Time Training). The initiative intends to address the risk of trainee burnout and support time for recovery and restoration of work life balance. HEE rolled this out in Emergency Medicine, Paediatrics and Obstetrics and Gynaecology initially.

[4] Enhancing Junior Doctors' Working Lives 2021 (hee.nhs.uk)

5.5 In response to the pandemic, HEE has accelerated the planned roll out of LTFT Category 3 to all remaining specialties. Trainees in intensive care medicine, higher physicianly specialties, radiology and psychiatry have had the opportunity to apply to train LTFT from August 2021, and trainees in all the remaining specialties are able to train LTFT from February 2022. The offer in the 2021-22 academic year is for trainees to be able to train LTFT for a 4-month window (to mitigate pressure on service/rotas). In 2022-23, trainees in all specialties (except foundation) will be able to apply for train LTFT for the entire year. Plans for Category 3 in Foundation are now in development.

5.6 A three-year longitudinal evaluation of LTFT Category 3 is underway. The findings of the Year 1 report 'Less than Full Time Training Category 3 Initiative Year 1 Evaluation Report' are particularly positive in respect of trainee wellbeing and work/life balance. HEE will continue to monitor this once LTFT Category 3 is rolled out across all specialties. Less than Full Time Training Category 3 Initiative Year 1 Evaluation Report.[5]

5.7 Since 2019, HEE has introduced the Out of Programme Pause (OOPP) which enables doctors in training, who have had at least two years of full registration with the GMC and are progressing satisfactorily, to apply to undertake clinical work, within a UK-based organisation, and without the training assessment burden. Any competencies gained during OOPP can be assessed on the trainee's return to the programme and, if appropriate, counted towards their CCT.

5.8 Regional programme pilots established in 2019 have been extended in 20/21 reflecting the impact of the pandemic. The OOPP pilot is now offered to trainees across all specialties and locations in England to give trainees the option of stepping out of training if they wished. Trainees are to apply for OOPP until end of July 2023, when the first full evaluation of OOPP will be published.

5.9 The SuppoRTT initiative aims to ensure all trainees are clinically confident and fully supported when returning to training following a sustained period of absence. SuppoRTT ensures that trainees know they can step out and step back into training in a safe and supportive way, including an offer of a period of supernumerary time, which helps with confidence.

Gender Pay Gap

5.10 HEE welcomes Professors Dame Jane Dacre and Carol Woodhams research and the review into the gender pay gap in medicine, in the 'Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England'.

5.11 HEE acknowledges the important issues flagged during this review process and highlighted in the report. HEE is committed to tackling the gender pay gap through the actions within our remit and in supporting the work of the Gender Pay Gap Panel.

Action to understand doctors' and dentists' experience of the medical and dental training systems

[5] https://www.hee.nhs.uk/sites/default/files/documents/HEE%20LTFT%20Cat%203%20Initiative%20Year%201%20Report_0.pdf , Pg. 18

5.12 We note the request for more details of action taken to understand and address concerns about doctors' and dentists' experience of the medical and dental training systems, including concerns about the cost of training and exams, and about the impact on trainees' family lives of the way that training placements are distributed through the deanery system.

5.13 In 2021, HEE published the updated Quality Strategy and Quality Framework documents which provide the basis for our local work in ensuring quality in the healthcare learning environments. The Quality Strategy is underpinned by the HEE Quality Framework, which makes clear the quality standards we expect of clinical learning environments, safeguarded through the NHS Education Contract. Both the strategy and the framework describe how we will monitor and assess quality, respond to quality concerns and capitalise on good practice, innovation and technology.

5.14 To enhance our role in ensuring the quality of education and training HEE introduced the National Education and Training Survey (NETS) in 2016. NETS is the only national survey open to all undergraduate and postgraduate students and trainees undertaking a practice placement or training post in healthcare as part of their education and training programme. The survey gathers opinions from students and trainees about their time working and training in practice placements and training posts, asking them to provide feedback on what is working well and what they think could be improved.

5.15 The most recent survey closed on Tuesday 30 November 2021. The results will be published in January 2022. Further information is gathered through the GMC's national training survey.

5.16 HEE undertakes additional engagement through national workstreams where we seek solutions to key issues with partner representatives of trainee associations such as the HEE Study Leave Group, Training in the Independent Sector and the inaugural HEE Equality, Diversity and Inclusion learner assembly. The latter event has helped inform a national EDI Quality Improvement plan, that will be delivered through the HEE Quality Framework.

Cost of training and exams

5.17 There has been an ongoing commitment from all Royal Colleges to be transparent in the use of income obtained from doctors in training, e.g., for examination fees etc. Colleges have worked with their trainee groups on how best to achieve this. For example, the Royal College of Psychiatrists is one of several colleges to have issued a financial report articulating how they spend their exam-related income. The Academy Trainee Doctors' Group (ATDG) is continuing to encourage transparency and is sharing best practice in achieving this.

5.18 HEE has also reformed the study budget system for doctors in training. The reforms are designed to ensure that access to educational resources is fair, based on individual need, and that the process promotes higher quality, more efficiency, flexibility and transparency. HEE work is supported by the HEE Study Leave Group with wide representation including from the BMA Junior Doctors Committee, NHS Employers and HEE teams, alongside other stakeholders.

5.19 COVID-19 has had a profound effect on the accessibility and provision of study events and education. Evaluation of HEE's study budget reforms is with that background. HEE's Study Leave Report Testing accessibility document published in July 2021 highlighted two issues for further consideration. Firstly, the current study budget allocation is not fairly weighted for NHS Trusts with medical training posts directly funded by Trusts. Secondly more effective recording of Study Leave data across HEE is needed - linked with the Trainee Information System. It is hoped progress in these key areas will be seen in 2021/22.

The impact on trainees' family lives of the way that training placements are distributed through the deanery system

5.20 HEE has worked closely with the other nations and in conjunction with the BMA to develop a system to give trainees with special circumstances flexibility of where they train. The process ensures that applicants with special circumstances and a requirement to train in a particular location are treated in a fair and consistent way. Any applicant who fails in one of the two eligibility criteria can apply to have their circumstances taken into consideration, allowing them to be pre-allocated into a post, subject to it meeting the requirements of their training programme. The two criterion are:

- Criterion 1 – the applicant is the primary carer for someone who is disabled as defined by the Equality Act 2010.
- Criterion 2 – the applicant has a medical condition or disability for which ongoing follow up for the condition in the specified location is an absolute requirement.

5.21 Applications are reviewed by a national panel following each major round of recruitment. Applicants are entitled to appeal the decision of the national panel and are given the opportunity to submit additional evidence which is reviewed by an appeal panel.

5.22 HEE's work on the national Inter Deanery Transfer (IDT) process provides a consistent, robust and transparent process to support trainees to transfer around the UK. The national process has been established by the Conference of Postgraduate Medical Deans (COPMeD), HEE, Northern Ireland Medical & Dental Training Agency, NHS Education for Scotland, Wales Deanery, and the BMA.

5.23 This process supports doctors in training who may consider inter deanery transfer / relocation due to an unforeseen and significant change in circumstance since accepting an offer of a post in a training programme.

5.24 An unforeseen and significant change in circumstances should relate to, a personal disability as defined by the Equality Act 2010, a mental health condition, primary carer responsibilities, parental responsibilities, or a committed relationship (or the breakdown of a committed relationship).

5.25 In November 2020, HEE announced new arrangements for the payment of relocation and expenses for junior doctors appointed to a new training programme, which applies nationally. The arrangements took effect on 1 November 2020 and apply to all new starters from August 2020.

5.26 The single framework replaced a wide range of different arrangements and funding allocations which existed across the country. Under the new national framework eligible trainees will be able to claim up to £10,000 to cover relocation and excess mileage costs over the duration of their postgraduate training which will be fully funded by HEE.

5.27 HEE has worked closely with the BMA and other stakeholders on the new national framework which aims to provide a consistent approach to support all trainees across the country who face the financial costs of moving house to take up training, and/or may be financially disadvantaged because of their training programme covering a large geographical area.

6. Impact of COVID-19

Impact of COVID-19 on undergraduate medical education

6.1. The COVID-19 pandemic led to significant changes and disruptions to medical education due to loss of teaching time and placements. The pandemic has disrupted the well-established, traditional structure of medical education and functioned as a springboard for the development of remarkable innovations, such as accelerating the development of online learning, introduction of novel ways of student assessment, simulation software, remote consultations, changes to clinical assessment, and repurposing elective periods. However, the challenges remain, and medical schools and students continue to be monitored to assess whether further mitigating action will be required.

6.2. A second issue was the impact of COVID-19 on the 2021 A-level results that for a second year resulted in more applicants achieving the requirements of their conditional offers for a place at medical school. Every year, UK medical schools make more offers than there are places, with exams acting as a triage for final allocation of places.

6.3. As also happened in 2020, the greater number of higher A level grades resulting from teacher assessment grades compared with previous years resulted in a significant over-subscription. The Government committed to ensuring all successful applicants should be provided a place, so HEE worked with the General Medical Council, the Office for Students and the Medical Schools Council in the creation of additional capacity, helping to broker arrangements with individual medical schools and securing funding for the additional places from Government.

6.4. Grade inflation may result in rises in successful applications for medical, dental and other healthcare courses, with potential impacts on number controls and opportunities for Widening Access and Participation applicants. The pandemic may result in a long-term disproportionate negative impact to students applying to medical school from a low-socioeconomic background. In addition, the upsurge in medical school applications increases the likelihood of stricter University entry criteria over the coming years.

6.5. Intake targets in 2022 will revert to pre-pandemic levels, so work is underway with medical schools to ensure these targets are adhered to whatever method is employed in the grading of A-level results, and to ensure that there is no detrimental impact on opportunities for applicants from lower socioeconomic backgrounds.

Impact of COVID-19 on postgraduate medical education

6.6. National and regional pandemic surges have had a significant cumulative impact on postgraduate medical trainees’ experiential learning and attainment. From our data collections and engagement with employers, we know that the experiential learning of

trainees has been materially affected during each surge of the pandemic. These trainees have been either formally or functionally redeployed[6] to COVID-facing settings, or had elective learning opportunities cancelled, resulting in a diminished and "monochrome" training experience. HEE's analysis in Spring 2021 indicated that this impact could risk the progression of up to 50% of trainees, posing a major risk to the continued flow in medical workforce supply.

Training extensions may be necessary for trainees to obtain the education outcomes required by the medical regulator before they can complete training and be entered onto the specialist register. **Figure 1: Training recovery to enable service reset and minimise bottlenecks to progression**

6.7. shows how training extension have the potential to disrupt the workforce supply pipeline. Foundation doctors (F1 and F2) would not be able to progress into training posts (ST1-8 or CT1-2), which would disrupt the workforce supply pipeline, as the "product" of training (Consultants and GPs with CCTs) cannot be achieved. This would cause congestion to the training pipeline.

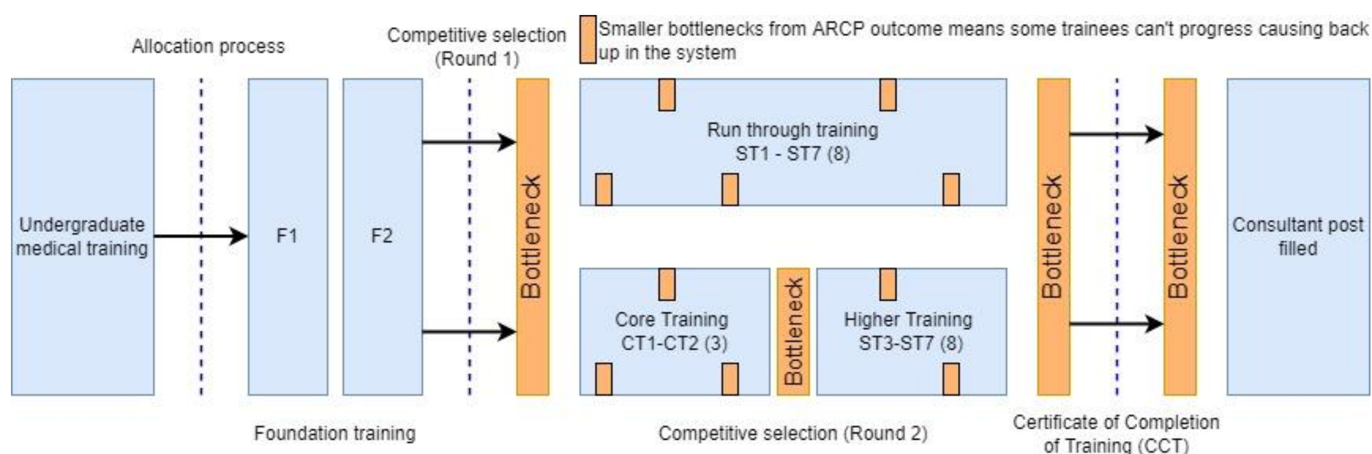

Figure 1: Training recovery to enable service reset and minimise bottlenecks to progression

6.8. Without targeted intervention, there is therefore a risk to the supply of consultant, GP and middle grade doctors. These senior decision-makers will be essential to the COVID-19 recovery. The Programme's aims include:

- Stage 1. Reset (March 2020 – August 2021) – Maintain PGME processes and workforce supply using the necessary adaptations initiated during the pandemic to allow training progression.
- Stage 2. Recovery (April 2021 – December 2022) – Enable trainees to gain essential competencies lost or inaccessible during the pandemic and address wellbeing issues.
- Stage 3. Reform (ongoing) –Ensure that the medical education reform programme (MERP) builds on the lessons learned from COVID-19 in implementing further reforms.

6.9. Our recently published Interim Report[7] focuses on the impact on the Postgraduate Medical Education (PGME) of England's 55,000 junior doctors in training, who are not only an essential part of the current workforce but also the future consultant, GP and decision-making registrar workforce to managing the significant NHS care backlog post-

[6] "Formal redeployment" refers to the movement of a trainee to a different clinical area to their planned placement, agreed in advance between the employer and postgraduate dean. "Functional redeployment" describes when a trainee's placement setting is repurposed by their employer for COVID care, e.g., an acute elderly ward being redesignated as a COVID step-down ward.

[7] COVID-19 Training Recovery Programme Interim Report (October 2021). https://www.hee.nhs.uk/sites/default/files/documents/C-19_Recovery_Sept21_Final.pdf

pandemic. The report outlines the approach taken to define, manage and reduce risks to medical workforce wellbeing, numbers and future supply.

6.10. We have therefore signed up to 18 joint commitments, that set out to: continue system engagement; increase opportunities for training recovery, ensure wellbeing for training recovery and future resilience, embed improvements to training and share best practice.

These system-wide commitments will be essential to avoid further extension costs, and to support trainees who are managing ongoing curriculum gaps. We will continue to work with partners to support trainees, maximise training opportunities while supporting service recovery, and embed continuous improvements to training structures and delivery. We must ensure service and training recovery are integrated. As pressures increase, embedding training recovery into service delivery remains crucial to ensure progression through training (as in **Figure 1: Training recovery to enable service reset and minimise bottlenecks to progression**

6.11.) and supply the workforce needed to deliver COVID care and recovery, restore services and reduce waiting lists.

6.12. As a result of HEE and partners' interventions, extension rates are currently significantly lower than original projections. Annual Review of Competency Progression (ARCP) and assessments

6.13. Training extensions have been the traditional way of achieving outstanding curriculum requirements during a set training period. These have been necessary to ensure that trainees obtain the education outcomes required by the medical regulator to complete training and be entered onto the specialist register. This congestion to the medical workforce supply pipeline due to the pandemic would hold doctors back from progressing to the next stage of training, resulting in post unavailability for new recruits, as these positions would continue to be occupied.

The numbers affected during the pandemic are such that if every trainee were simply given an extension to cover the period of the pandemic, this would lead to very significant costs to the system in terms of additional funding and workforce supply and risking significant discontent and attrition in the junior medical workforce. Although retention in postgraduate medicine is high, the impact of COVID threatened to affect trainees' progression (as in **Figure 1: Training recovery to enable service reset and minimise bottlenecks to progression**

6.14.).

Mitigating the length of extension to encourage progression

6.15. HEE has worked with the GMC, the other UK Statutory Education Bodies (SEBs) and medical Royal Colleges, on curriculum and Gold Guide (GG) derogations aiming to optimise training progression across the specialties, maintaining workforce flow. SEBs have approved GG derogations (ARCP Outcome 10.1 & 10.2) as no fault equivalents to Outcomes 2 and 3 respectively, recognising the impact that COVID may have had on training. These temporary derogations have enabled many trainees to achieve the required capabilities, progress and where appropriate to achieve Certificate of completion of training (CCT). **Error! Reference source not found.** provides a breakdown of trainees on outcomes 10.1 and 10.2 by grade in 2021.

Count	CT1	CT2	CT3	F1	F2	ST2	ST3	ST4	ST5	ST6	ST7	ST8

10.1	342	741	53			151	321	440	316	236	134	25
10.2	4	70	35	44	24	14	112	58	101	65	100	72
Total	346	811	88	44	24	165	433	498	417	301	234	97

Table 2: ARCP 2021 Data for trainees on 10.1s and 10.2s by grade

6.16. We are confident that mitigating measures will continue to enable ARCPs to proceed with more permissive use of outcomes, fully informed by the most up to date curricula and decision aids across all specialties, optimising and enabling progression for trainees. However, the number of trainees with a training backlog has grown over the duration of the programme. These trainees carry a future extension risk, with the same resultant risks of cost, attrition from training programmes, slowed production of GPs and consultants and reduced service from lack of senior grades in training. HEE support and investment will continue to be required.

Identifying individualised training needs and recovery options

6.17. The COVID-19 pandemic caused significant training disruption, anxiety and distress to both trainees and educators. Since the establishment of the programme, HEE has gathered data insights and worked closely with educators to define the size and scale of disruption to postgraduate training, estimate potential extension requirements, and put mitigations in place.

6.18. Through the HEE Postgraduate Deans, their faculties and trust Directors of Medical Education (DMEs), the programme has emphasised the importance of individualised training recovery. To deliver on this principle, every trainee in the country has been offered a 1:1 conversation with their educational supervisor or training programme director (TPD), to identify their training and wellbeing needs. With the Academy of Medical Royal Colleges, we have encouraged educators to explore wide-ranging options for obtaining competencies, and to tailor training activities to individual trainees' learning needs.

6.19. The training recovery conversations are an opportunity for trainees and educators to reflect on the past year, think about learning and wellbeing needs, and plan for training recovery. This is the initial step to getting postgraduate medical education back on track. All trainees are offered a one-to-one training recovery discussion.

Support for displaced or shielding trainees

6.20. The supervision of COVID-19 displaced or shielding trainees programme was developed for the educational supervisors of displaced or shielding doctors in training. The programme may also benefit supervisors and educators of trainees in other settings.

6.21. The e-learning content was developed in collaboration with displaced trainees who share their experiences of being displaced and demonstrates how they can be supported to progress in their training.

6.22. We have developed specific guidance[8] for postgraduate trainees who have been shielding during the pandemic, supporting these trainees to acquire competencies in non-patient facing settings wherever possible. We have also signposted all learners to wellbeing resources and guidance for supporting NHS staff in high-risk groups.

[8] Coronavirus (Covid-19) Information for trainees | Health Education England (hee.nhs.uk)

6.23. Local PGME teams will support TPDs and DMEs in identifying lower risk placements and enabling vulnerable trainees to be placed in these posts if needed in future pandemic surges. Learning from this, we will develop future plans for more personalised training that include the identification of placements that support trainees with specific needs.

Aligning training and service recovery

6.24. Elective procedures offer significant educational opportunities for trainees, as well as enabling service recovery. HEE and NHSE/I are therefore liaising closely to build training into elective service recovery and service restoration plans.

6.25. In particular, NHSE/I's Getting It Right First Time programme is focusing on high volume, low complexity work to maximise service efficiency and reduce the elective backlog at pace. This work has potentially enormous educational value, and we are therefore working with NHSE/I colleagues at multiple levels to build training recovery into the elective recovery guidance.

6.26. Recovery of medical education and its ongoing delivery is very dependant on educational supervision delivered by senior clinicians. A conflict may arise as these clinicians are also key to the service recovery. To ensure the needed recovery of training and its future high quality delivery to an expanding trainee workforce, there is a requirement to appropriately fund educational time.

Rotations

6.27. Currently most training programmes start at fixed points in the academic year – the majority being the first Wednesday of August. When the pandemic first emerged, HEE and the SEBs took the decision to pause April rotations, to support the service with its COVID-19 response. August scheduled rotations have continued as planned wherever possible, particularly for foundation and core trainees.

6.28. Facilitating individual flexibility in these start dates could support trainee wellbeing and will enable faster training recovery, decreasing workforce supply delays due to time out or additional training, by enabling progression at multiple points in the year.

6.29. HEE has permitted regional flexibilities to rotation dates for higher trainees, with a view to balancing regional training and service needs. This flexibility facilitates provision of high-quality training posts for trainees to rotate into and support resilience within the system.

6.30. Local and regional demand scenarios will allow the system to respond with appropriate interventions at transparent trigger points as the pandemic develops at different speeds in different places.

6.31. HEE is making the most of local knowledge and expertise and minimising disruption to planned placements wherever possible. HEE offices are working with relevant colleagues locally to determine the pace and timing of rotational changes for existing trainees, facilitating discussions around geographical location, workload management and around induction. HEE is now planning to pilot different rotation models.

Ensuring wellbeing for training recovery and future resilience

6.32. HEE has worked closely with national, regional and local partners to ensure that the health and wellbeing of students and trainees is prioritised throughout their learning, working and training. HEE local Professional Support and Wellbeing Service (PSW) leads have met on monthly basis throughout the pandemic to share good practice and learning, and each PSW has maintained an online wellbeing hub for their trainees.

6.33. We have encouraged trainees and educators to consider HEE's enhanced flexibility offer to promote recuperation and wellbeing, reduce burnout, and support trainees to consolidate skills acquired during the pandemic, rather than continuing at full pace in their training programme. Initiatives such as the Out of Programme Pause (OOPP) and Category 3 Lless than Full Time are important (Section 5).

6.34. HEE will continue to extend its flexible offers for trainees in England and will conduct a full impact analysis and evaluation of the flexible training offer, working with system partners to resolve any issues.

Ongoing monitoring and mitigating against further disruption

6.35. Recognising the impact of earlier waves on the pandemic on the education and training of health and care trainees, we have refreshed HEE's guidance on managing the training workforce[9].

6.36. During autumn/winter 2021-22, with the emergence of the COVID-19 Omicron variant, HEE is capturing consistent and accurate data on the pandemic's impact on postgraduate medical education (PGME) at a local office, regional and national level. Data collection broadly falls into three categories:

- changes to trainee's planned placements that materially affect their access to learning and curriculum opportunities, captured in real time by HEE local offices;
- perceived risks to experiential learning and progression, as identified by trainees, training programme directors (TPDs) and Heads of Schools (HoS); and
- actual impacts on trainee progression, including extensions, as identified by the ARCP process.

6.37. Taken together, these datasets allow postgraduate deans to monitor and identify developing risks to trainee progression prior to ARCP dates, and to develop an understanding of challenges to specialty training progression. This will inform plans to assist recovery of lost training at a system and individual level.

Funding implications

6.38. HEE has baseline funding for a finite number of doctors in training and contributes approximately 42%-43% of their basic salary whilst in Secondary Care and 100% salary in Primary Care. There are already pressures emerging from a greater number of doctors able to complete training or progress to the next level (foundation > core > higher) because COVID-19 has impacted their training and they have not yet attained the required competencies. This is resulting in extensions to training that either need additional funding or it will reduce the number of training posts available for recruitment.

6.39. It is important to remember that these are qualified doctors who are making a valuable contribution to responding to the COVID-19 pandemic at the expense of their training requirements. The numbers affected during the pandemic are such that if every trainee were simply given an extension to cover the period of the pandemic, additional funding would be needed at a cost of £300 million.

6.40. The workforce supply would halt, resulting in insufficient numbers of consultants and GPs with CCTs over the next few years. This would increase service pressure at a time of

[9] COVID-19 Guidance.
https://www.hee.nhs.uk/covid-19/covid-19-guidance

increasing demand to recover from COVID-19, especially in places where there were workforce issues predating the pandemic. Trainees are essential to service delivery in the UK, and the possible impact of non-progression on patient care is significant.

6.41. The future pipeline of trainee doctors into consultant posts will be affected in the longer term. HEE is working with the Royal Colleges and other system partners to introduce mitigations intended to minimise the impact of the pandemic on training and workforce planning. The DHSC and NHSEI will work with HEE to ensure funding for training recovery.

7. The Dental Workforce

Dentistry workforce

7.1. Dentistry workforce data is limited and there has not been a recent workforce survey or data collection to present a comprehensive picture of the composition, spread and hours committed to NHS services by dentists. Disparate workforce data is available and HEE examined some of this as part of an evidence review of dental education and training.[10]

7.2. There are major variations in the average number of dentists per head of population[11] across England (see Fig.2). In 2018, the average population size per NHS dentist in North West London was 797 at one end of the scale, while at the other it was 3,853 in Shropshire, Telford, and Wrekin, with a weighted average for England of 1,684.

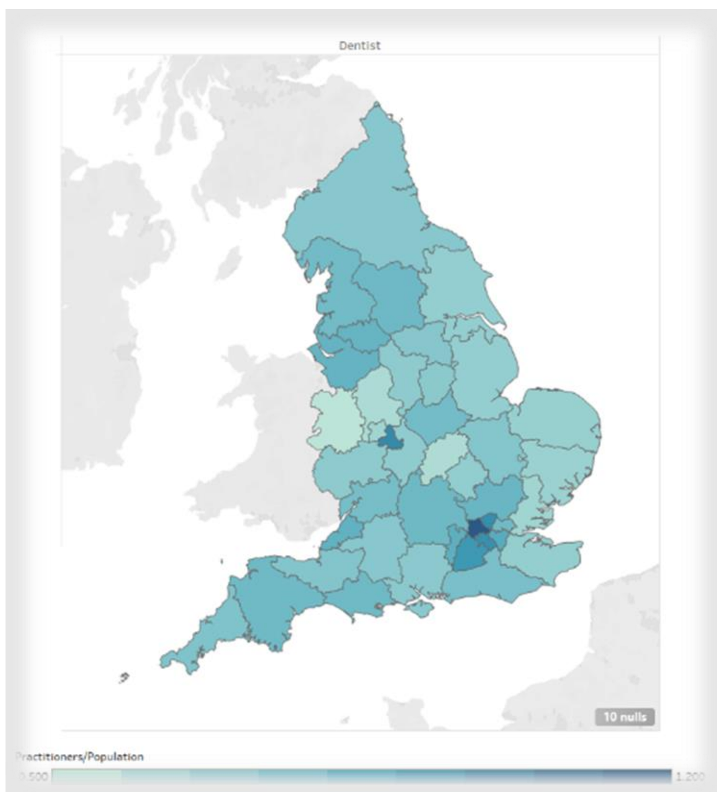

Figure 2: Dentists per 1,000 population (2018)[12]

7.3. The majority of dentists work in primary care delivering NHS services through General Dental Services (GDS) and Personal Dental Services (PDS) contracts and through the private sector. The two types of NHS contracts govern how dental treatment will be delivered to NHS patients by a dental practice. A smaller number of dentists deliver NHS services in secondary care and community services.

7.4. There were 43,271 UK dentists registered with the dental workforce regulator, the General Dental Council (GDC) as of December 2021. The total number of dentists registered in

[10] HEE (2020). Advancing Dental Care: Interim Evidence Report.
[11] This data takes account of appointments across all specialities across the whole population.
[12] Based on ONS population statistics and on GDC registrant data (2019).

England, including NHS primary and secondary care, including SAS[13] dentists, plus 'private-only' dentists, was 34,418 in December 2021. Although some might not be practising, working instead in research or overseas, for example, this equates to 61.2 dentists per 100,000 population in the UK, and 59.4 in England. However, these data do not include information on whether or not the dentist is working full or part-time and recent trends indicate a greater move to part-time working.

	Population per Dentist			
Country	2018	2019	2020	2021
England	1684	1677	1658	1656
Scotland	1331	1330	1325	1354
Wales	1858	1869	1832	1825
Northern Ireland	1148	1148	1145	1151
United Kingdom	1634	1629	1612	1614

Table 3 [14]

7.5. Dentists working to the GDS contract working similar hours in the NHS as compared to 10 years ago: 26.4 hours in 2019/20 compared with 26.4 hours in 2012/13 in England.[15] Access to NHS dental services does however remain an ongoing issue for patients and access varies across the country. These differences are likely to be explained by many factors, including an overall shortage of dentists and the continuing attractiveness of private practice to dentists. The lack of access to dentists offering NHS dental services in parts of England has often left patients with no access to an NHS dental practice, consequently leading to patients having to visit hospitals, general medical practitioners or perform their own treatments to manage dental pain.[16]

Workforce supply - undergraduate

7.6. HEE supports the quality management of undergraduate dentistry clinical placements and provides placement funding across years 2-5 of the five-year degree. As with medicine, undergraduate dentistry student intake numbers for home and international[17] students are capped by government; more than 800 places are available each year in England (see **Table 4**).

[13] Along with consultants and auxiliary staff, SAS dentists are a consistent presence in a department. They can establish continuity and stability in teams where the junior workforce frequently moves between posts. SAS dentists experience varies from recent completion of dental core training up to and including senior clinicians involved in senior management and training. As a result, they are uniquely positioned to play an important role in teaching, management and quality improvement.
[14] Source: General Dental Council and Office of National Statistics, National Records Scotland, and Northern Ireland Statistics and Research Agency
[15] ADC calculations based on data from NHS Digital. https://digital.nhs.uk/data-and-information/publications/statistical/dental-working-hours
[16] NHS Dentistry Services, House of Lords Briefing, 2019. https://lordslibrary.parliament.uk/research-briefings/lln-2019-0096/
[17] Applicants who are from countries outside of the European Economic Area are defined as international students.

7.7. Following the rise in A-level grades in 2020 and 2021 the Government lifted the cap on medical and dental school places for those years to ensure a place for every applicant that met the terms of their offer.

Unique Applicants and Entrants to Dentistry Courses at English Providers (2017-2021)					
Year of Entry	**2017-18**	**2018-19**	**2019-20**	**2020-21**	**2021-22 (provisional)**
Unique Applicants	2,185	2,368	2,768	2,859	3,192
Intake*	805	808	811	898	972

Table 4: Dentistry undergraduate intake numbers[18]

Workforce supply – postgraduate training

7.8. HEE is responsible for coordinating and quality assuring training places for postgraduate dental training. This is organised through the seven HEE English Dental Deans, who are part of the UK wide Committee of Postgraduate Dental Deans and Directors (COPDEND). Postgraduate dental training comprises:

- One year of Dental Foundation Training (DFT)
- Dental Core Training (DCT; years 1, 2, 3)
- Dental Specialty Training[19] (DST; 3-5 years)

7.9. Appendix D presents recruitment data for ST1/4 posts in 2021/22. Appendices F and G present trainee numbers and overall fill rates across England for these three postgraduate training programmes managed by HEE. Posts have consistently been filled, or close to filled, across all training programmes.

7.10. One workforce issue related to supply through postgraduate training we are aware of is the numbers of dentists on speciality lists, particularly in Oral Surgery / Special Care Dentistry and Additional Dental Specialities[20] has fallen. The number of trainees in training does not match those retiring from posts, the majority of which had been grandfathered onto these lists. The Dental Education Reform Programme will seek to address lack of access for patients to specialist dental services within the Dental Training Distribution workstream.

Immigration changes and EU Exit

Overview

7.11. Individuals can register as a dentist with the GDC if they possess a recognised qualification from a UK institution, an EEA/Switzerland qualification as part of EU directive

[18] *Source: UCAS End-of Cycle Bespoke Data 2021* Office for Students Medical and Dental Students' Survey 2017-2021*
[19] Specialist Lists, GDC. https://www.gdc-uk.org/registration/your-registration/specialist-lists
[20] Additional Dental Specialties includes Dental and Maxillofacial Radiology, Oral and Maxillofacial Pathology, and Oral Medicine.

2004/38/EC, or a select number of recognised overseas qualifications.[21] Dentists from outside the EEA whose qualifications are not recognised for full registration with the GDC need to take the overseas registration examination (ORE) and obtain the necessary permits/visas to stay and work in the UK. [22] Temporary registration is available allows dentists who are not eligible for full registration to practise dentistry in the UK in secondary care if they have had the offer of a supervised post for training, teaching, or research purposes only, for a limited period.[23]

7.12. As shown in Table 5, two-thirds of new dentists joining the register in 2020 were from the UK, with the remainder coming from the European Economic Area (EEA) and entering the register either via the GDC's ORE or directly as a result of the recognition of their home country qualification. In 2019 32% of EEA-qualified dental registrants surveyed by the GDC reported they are considering leaving the UK in the next few years. However, the registration data shows the number of new registrants coming from the EEA has remained stable – 23% of applicants in 2019 and 22% in 2020.[24]

Regions of Qualification	Registrants	% of total
UK Qualified	1,070	66%
EEA Qualified	357	22%
ORE (UK overseas registration exam)	106	7%
Overseas Qualified	94	6%
TOTAL	**1,627**	**100%**

Table 5: New additions to the register in 2020 by region of qualification[25]

7.13. The UK left the European Union on the 31st of January 2020 and unilateral legislation implemented by the government provides a temporary arrangement for regulators to continue recognising qualifications from the EU/EEA for a period up until December 2022. Moving forward, proposals outlined in the Professional Qualifications Bill will mean EU/EEA applicants will be assessed in the same way as all other international applicants, and regulators will be able to establish Mutual Recognition Agreements on a UK-EU wide basis should regulators/professions want to pursue this. Dentists are not on the shortage occupation list compiled by the Migration Advisory Committee.[26]

Dentistry education and training reform: Advancing Dental Care

[21] Apply for registration, GDC.
https://www.gdc-uk.org/registration/join-the-register/how-to-join-the-register
[22] Apply for registration, GDC.
https://www.gdc-uk.org/registration/join-the-register/how-to-join-the-register
[23] Temporary registration, GDC.
https://www.gdc-uk.org/registration/join-the-register/temporary-registration
[24] Survey of European Qualified Dental Professionals, GDC, January 2019.
[25] 2020 (latest figures: page 9 - https://www.gdc-uk.org/docs/default-source/registration-reports/gdc-registration-statistical-report-2020---final311fef86-9e9f-44bb-81d8-68b3a44cae39.pdf?sfvrsn=918f77ec_8)
[26] Review of the shortage occupation list: 2020, Gov.uk.
https://www.gov.uk/government/publications/review-of-the-shortage-occupation-list-2020

7.14. HEE's Advancing Dental Care (ADC) Review[27] was commissioned in 2017 to develop a blueprint for future dental education and training that supplies a multi-professional dental workforce, consisting of dentists and dental care professionals (DCPs), with the skills to respond to the changing oral health needs of patients and services.

7.15. The Review's first phase concluded in 2018 with the ADC Report, setting out 20 recommendations for further developing HEE's evidence-base and understanding of the dental workforce required for the future NHS, with the aim of safeguarding dental workforce sustainability and supply.[28]

7.16. The ADC Review laid out the following objectives for Phase II of the review to take place during 2018-2021:

I. Collate a robust evidence-base on the population's oral health needs in a technology enabled, prevention-oriented system, and model the most appropriate dental workforce for meeting those needs.
II. Identify and evaluate new and existing innovative training approaches and develop or upscaling exemplars within the available funding envelope.
III. Understand the CPD requirements of the existing workforce and identify best practice.

7.17. Findings from evidence gathering in 2018-2021 demonstrated the need to consider alternative models of training that were more flexible and training experiences in varied settings. The importance of building better training pathways for the whole workforce, for both dentists and DCPs, was clear. This included opportunities to carry out academic training pathways and learn and develop leadership skills. Furthermore, our Review suggests that, in keeping with the direction of travel indicated by the NHS Long Term Plan and Interim People Plan, more multi-disciplinary working will be desirable in future. There is evidence to suggest that dentists could be released for more complex work if other members of the dental team (DCPs) were working to the limit of their full scope of practice.

7.18. The Final ADC report was published in September 2021 and included a focus on developing education and training models for the whole dental workforce including two-year longitudinal foundation training and two-year broad-based training (combining two years of current DCT training). This builds on successful pilot programmes that have been carried out in a similar format, in contrast to the one year DFT and DCT posts that are commonly available. The benefits of education reform and workforce transformation identified so far by the ADC Review include:

I. improving the skills and competencies of dental professionals to support them to carry out future roles in line with their full scope of practice and capabilities;
II. improved flexibility within individual training pathways and between other training pathways (as stated in Interim NHS People Plan);
III. improved training quality and learner experiences compared to existing models;

[27] Advancing Dental Care Review: Final Report, HEE. https://www.hee.nhs.uk/our-work/advancing-dental-care
[28] Advancing Dental Care Review: Final Report, HEE. https://www.hee.nhs.uk/our-work/advancing-dental-care

IV. establishing new and effective training models that can be delivered to more learners across HEE regions;
V. improved retention of the NHS dental workforce;
VI. improved ability to work within multi-professional teams;
VII. a realignment of the workforce to where the greatest service need is and a shift to a more equitable balance of workforce distribution to meet local service and population needs.

7.19. HEE has now established a Dental Education Reform Programme to deliver the recommendations of the ADC Review. The programme is expected to establish governance, stakeholder engagement and develop delivery plans in 2021/22, deliver the workstreams in 2022 – 2024 and undertake benefits realisation in 2024/25.

7.20. HEE continues to engage closely with key stakeholders across the systems, including NHSE/I, Royal Colleges, GDC, BDA, DCP representative groups, members of the professions and patients and public in developing models of training and implementation of all the ADC recommendations. The Review has taken account of the impact of COVID-19 on education and training and of the opportunities for modifying training programmes as a result; for example the use of technology enhanced learning for virtual training sessions and streamlined recruitment.

Impact of COVID-19

Undergraduate Dental Students

7.21. There has been greater impact from Covid-19 on the teaching of Undergraduate dental students, due to the aerosol generating procedures of the clinical teaching coupled with aging estate and infrastructure that require capital investment to ensure delivery of clinical placements are safe for students, supervisors and patients.

7.22. HEE has invested additional non-recurrent revenue funding to support new kit for teaching and staffing and secured non recurrent capital funding from HMT via the DHSC. The level of additional revenue funding to support the graduation of final year Dental students in summer 2021 was £3.8m, coupled with an additional £5.4m to support initial recovery of the training deficit between September 2021 and March 2022.

7.23. 98% of dental students graduated with the required competencies to begin Dental Foundation training from September 2021. Without the additional revenue funding made available, there would have been very few Undergraduate Dental students graduating in England in summer 2021 and progress onto the dental foundation programme. Further extensions may be needed for students moving up a year from September 2021 due to the teaching deficit although there is also greater scope to recover the teaching deficit based on the additional revenue funding made available to March 2022.

7.24. Progression of students continues to be monitored closely by the Dental Schools Council (DSC) and other stakeholders including HEE.

7.25. Following the problems encountered with the scoring of A-level and equivalents earlier in the year, there has been an increase in 20/21 and 21/22 dental undergraduate places by

approximately 100/170. This will have an impact on HEE's business in 2025 and 2026 when this larger than average cohort will graduate and move on to foundation training.

Postgraduate

7.26. **Dental Foundation Training (DFT).** There was a reduced impact on COVID for the 20/21 cohort of DFT's with 96% (784) successfully completing training, compared to 77% in the 2019/20 cohort. Outcome 6C, introduced in 2020 to manage dental foundation trainees judged to be able to work independently in NHS primary dental care services, but needing development in identified competency elements to complete training (Outcome 6), was retained but was only required for 0.5% (4) DFT's. 3% (23) of DFT's required an extension, this is higher than the pre covid level but not significantly.

7.27. **Dental Core Training (DCT).** DCT progression was not impacted significantly in 20/21 by COVID with 98% (514) receiving a standard outcome, COVID was not considered a factor in the 2% (8) who did not receive a standard outcome at FRCP (Outcome 1). In the 2019/20 cohort 98% received standard outcomes with an additional 9 trainees receiving a Covid related Outcome 10.

7.28. **Dental Specialty Training (DST).** The impact of COVID-19 on DST has impacted less in 2020/21 than 2019/20, as many trainees (40) had to have extensions to training in 2019/20 due to delayed college examinations. The examinations as of Autumn 2020, have all now been made available virtually when face to face has not been possible. Of the 364 dental trainees in DST in post in 2020 85% received a Standard outcome at ARCP 1 or 6 with 18% completing training. A further 6 (1.6%) DST's required a non-Covid related extension to training.

Mitigating implications of further waves (approximately September 2021 onwards)

Undergraduate

7.29. All undergraduate dental students will continue their academic learning, restart placements that were paused during the first wave and commence scheduled clinical placements as part of their programme. There are no plans for redeployment.

7.30. Dental Schools Council and the Association of Dental Hospitals (ADH) have published a new report outlining a set of guiding principles to support all UK and Irish dental hospitals and schools towards the safe return to educational placement provision within open plan clinics.[29]

7.31. HEE are working closely with DSC, ADH and the GDC to monitor undergraduate progression, currently it is expected that most students will graduate by mid July 2022.

Postgraduate

7.32. **DFT**. Due to pandemic, the 2021 DFT national recruitment in England, Wales and Northern Ireland consisted of the Situational Judgement Test (SJT) only. In response to

[29] https://www.dentalschoolscouncil.ac.uk/wp-content/uploads/2020/09/COVID-19-Planning-return-to-Open-Plan-Clinics-Guiding-Principles-to-mitigate-risk.pdf

applicant feedback and experience gained in the use of virtual interview techniques, the 2022 cohort recruitment process will utilise an SJT, a virtual communications station and an interview.

7.33. Outcome 6C may be retained for Foundation Dentists who have been unable to demonstrate all curriculum requirements due to the pandemic but are safe to successfully exit the programme. In these cases, the outcome will outline the outstanding requirements and provide the dentists with a personal development plan for obtaining these competencies. The COVID-19 outcome 10 will remain an option to use for speciality and core training ARCP outcomes.

7.34. **DCT and DST**. HEE will work with employers of Dental Core and Speciality trainees to ensure that they can best support the pandemic surge. Trainees within 6 months of CCT, who have not yet received an Outcome 6, should, where possible, be supported to remain within curriculum aligned activity.

Health Education England
January 2022

Appendix A

Recruitment into specialty at CT/ST1 – 2021/22

Specialty	Level	Posts	Accepts	Fill Rate %
Core Anaesthetics	1	526	526	100
Emergency Medicine	1	322	322	100
Internal Medicine Training	1	1336	1336	100
Cardio-thoracic surgery	1	5	5	100
Clinical Radiology	1	301	301	100
Community Sexual and Reproductive Health	1	5	5	100
Core Psychiatry Training	1	593	593	100
Core Surgical Training	1	498	473	94.98
General Practice	1	4000	4000	100
Histopathology	1	91	91	100
Neurosurgery	1	13	13	100
Obstetrics and Gynaecology	1	231	231	100
Ophthalmology	1	76	76	100
Oral and Maxillo-facial Surgery	1	10	10	100
Paediatrics	1	368	368	100
Public Health Medicine	1	80	80	100
Total		**8455**	**8430**	**99.70**

Appendix B

Recruitment into specialty at ST3/ST4 – 2021/22

Specialty	Level	Posts	Accepts	Fill Rate %
Allergy	3	5	5	100
Anaesthetics	3	445	445	100
Audio vestibular Medicine	3	8	4	50
Cardiology	3	79	79	100
Cardio-thoracic surgery	3	2	2	100
Chemical Pathology	3	14	9	64.29
Clinical Genetics	3	13	13	100
Clinical Neurophysiology	3	7	7	100
Clinical Oncology	3	108	98	90.74
Combined Infection Training	3	57	55	96.49
Dermatology	3	32	32	100
Diagnostic neuropathology	3	7	3	42.86
Emergency Medicine	3	35	19	54.29
Gastroenterology	3	36	36	100
General and Vascular Surgery	3	109	109	100
Genito-urinary Medicine	3	57	11	19.30
Haematology	3	75	73	97.33
Immunology	3	8	8	100
Intensive Care Medicine	3	174	173	99.43
Internal Medicine Training	3	507	278	54.83

Specialty	Level	Posts	Accepts	Fill Rate %
Medical Oncology	3	67	67	100
Medical Ophthalmology	3	2	2	100
Neurology	3	44	44	100
Nuclear Medicine	3	3	3	100
Obstetrics and Gynaecology	3	19	19	100
Occupational Medicine	3	8	6	75
Ophthalmology	3	12	12	100
Oral and Maxillo-facial Surgery	3	22	15	68.18
Otolaryngology	3	28	28	100
Paediatric and perinatal pathology	3	7	3	42.86
Paediatric Surgery	3	8	8	100
Paediatrics	3	17	17	100
Palliative Medicine	3	35	31	88.57
Plastic Surgery	3	56	54	96.43
Rehabilitation Medicine	3	16	14	87.50
Sport and Exercise Medicine	3	6	6	100
Trauma and Orthopaedic Surgery	3	175	175	100
Urology	3	40	40	100
Child and Adolescent Psychiatry	4	58	50	86.21
Emergency Medicine	4	57	48	84.21
Forensic Psychiatry	4	44	33	75
General Psychiatry	4	177	158	89.27
General Psychiatry and Medical Psychotherapy	4	14	14	100
General Psychiatry and Old Age Psychiatry	4	73	67	91.78
Medical Psychotherapy	4	1	1	100
Old Age Psychiatry	4	64	38	59.38
Paediatric Cardiology	4	6	6	100
Paediatrics	4	23	23	100
Psychiatry of Learning Disability	4	57	21	36.84

Appendix C

2021/2022 – GP Target Enhanced Recruitment Scheme (TERS)

Programme	Places	Accept	Fill
East Midlands – Boston	25	25	100%
East Midlands – Lincoln	20	20	100%
East of England – Great Yarmouth	19	19	100%
East of England - Ipswich	24	24	100%
East of England - King's Lynn	19	19	100%
East of England - Peterborough	18	18	100%
Kent, Surrey and Sussex – East Kent Thanet	8	8	100%
Kent, Surrey and Sussex – Medway Swale	4	4	100%
London – North Central and East London – Barking Dagenham	4	4	100%
London – North Central and East London – Havering	5	5	100%
London – North Central and East London – Newham	6	6	100%
London – North Central and East London – Redbridge	6	6	100%
London – North Central and East London – Waltham Forest	6	6	100%
London – North West London – Brent	6	6	100%
London – North West London – Hillingdon	6	6	100%
London – North West London – Hounslow	6	6	100%
North East - North Cumbria	28	28	100%
North East - Rural Coastal County Durham & North Yorkshire	44	44	100%
North West – Blackpool	19	19	100%
North West – Lancaster	10	9	90%
North West - South Cumbria	17	17	100%
South West - North Devon	15	15	100%
South West – Plymouth	27	27	100%
South West – Somerset	12	12	100%
South West – Swindon	12	12	100%
South West – Torbay	3	3	100%
South West – Bristol, North Somerset and South Gloucestershire	3	3	100%
South West – Cornwall	4	4	100%
South West – Exeter and East Devon	3	3	100%
South West – Gloucestershire	4	4	100%
Wessex - Isle of Wight	9	9	100%
Wessex – Dorchester	17	17	100%
West Midlands – Hereford	18	18	100%
West Midlands – Shropshire (North Shrops and Oswestry)	7	7	100%
West Midlands – Shropshire (South Shrops and Ludlow)	7	7	100%

West Midlands – North Staffordshire Moorlands	14	14	100%
West Midlands – North Staffordshire Stoke on Trent	22	22	100%
West Midlands – Worcester (Rural and Remote)	11	10	90.9%
Yorkshire and the Humber - Hull GP Scheme	45	44	97.8%
Yorkshire and the Humber – Northallerton GP Scheme	10	9	90%
Yorkshire and the Humber – Scarborough GP Scheme	10	10	100%
Totals	**553**	**549**	**99.3%**

Appendix D

Postgraduate dentistry data – 2021-22 recruitment numbers and fill rates

	London + KSS	Midlands and East	North East	North West	South West	Thames Valley + Wessex	Yorkshire and the Humber	Grand Total	Post fill rate
Dental Foundation training	182	229	62	112	73	64	94	816	100%
Dental Core Training	142	145	39	74	46	45	61	552	90.76%
Dental Speciality Training									
Dental and maxillofacial radiology							1	1	100%
Endodontics									
Oral and maxillofacial pathology	1							1	0%
Oral Medicine					1			1	100%
Oral Microbiology									
Oral Surgery	2	3		1	1		2	9	100%
Orthodontics	14	10		3	1	1		29	89.66%
Paediatric Dentistry	8	3	4	2			3	20	95%
Periodontics									
Prosthodontics									
Public health dental									
Restorative Dentistry	1	1	2					4	100%
Special Care Dentistry	2	6	2	1		3	1	15	100%

Appendix E

Postgraduate dentistry data – 2020-21 recruitment numbers and fill rates

	London + KSS	Midlands and East	North East	North West	South West	Thames Valley + Wessex	Yorkshire and the Humber	Grand Total	Post fill rate
Dental Foundation training								810*	100%
Dental Core Training	144	142	74	33	48	35	69	545	99.6%
Dental Speciality Training									100%
Dental and maxillofacial radiology	1	--	--	--	--	--	--	1	100%
Endodontics	--	--	--	--	--	--	--	--	--
Oral and maxillofacial pathology	1	--	--	--	--	--	1	2	100%
Oral Medicine	--	--	--	--	--	--	1	1	100%
Oral Microbiology	--	--	--	--	--	--	--	--	--
Oral Surgery	3	--	--	1	1	1	2	8	100%
Orthodontics	15	3	1	4	5	5	2	35	90%
Paediatric Dentistry	4	1	2	0	--	--	4	11	92%
Periodontics	--	--	--	--	--	--	--	--	--
Prosthodontics	--	--	--	--	--	--	--	--	--
Public health dental	--	--	--	--	--	--	--	--	--
Restorative Dentistry	3	1	--	2	--	--	2	--	100%
Special Care Dentistry	--	--	--	1	1	--	1	--	100%
Grand Total									

*Regional data is unavailable as currently being reconciled.

Appendix F

Postgraduate dentistry data – 2019-20 trainee numbers and fill rates

	London + KSS	Midlands and East	North East	North West	South West	Thames Valley + Wessex	Yorkshire and the Humber	Grand Total	Post fill rate
Dental Foundation training	197	254	78	81	79	65	102	856	100%
Dental Core Training	140	145	43	78	44	30	68	548	93%
Dental Speciality Training	190	60	34	56	13	12	72	437	100%
Dental and maxillofacial radiology	3	0	1	1	1	--	1	7	
Endodontics	20	--	1	1	0	--	--	22	
Oral and maxillofacial pathology	4	1	--	1	--	--	5	11	
Oral Medicine	7	1	--	3	2	--	3	16	
Oral Microbiology	--	--	--	--	--	--	--	0	--
Oral Surgery	11	7	4	8	5	3	10	48	
Orthodontics	57	27	11	18	11	6	18	148	
Paediatric Dentistry	18	7	5	8	3	--	13	54	
Periodontics	27	--	--	1	1	--	--	29	
Prosthodontics	20	--	--	--	0	--	--	20	
Public health dental	3	2	1	3	3	--	3	15	
Restorative Dentistry	12	9	5	8	5	--	13	52	
Special Care Dentistry	8	6	3	4	4	3	6	34	
Grand Total	**527**	**459**	**155**	**271**	**136**	**107**	**242**	**1897**	

Appendix G

Postgraduate dentistry data – 2018-19 trainee numbers and fill rates

	London + KSS	Midlands and East	North East	North West	South West	Thames Valley + Wessex	Yorkshire and the Humber	Grand Total	Post fill rate
Dental Foundation training	195	227	69	122	81	65	109	868	100%
Dental Core Training	140	126	24	77	44	29	61	501	91%
Dental Speciality Training									100%
Dental and maxillofacial radiology	2	--	1	1	--	--	1	5	
Endodontics	26	--	--	--	--	--	--	26	
Oral and maxillofacial pathology	3	--	1	--	--	--	4	9	
Oral Medicine	--	1	--	3	2	--	2	11	
Oral Microbiology	--	--	--	--	--	--	--	--	
Oral Surgery	10	5	--	6	4	3	9	37	
Orthodontics	52	22	8	16	10	4	10	122	
Paediatric Dentistry	15	4	1	7	2	--	14	43	
Periodontics	36	--	--	--	1	--	--	37	
Prosthodontics	30	--	--	--	--	--	--	30	
Public health dental	4	2	--	3	3	1	3	16	
Restorative Dentistry	9	8	5	10	3	--	8	43	
Special Care Dentistry	7	6	1	4	3	3	4	28	
Grand Total	**529**	**401**	**111**	**250**	**153**	**105**	**225**	**1778**	