# Questions from Distribution of Specialty Training Webinars held on 24 October and 6 November 2023.

## Contents

Some questions fell out of the remit of the programme and therefore we haven’t answered them here. Some comments taken from the chat function have also not been responded to. Thank you to everyone who submitted a question or comment the next Webinar will take place in March and information relating to this will be available on the events page soon.

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## 1. Questions relating to clinical specialisms

**Why has there been regular reductions in absolute training numbers across England (e.g. Anaesthetics CT1[[1]](#footnote-2) has gone from 552 in 2017 to 425 in 2023 and IMT[[2]](#footnote-3) has gone from 1423 to 1360 over the same time period)? Would it not make more sense to leave the London posts and just create new posts outside London?**

Absolute training numbers have grown during this period, both at foundation, core and higher training. The 2023 recruitment round is not yet complete for all specialties so is not comparable to previous years. How specialties recruit can also impact on advertised numbers e.g. increased number of programmes in Acute Care Common Stem (ACCS) Anaesthesia compared to core anaesthesia.

For doctors applying for higher training, we have welcomed the flexibility (following helpful discussions with The Royal College of Anaesthetists and Medical and Dental Recruitment and Selection) around CT3 ‘equivalent’ year recognition allowing a larger number of doctors than are in core programmes to be eligible. Recruitment numbers are only a proportion of the underlining number of posts.  The overall number of anaesthesia posts in recent years has increased rather decreased.

The drop in recruitment could be for a number of reasons e.g. curricula change, increase in Less Than Full Time Training (LTFT) and so on.

**Did modelling consider that for paediatrics and obstetrics training programmes that more doctors would be needed in younger diverse cities like Birmingham rather than coastal communities?**

The work that was done on the modelling does consider where the population needs are so within the city there are younger working families who will be having children and so will need the obstetric services and also the paediatric services. When we move into Phase B which covers paediatric services the modelling will look at the needs of the population including where the children’s population is the highest where there is an increase in pregnancy rates and also to look at inequalities that may be found for the population using paediatric services in specific areas, which will be reflected in the modelling.

The model differs by speciality, for example birth rates fall in some areas but rise in others though reduce overall with time. GP needs are expanding in London more than other areas as another example.

**Are there any specific plans with regards to Anaesthetics Training Expansion? particularly at ST4[[3]](#footnote-4) level where there has historically a high profile bottle neck between core and specialty training**

There has already been expansion of ST4 higher specialty training entry points. They have expanded by 70 every year over the past three years. We have also tried to put in additional places into Intensive Care Medicine (ICM) as well. There was an increase in ICM programme size by 100 places back in 2020 which virtually doubled the programme and we have had 30 in 2022 and 15 more in 2023 and 15 more in 2024. We have asked Trusts to look at whether they will fund additional ST4 entry points into higher specialty training. We are aware there is a bottleneck present in virtually all uncoupled specialities. It is the same for the physician specialties and it is a complex issue due as much to curriculum design as it is to availability in places. We are trying to argue for investment to meet population need. That means increasing investment but increasing it in proportion to the areas of need so it is a complex multifactorial issue.

**There is a massive drop off post FY2[[4]](#footnote-5) and reducing numbers going into speciality training. Do we know why this is and how is this being addressed? As now a senior reg I feel many rotas across many hospitals in different specialities are increasingly being filled by locums/have gaps.**

There are more people apply for and entering specialty training now than at any other point in time, although a lower proportion of entrants come directly from foundation programmes now than in the past.

**Does this include Radiology?**

The Distribution programme includes all 65 specialties and Clinical Radiology is in Phase C which is the final phase of the programme. There have been questions about the rationale for which speciality is in which phase and when each phase starts. The rationale for staging is that it isn’t possible to cover 65 specialisms in one go as there isn’t sufficient resource to do that. The aim is to make sure the changes occur over the length of the long-term workforce plan.

In relation to Radiology the expansion has started and there have been some challenges. The Royal College of Radiologists (RCR) have had challenges with how best to roll out the expansion of posts because of what is required for every radiology trainee.

## 2. Questions relating to National Training Numbers and overall training numbers

**With the increasing number of graduates from medical schools, will there be an introduction of more training numbers to match? There are already unsustainable competition ratios even for GP and IMT. There is a shortage of specialised doctors, yet there’s been no increase to the number of trainees in clearly understaffed areas such as in anaesthesia or ACCS EM[[5]](#footnote-6).**

NHS England has invested in over 800 new training programmes in each of the last three years. Further discussions are underway to determine through the Long Term Workforce Plan to determine expansion numbers for 2025 and beyond.

With an increasing population it has been recognised that we need more doctors so the number of trainees is increasing. The posts have to be resourced so our ability to increase numbers is subject to funding. The new Long Term Workforce plan and the agreements around the funding of that increase those numbers significantly, although this will occur over time. Posts are increasing and we recognise that currently there is much competition for posts at the moment. As medical school places increase in the future that then feeds into foundation year and as those numbers increase the increase in numbers of training posts will also go up.

**My understanding of this plan was that there wasn't going to be an expansion of training numbers but a 're-distribution'. Can you clarify whether there will be an expansion of training numbers (for doctors, not other MAPs[[6]](#footnote-7)).**

Where additional investment in training posts is obtained, this will be used to offset changes conferred by the fair share distribution approach. There has already been an expansion of training numbers across multiple specialties.

**Why don’t you just increase numbers of NTN’s?**

Any increased investment in training will result in a greater number of training posts, which would correspond to a greater number of NTNs.

**Will consultant numbers increase to match an increase in NTN’s as many colleagues have struggled to find consultant posts after CCT[[7]](#footnote-8) and this looks set to become a bigger issue in the UK**

The NHS long term workforce plan describes the need for an increased healthcare workforce and increased numbers of medical school places, with a commensurate rise in the number of postgraduate training places.

**How will you match NTN to the ever increasing number of medical students? I don’t feel confident about this**

It is recognised that there is some anxiety about posts as people come out of medical school but the aim is to get the workforce numbers balanced which we hope will provide reassurance.

**Are there any plans to ‘share’ NTNs such as 2 people doing 50% each? Same money but two trainees?**

Recruitment to flexible training (LTFT) is already occurring across many different programmes.

**Could you project actual numbers of postgraduate training posts starting this year? Also it seems the increase in speciality trainees seems to be much slower than the increase in FY1 and FY2 posts.**

Whilst additional investment has been forthcoming this year, the exact disposition and numbers of posts by speciality and place are yet to be finalised.

**Does the table include other health professionals and does it also include foundation posts as well. If that is the case is it right there would be an expansion of significant training numbers across all specialities including the foundation training as well? How is this meant to cover the extra 1,500 medical students?**

**Does that table include foundation training posts as well? If that’s the case am I right in saying there would only be an expansion of 853 training numbers across all specialties including foundation training as well?**

(Slide2024/2025 Draft PMDE Training Post Overview)

The slide which shows the table does include Post Foundation Specialty Places for doctor training and for dental training. The slide doesn’t include other healthcare professionals. It’s just doctors, dentists and speciality training posts including all programmes. That includes GP which is a big speciality and as already described its differentiated between the majority which are essentially funded through NHSE Workforce Transformation (WFT) tariff funding and locally funded. The expansion of the medical school places is matched by foundation programme expansion.

The additional 1,500 undergraduate medical students who have already come through are in funded places. As the programme rolls through and those trainees who are going to come into the next part of the undergraduate expansion the 7,500 to double output for medical schools. There will be a similar ambition to match the foundation posts and our ambition is to make sure that there is a commensurate increase in the speciality training posts availability. It is important that the different elements are aligned so that we get medical school places in the right areas and they are aligned to the foundation places which in turn are aligned to speciality training places. This will ensure there is a continuous path of training and increasing expertise meaning less need to move all around the country to do the things many trainees are required to do to gain a CCT. The alignment should help the population’s healthcare needs in the way we need and that includes the training path from medical student right through to consultant level. This is one of reasons we have the Long Term Workforce Plan as we know we have outstanding issues with workforce numbers in relation to healthcare need.

**Why was the response to whoever tasked this work simply-expand training numbers rurally, rather than move them from other areas? If this is a matter of funding, surely NHSE has an immediate responsibility to argue with the government given the clear and pressing need for more training posts. Not movement of training posts. If it is a matter of funding . there has been funding for MAP roles on the workforce plan. Trusts are making the decision now that they are structuring the workforce to MAPs.**

Where we have secured additional money for expansion, we have used this to reduce the need to distribute existing investment. The scale of increases in population demand now and in the future require a multiprofessional response to help meet it.

**Overall aren't the numbers of redistribution pretty small compared to overall numbers? I am not sure there will be much of significance. We need a significant increase in NTNs please. Peers are leaving in droves**

The numbers of posts attached to the Distribution Programme are small in part because they have to be considered in relation to the expansion posts which we use when we can. Some specialties are also affected more than others. We are trying to match numbers to predicted need and if we can do this without taking posts away from any region we do. Overall, there will be impact but this is only a small part of dealing with health inequality which is the primary driver for the programme.

## 3. Questions relating to Remote, Rural and Coastal

**Does NHSE acknowledge that doctors in rural and coastal areas could face more racial discrimination? When I worked outside London as an FY2 I was asked many times where I was from and many patients asked to see a white Doctor. I chose to work in London to avoid this. When I worked outside London as a FY2 I**

**Redistribution will involve expansion of posts in rural and coastal areas. Some of these places are much more challenging for those from ethnic minorities and international medical graduates.**

The Distribution Programme like other programmes within NHSE does acknowledge that the broad answer to the question is ‘yes’ and we’re sorry to note those behaviours are still present in our society. The expansion of the medical labour market means there are more Doctors who qualified overseas working in the UK health system than at any other time in the past. That does mean that all our programmes fill pretty consistently everywhere in the country. Which also means that doctors from overseas doctors from different backgrounds and different beliefs are exposed to more of the population in more places including rural and coastal areas. We acknowledge this is a risk and there isn’t a guarantee this won’t happen in future. The excellent healthcare that everyone strives to deliver is the best testament to the skill and expertise that doctors care for patients with.

**Would distribution mean that there would be more movement between the hospitals during the training to compensate for inadequate learning opportunities in rural areas?**

The movement between different providers depends on the curriculum and its requirements of trainees within it at different stages of the programme. Postgraduate Deans and their Heads of Schools will take careful account of curriculum exposure when designing programme for trainees.

**How will you entice trainees to train in less ‘competitive or ‘attractive’ regions and hospitals, with this shift of training numbers away from more competitive regions and larger major cities**

Competition for posts is currently high so most places are filling across most programmes at the moment. The programme will continue to examine the factors that are likely to attract and keep trainees in the different locations where patients will need the skills that they bring throughout and beyond their training.

**Have you considered a ‘non urban’ pay scale (in parallel to the uplift London trainees receive) to incentivise uptake of rural and coastal training numbers?**

These arrangements are currently under review through a separate programme running in NHS England.

**Thanks for this update, really interesting and am very glad this engagement process is happening. Have other health inequalities aside from geographical change been considered with this programme? e.g. socioeconomic inequality in some inner city areas – how will this redistribution affect this in the long run? Also. What specific health outcomes are being looked at to measure success with this programme and when will this be assessed?**

We recognise there is a wide range of approaches needed to address health inequalities and multiple parts of the system are working on various elements of this really important issue.

**How are you using the existing examples from Wales and Scotland, to understand both successful practice and the challenges of recruitment and retention in rural, under-doctored areas?**

We are sharing our approaches with the other nations of the United Kingdom and we all hope to learn from one another.

## 4. Questions relating to training and Rotations

**What options are there for Drs applying to different specialties who will be married and/or starting families where they have been placed in different regions? I understand the inter deanery transfer is difficult/not guaranteed, and impossible if applying between England and Scotland for some specialties.**

NHS England has been working with trainee representative groups to create greater flexibility in the Inter-Denery Transfers (IDT) process to allow more trainees to move regions. However, this is dependent on available training programmes. Inter deanery transfer process is something which has been established with trainee, General Medical Council (GMC) and British Medical Association (BMA) input so all the parameters about what makes this fair and sustainable have been considered when producing the transfer documentation and process.

**Could the frequency of training rotations be reduced? Moving every 6 months is pretty unanimously disliked and not advantageous**

Rotation training programmes are key to ensure that trainees get a breadth of experience while training and are able to meet all aspects of the required curriculum. NHS England has worked with trainees to reduce the impact of training rotations and progress can be reviewed via the [Enhancing Junior Doctors Working Lives Programme](https://www.hee.nhs.uk/our-work/doctors-training/enhancing-working-lives).

**Will trainees be able to train and live without moving annually? It is no longer justifiable nor economical and contributes to burnout**

There are some pilots which are being looked at currently to limit the number of rotations or setting out in advance years ahead where a trainee may rotate to. Further work is being undertaken to see if the number of rotations can be reduced while balancing this with the curricular requirements.

**Can you improve dual training for specialities so that you don’t have to try and just get a training number in both but also a training number in both in the same deanery. It makes it very difficult to achieve, especially as there is a now also a time limit of managing to get a job in both specialities.**

We hope that by creating more posts that will create more flexibility so we can see an impact going forwards.

**Also can you improve training in specific deaneries for trainees? Hospitals in some deaneries are very spread out - meaning for trainee programmes where you have to change hospital each year you have no option but to move house each year. Renting is difficult in some of these regions as well, especially if you have children and pets, and especially when you only know your next placement 2 months in advance. Is it possible to create a 2-year placement in hospitals rather than 1 or at least be told your hospital placement in advance at the start of your programme rather than on a year-to-year basis.**

We understand there can be challenges in training and working in a large geographical area. There is a balance between the curriculum needs for each rotation, and on the speciality you have chosen. For example, in vascular surgery in say Kent, Surrey and Sussex there are three centres that you rotate around across a large region. The curriculum requires people to do that. For some specialties we are going to be looking at pilots to see whether it is possible to limit those rotations, particularly in Phase B and Phase C. It does fall under the LongTerm Workforce Plan and under the Enhancing Doctors working lives. Regional Deans have been working to Schools to try and limit the number of moves a doctor in training must undertake to meet all the requirements for the curricular. For some areas, this will depend on the regional access in various trust to sub-speciality elements required within the curricular. Heads of Schools and Training Programme Directors (TPDs) have within each region to balance the curricular requirements and trainee needs to ensure trainees are able to achieve their CCT.

**The final part of the question was around improving hospital accommodation options as these are very limited. The Registrar years are often the years people want to settle down and have children and not upset their lives every year by constantly moving and its very stressful.**

Accommodation provided by trusts for doctors has changed over the last 10 years due to pattern of rotas and the reduction in the need for accommodation with current shift patterns. As outlined by the BMA, there is still a need for trusts to ensure accommodation is available for doctors who are unable to drive home after a particularly long or challenging shift and for those who travel long distances, (see the BMA Fatigue Charter). Most trusts have a policy for an emergency for accommodation for the doctor and at induction all doctors who need regular accommodation when they do certain shifts and encourage doctors to book accommodation early for shifts when the doctor will need accommodation where there is limited availability of accommodation.

Trusts often have limited accommodation and they need to ensure that they are made aware prior to a doctor starting. It is a challenge particularly with the medical student undergraduate increase because of the increasing number of people wanting accommodation. The responsibility to provide accommodation does not sit with NHSE Workforce, Training and Education (WTE) as this is primarily a trust function - we would encourage early discussion with the trust.

Most trusts support the BMA charter and if hospital accommodation is not possible to consider one of the local hotels or B&Bs.

Trainees should consider checking what the options are by talking to HR before they take up any post to ensure their needs can be met. The Directors of Medical Education (DME) and the Deans will support trainees in doing this and this is about making the trust accountable to ensure they deliver on their responsibilities.

## 5. General Questions

**Where exactly are these changes affecting?**

The changes relating to the Distribution Programme are currently affecting approximately 20 ‘Phase A’ specialities but will in time move on to affect all 65 specialties as recognised by the GMC. When the distribution posts are seen in relation to the whole number of posts the 60,000 posts seen earlier it equates to 6% of the total number of posts. The ‘Phase A’ specialty distribution relates to around 3% of all posts.

**What percentage of trainees are informed of these changes which may affect their lives (other than those who attend forums)? Who/which organisations have been consulted in implementing these changes? How transparent do you think have you been about making decisions which affect doctors lives?**

It’s a small proportion of the total number of posts but we mustn’t underestimate how long it has taken to get to this point the planning commenced in the 2010’s Framework 15 work and the subsequent refresh more recently. It was outlined after a period of consultation in the HEE 2017 Strategy about workforce and the need to look forward, ‘Facing the facts, shaping the future’. It was outlined in the 2019 Long Term Plan of the People Plan and arriving at the programme in its final iteration we consulted widely with the GMC, BMA (both the Junior Doctors committee and Consultants and Specialists committee), with the Royal Colleges, the Department of Health and with health think tanks to source a variety of views and interests and critique and allow them to challenge the assumptions we were making. After this extensive period, we brought this programme forward and there have been other opportunities for trainee engagement but we want to repeat sessions like this so everyone knows what is happening, when it is happening and plan accordingly.

**Would these changes affect Allied Health Workers and PAs[[8]](#footnote-9) and ACPs[[9]](#footnote-10)?**

The changes occurring in the training of doctors is because of the peculiarities of the funding for postgraduate medical training which is largely held centrally not locally. We do know that the template for this alignment of workforce with where there is current and future population need is being looked at very carefully by the DOH (Department of Health) and may inform how we might guide other professions in the future. There is a gravitational effect in that where you get more doctors in a geographical community you tend to get more nurses, more Allied Health Professionals (AHPs) and other health professionals. This helps with the vibrancy of the care community and with the sufficiency of the healthcare that a geography can provide for its residents.

**Where can I find information about Phasing I don’t understand what it means?**

Phasing is a way of gradually adopting a fair share approach across all 65 GMC recognised specialties. The approach was agreed in 2022 after undergoing a thorough consultation process with local offices at Health Education England. The approach was implemented to ensure local teams had the opportunity to formally express preferences and opinions whilst the national programme team found a solution that worked in favour of most parties.

[More information can be found in the weblink which shows the three phases and lists the specialisms in each phase](https://www.hee.nhs.uk/our-work/doctors-training/addressing-health-inequalities-distribution-medical-specialty-training-programme/frequently-asked-questions-faq/overview-0).

**Are 53 participants able to provide statistically significant enough results to extrapolate to a national plan? I may have misheard.**

The qualitative work carried out to engage with doctors in training about the Distribution programme is one of many ways we have gathered feedback. As is the nature of qualitative work, it is not possible to speak with large numbers of participants. However, we had many participants who were interested in taking part and we ensured that those who did were from a varied professional background, including specialty, training grade, and location.

There is no universally agreed metric for achieving statistical significance in qualitative work. One such way is when data saturation is reached, which is when no new significant information comes from the focus group discussions. This was reached in this qualitative work.

The outputs of this work are not setting policy, but rather providing key learning to the programme to help facilitate better communications with doctors in training and ensure their voices are incorporated in decision-making.

We acknowledge that it would be ideal to ensure all doctors in training voices are heard, but we hope this work has provided deeper insights into the concerns raised by doctors in training and that repeated engagement in the future will build on these insights.

**What is done for lobbying for more funding for training posts**

There are ongoing discussions with government around the funding of training programmes for all programmes, including medicine.

**Thank you for putting on this Webinar. It’s nice to hear from HEE – it makes trainees feel valued to be included in the processes. This needs to be increased and we need more regular communication from HEE.**

These webinar opportunities are being planned to continue into the future.

1. Core Training (CT) [↑](#footnote-ref-2)
2. Internal Medical Training (IMT) [↑](#footnote-ref-3)
3. Specialty Training (ST) [↑](#footnote-ref-4)
4. Foundation Year (FY) [↑](#footnote-ref-5)
5. Emergency Medicine (EM) [↑](#footnote-ref-6)
6. Medical Associate Professions (MAPS) [↑](#footnote-ref-7)
7. Certificate of Completion of Training (CCT) [↑](#footnote-ref-8)
8. Physician Associates (PAs) [↑](#footnote-ref-9)
9. Advanced Clinical Practitioners (ACPs) [↑](#footnote-ref-10)