Health Education England

Review Body on Doctors' and Dentists' Remuneration

Health Education England's written evidence for 2023/24

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 2023/24.

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.

1.3. This will be the final year HEE submits evidence to the pay review bodies. From April 2023 Health Education England and NHS Digital will become part of the new NHS England that will bring together the three organisations to create a smaller, simpler high performing organisation that leads the health service more effectively. HEE has long argued for better alignment of service, financial and workforce planning. Collaboration and cooperation have taken us some way along this path. Creating a new single national and regional leadership organisation will further build this alignment.

1.4. The new organisation brings education and training spending into NHS England's funding allocation and simplifies NHS national leadership creating greater synergy across the Long-Term Plan, People Plan, education and training reform, and workforce transformation.

1.5. This will help us better support colleagues to recruit and develop the health professionals needed to deliver exceptional patient care, now and in the future.

1.6. The timeline for Heath Education England to be legally incorporated into the new NHS England is on schedule for 1 April 2023. This is subject to Parliamentary approval of Regulations made under Part 3 of the Health and Care Act (2022).

2. Workforce planning and long-term workforce demand

2.1. 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.

2.2. The Long-Term Strategic Framework for Health and Social Care Workforce Planning (F15) has been developed through a detailed engagement and evidence gathering process with partners across health and social care. Through this process HEE and partners have developed 5 key actions that the system needs to undertake now to ensure that we have a workforce fit for the challenges of service delivery both now and in the future, through a workforce that is both 'more *and* different'. The first of these, which is the foundation and arguably the most important, is to keep the people we have, with a relentless focus and improved work offer. Whilst this is not just about pay and conditions, making these as

attractive as possible will better enable the health and care system to deliver on this action.

2.3. In February 2022, the Secretary of State commissioned NHS England and Health Education England to develop a long-term workforce plan for the NHS. The plan focusses on the practical action the NHS must take, working with partners in government, to grow and transform the workforce, and continue to embed compassionate and inclusive cultures. Guided by a new strategic framework for the health and care workforce, the long-term workforce plan will provide a roadmap that will ensure the NHS has the right number of people, with the right skills, working in the right areas to deliver high quality care. Combined, these actions will put the NHS on a sustainable footing over the long term. Key outputs from the workforce plan will be published in due course.

3. The Medical Workforce

Workforce Context

3.1 The total number of specialty training posts in any given medical specialty is determined by HEE in collaboration with partner organisations, contingent on:

- funding available (provided through HEE's budget and by providers);
- the training infrastructure to support training to required standards.

3.2 As has been highlighted in previous submissions, there are challenges in developing assessments on current and future supply and demand. We do not have up to date data on shortfalls of doctors at specialty level. HEE plans are developed by engaging with partner organisations to collate a range of informal sources which are then used to assess future workforce gaps.

3.3 Although there is no straightforward algorithm for deciding on Postgraduate Medical Education specialty training numbers, the forthcoming establishment of the new NHS England provides an opportunity to gather intelligence on the current shortfall of doctors at specialty level. Work underpinning the Strategic Workforce Plan is aiming to establish a system wide assessment of future demand which can be agreed with delivery partners.

3.4 Over recent years funding for specialty training posts has remained stable with increases directed towards specialties where addressing shortfalls is a priority. Expansions have mainly been focused in Mental Health and Cancer and Diagnostics.

3.5 An additional 333 posts were created in 2022 in a range of specialties to address:

- service recovery (post covid),
- supporting the unselected take (patients admitted as emergencies, patients with multiple disorders, patients requiring investigation and diagnosis, and inpatient referrals),
- in response to the Ockenden review; and
- in Public Health.

Recruitment into specialty training

3.6 Recruitment into specialty training remains competitive with over 45,000 applications across UK training programmes in 2022/2023 compared to 40,000 in 2021/2022. The below table provides an overview of applicants by their country of primary medical qualification. This highlights an increase in overseas applications seen since the introduction of the Health and Care Visa in 2020.

Recruitment Year	UK	EU	Rest of World	No Qualification (Public Health)
2022/2023	40.40%	6.82%	50.37%	2.40%
2021/2022	46.66%	6.04%	44.81%	2.49%
2020/2021	47.68%	6.30%	44.71%	1.31%

3.7 The data in Appendix A shows the fill rates across training programmes. At CT1/ST1 level 8497/8518 posts were filled, creating 99.75% fill rate. This includes HEE successfully hitting the GP manifesto target of 4000 acceptances.

3.8 In higher specialty training, fill rates remain generally strong, with an overall fill rate of 87%. However, there are a number of specialties which require remedial action due to a low fill in recent years, these include Palliative Medicine, GU Medicine, Paediatric and Perinatal Pathology (see para 4.31). Action could include financial recruitment incentives (similar to the GP TERS scheme) and reviewing eligibility criteria on person specifications.

4. The Medical Education Reform Programme

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 significant changes in how medical education is delivered. To ensure successful delivery, the programme is 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 several 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. Many of these key initiatives are drawn from *The Future Doctor, the* co-created vision that 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 the following reform streams set out below:

1. **Enhanced Generalist Skills** – ensuring doctors can provide high quality whole person care for patients with multimorbidities and disease clusters through the development of enhanced generalist skills. This will change how doctors function within local health systems and support more seamless working across community, primary and secondary care.

2. **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, rural and coastal healthcare challenges.

3. 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.

4. **Boosting multi-professional team working alongside producing more doctors with generalist skills,** we will support service provision to be more efficient through promoting and rewarding generalism, skill mix and multi-disciplinary team (MDT) innovations e.g., supporting new roles, Anaesthesia Associates, Physician Associates and Advanced Clinical Practitioners (see also HEE's PRB submission on these new roles).

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 is being delivered by an interwoven professional educational offer which augments traditional training using innovative educational methods. This development 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 continue to 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 and healthcare professionals to learn and apply these skills confidently.

4.8 HEE's enhance trailblazer programme will drive this change where there are the best opportunities in the system. It will produce a cohort of trainee doctors and healthcare learners with enhanced generalist skills, recognised by a generalist certification. Seven trailblazers are in place within each of HEE's seven regions, the first cohort of learners commenced the programme in November 2021 and there are currently 150 learners undergoing the enhance offer. Further expansion is planned for 2023/24 and beyond.

Medical Doctor Degree Apprenticeship and Blended Learning Medical Degree

4.9 The Medical Doctor Degree apprentice standard is now approved by the Institute for Apprenticeships and Technical Education. HEE supported development of the apprenticeship to make the profession more accessible, more diverse and more representative of local communities. We want to spread opportunity out to local communities and help to address the challenge of recruiting and retaining doctors in areas where recruitment is proving difficult.

4.10 Employers and medical schools are currently considering how to make the apprenticeship available. GMC approved medical schools that wish to offer the apprenticeship will need approval by the GMC that the apprenticeship programme meets the high-quality standards required of all medical degrees which lead to the award of a Primary Medical Qualification.

4.11 Individual NHS employers will need to work with medical schools to deliver the apprenticeship. Decisions will be made at a local level based on local workforce needs.

4.12 Health Education England will soon be launching a blended learning medical degree delivered by Queen Mary University of London. The programme will blend face-face, online and digital learning to develop theoretical and practical knowledge and skills.

4.13 The new blended programme aims to give students wanting to complete a medical degree more flexibility over how they study and a wider choice of where the University can provide practice placement learning opportunities to complete their training.

4.14 The blended learning medical degree follows on from the nursing and midwifery blended programmes that Health Education England introduced in July 2020 and June 2021, respectively.

4.15 The flexibility offered by the blended degree is designed to reduce some barriers to higher education and attract applicants from diverse backgrounds. The programme is on track to start the first cohorts in October 2023.

Addressing Health Inequalities – distribution of training places

4.16 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.

4.17 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 was 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.

4.18 The first tranche of training posts within these three specialties commenced first year post movement for in August 2022. After discussion, the remaining medical specialties have been allocated into phases that will be explored over the next 10-15 years. Whilst further post movement is still to take place within the initial three specialties, implementation has moved onto the next phase with guided modelling for twenty specialties, with considerable stakeholder engagement underway.

4.19 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. A network of six remote and rural pilot sites has been created to support the educational offer and build on the required infrastructure.

4.20 The guided model 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.

4.21 The programme has implemented and trialled a range of methods to transition the distribution of training to the future guided position, while maintaining continuity of care and patient quality and safety at the same time.

Flexible Pay

4.22 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.

4.23 In terms of providing evidence, HEE's experience of introducing pay premia is limited to the General Practice Targeted Enhanced Recruitment Scheme (TERS). The TERS Scheme was originally introduced in 2016. Successful applicants who commit to training for three years in TERS areas are offered a one-off £20,000 salary supplement, funded by NHS England through HEE.

4.24 The scheme was designed to test whether additional financial incentives attract trainees to these parts of the country and would provide some potential workforce supply into areas facing most severe recruitment pressures. The payment is offered to GP trainees in programmes (or sub programmes) which are either in an area of deprivation and/or 'under doctored' and/or a previously hard to fill training programme.

4.25 The 20/21 GP Contract agreement committed the then NHSEI and HEE to expanding the number of TERS places available from 276 to 500 in 2021/22, and from 500 to 800 in 2022/23 (at which point it would account for 20% of the 4,000 GP specialty training places available nationally)

4.26 TERS has proved successful in attracting GP trainees to areas with the most significant under-recruitment challenges. In 2015, hard-to-recruit areas had placement fill rates of between just 12.5% and 62.5%. In 2019/20, fill rates were close to 100% (see appendix B for latest TERS placement fill rates).

4.27 As a relatively new scheme, evidence does not yet exist that the scheme improves long term retention post qualification. TERS may be playing a key role in helping HEE deliver the target of filling all 4,000 training placements by making the option of undertaking GP training more attractive to more prospective trainees.

4.28 HEE believes caution should be exercised in the evaluation of TERS results as longitudinal tracking is required to ascertain if TERS trainees remain in an area post CCT. Whilst on the face of it, the programme is successful in filling training places, the programme will only demonstrate success if trainees are found to remain in those areas longer term. HEE is working with NHS England to conduct a review of TERS to support negotiations for the next iteration of the GP Contract. As part of that process a decision will be made whether to continue with the payments or if funding would be better prioritised on other initiatives.

Foundation Priority Programmes

4.29 Following the 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.

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

- 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;
- 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.
- All Foundation Schools are offering programmes which include a fellowship with the Royal College of Pathology with the intention of supporting recruitment to pathology specialties

Recruitment Incentive - Paediatric and Perinatal Pathology

4.31 HEE have also recently announced a Recruitment Incentive for Paediatric and Perinatal Pathology. For all trainees accepting a Paediatric and Trainee Pathology training post in England from 2023, they will be eligible for a £20,000 recruitment incentive. Further retention payments will be available for trainees continuing in training. This is to recognise the need to improve in recruitment into the specialty and grow the paediatric pathology workforce.

4.32 The recruitment and retention initiatives will be in addition to the flexible pay premia already available under the junior doctor contract for pathology trainees.

S/AS Doctors

4.33 HEE acknowledges many doctors choose a career as a S/AS doctor, but that some S/AS 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 S/AS doctors. To support this, HEE administered a fund of £4.5m in 2019/20 and £5m in each year since 2020 for the development of S/AS doctors through a network of tutors in each provider.

4.34 S/AS and locally employed medical staff provide a very significant service contribution and workforce flexibility. Doctors who trained outside the UK are significantly over-represented within this cohort. Attracting and supporting these individuals into UK practice is a key part of our ability to deliver the required NHS workforce, so it is important that S/AS doctor roles are seen as a viable, and fairly remunerated, 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,[1] details the progress we have made to enhance junior doctors' working lives during 2021- 2022.

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 train flexibly;
- extending the Out of Programme Pause (OOPP) offer, allowing trainees to 'step in step out' of training without unnecessary burden, and can request to have capabilities gained whilst out of training recognised on their return;
- embedding the Supported Return to Training (SuppoRTT) programmes which support trainees return onto programme after a period of absence – regardless of the specialty; and
- continuation of the Flexible Portfolio Training (FPT) scheme, with exploration underway to extend the scheme to all specialties. This scheme allows trainees in higher medical specialities to have one day protected time per week for additional personal development within a defined pathway theme.

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.

5.5 In response to the pandemic, HEE 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 since August 2021, and trainees in all the remaining specialties from February 2022. The offer in the 2021-22 academic year was for trainees to be able to train LTFT for a 4-month window (to mitigate pressure on service/rotas). Trainees in all specialties from August 2022 are now able to apply for train LTFT for the entire year.

5.6 A three-year longitudinal evaluation of LTFT Category 3 is near completion and due to report in January 2023. The findings to date are positive in respect of trainee wellbeing and work/life balance. A total of 770 doctors in training have now undertaken Category 3,

[1] Enhancing Junior Doctors' Working Lives 2022 (hee.nhs.uk)

which has helped with retention of this vital workforce. HEE will continue to monitor this once LTFT Category 3 is rolled out across all specialties. It is evident that the number of doctors and dentists in training requesting to train less than full time is increasing year on year. In a survey of doctors and dentists in training conducted in January 2022, 86% of trainees (n=676) currently training full time would consider training less than full time in future, and 93% of trainees currently training less than full time (n=108) indicated that training less than full time has made them more likely to remain in training.

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 capabilities gained during OOPP can be assessed on the trainee's return to the programme and, if appropriate, counted towards their CCT.

5.8 Local programme pilots established in 2019 were extended in 2020/21 reflecting the impact of the pandemic. In 2022 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 currently able to apply for OOPP until end of July 2023, when the first full evaluation of OOPP will be published. To date, 233 doctors in training have undertaken OOPP.

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 welcomed 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 continuing to tackle the gender pay gap issues through the actions within our remit and in supporting the work of the Gender Pay Gap Panel.

5.12 HEE notes that a number of reform initiatives have had a positive impact on female doctors and dentists in training. In terms of access to Out of Programme Pause, 62% of applicants are female. For Category 3 Less than Full Time Training, 68% of applicants are female. The Supported Return to Training (SuppoRTT) initiative has high levels of uptake for both female trainees and trainees with caring responsibilities.

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

5.13 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.

5.14 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.

5.15 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.

5.16 The most recent NETS ran from 2nd to 30th November 2021. The Postgraduate Medicine responses[2] included feedback that 87% had satisfactory or better educational supervision and overall supervision was satisfactory or better for 92%. In response, HEE have established a group chaired by a Regional Postgraduate Dean to review options to improve all supervision. Feedback also showed that between 16 and 18% reported or had witnessed bullying and harassment. Through the new quality framework and liaising via Freedom to Speak Up Guardians HEE is prioritising efforts to reduce bullying and harassment and encourage its reporting to facilitate solutions.

5.17 The most recent survey opened on October 18th, 2022 and is due to remain open for six weeks. The results will be published in January 2022. Further information is gathered through the GMC's national training survey.

5.18 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

5.19 HEE has ensured that the costs to individual applicants and to the NHS is minimised by working with the devolved nations to prevent named courses from being included in curricula, so that more cost effective regional or local options can be developed.

[2] NETS Results Overview, Postgraduate Medicine, November 2021

5.20 HEE has raised the exam issue with the Medical Royal Colleges, who create, set and deliver the exams and with the GMC who approve the need for exams within the curricula.

5.21 We have asked the GMC that they carefully consider any added benefit against the cost, both to trainees and to consultant time in the NHS. The GMC discussions have highlighted an interest in reviewing the place of postgraduate exams in training.

5.22 The Academy of Medical Royal Colleges has raised this with members. Some colleges are proactive in sharing the nature of the costs of exams others have resisted this and we continue to support the Academy trainee representatives who are working to encourage colleges to be more transparent about exam costs.

5.23 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.

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

5.24 Trainee placements are distributed to enable patient care across the country and so address health inequalities. They cover a range of sites which helps trainees experience working in different sizes of organisations, preparing them for consultant or GP practice anywhere in the country. In recognition of the strains that movement between placements can cause, HEE Deans asked their teams to minimise rotational distance where possible, and review all training programmes to achieve that.

5.25 In order to deliver training and the necessary service trainees provide for patients across the country, there will continue to be some placements at a distance from the trainees base. HEE mitigates this with financial support for relocation and flexibility in where they train for trainees with special circumstances, further information on this can be found below.

5.26 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.

5.27 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.

5.28 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.

5.29 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.

5.30 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).

5.31 National HEE arrangements for the payment of relocation and expenses for junior doctors appointed to a new training programme have applied since 2020. Eligible trainees can 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.

5.32 HEE worked closely with the BMA and other stakeholders on the 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 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. Although the removal of restrictions has diminished this challenge, these innovations remain valuable options in the delivery of undergraduate medical education. At the same time, the progress of students continues to be monitored to assess whether any further mitigating action will be required.

6.2 A second issue was the impact of COVID-19 on the 2020 and 2021 A-level results arising from the use of teacher assessed grades, that for those years resulted in more applicants achieving the requirements of their conditional offers for a place at medical school and consequently resulted in a significant over-subscription. The return to normal A-level assessment methods, coupled with Government communications to medical schools that offer-making should be amended to ensure no further over-recruitment, has meant this issue was not repeated in 2022. Intake targets reverted to pre-pandemic levels, and provisional data suggests these have been adhered to.

Impact of COVID-19 on postgraduate medical education

6.3 The pandemic had a significant cumulative impact on postgraduate medical doctors in training (DiT) experiential learning and attainment. From our data collections and engagement with employers, we know learning was materially affected during each surge of the pandemic. These DiT were either formally or functionally redeployed[3] to COVID-facing settings, or had elective learning opportunities cancelled, resulting in a diminished and "monochrome" training experience.

6.4 During the initial waves of the pandemic, many DiT were redeployed or had elective learning opportunities cancelled, with up to 50% of DiT' progression identified as being at risk. In April 2021, HEE with our partners NHS England & NHS Improvement, NHS Employers, the Department of Health and Social Care, the General Medical Council, the Academy of Medical Royal Colleges established the Post Graduate Medical Education (PGME) Training Recovery Programme to reset, recover and reform postgraduate medical education.

6.5 Training extensions have been necessary for DiTs to obtain the education outcomes required by the medical regulator before they can complete training and be entered onto the specialist register. Figure 1 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.

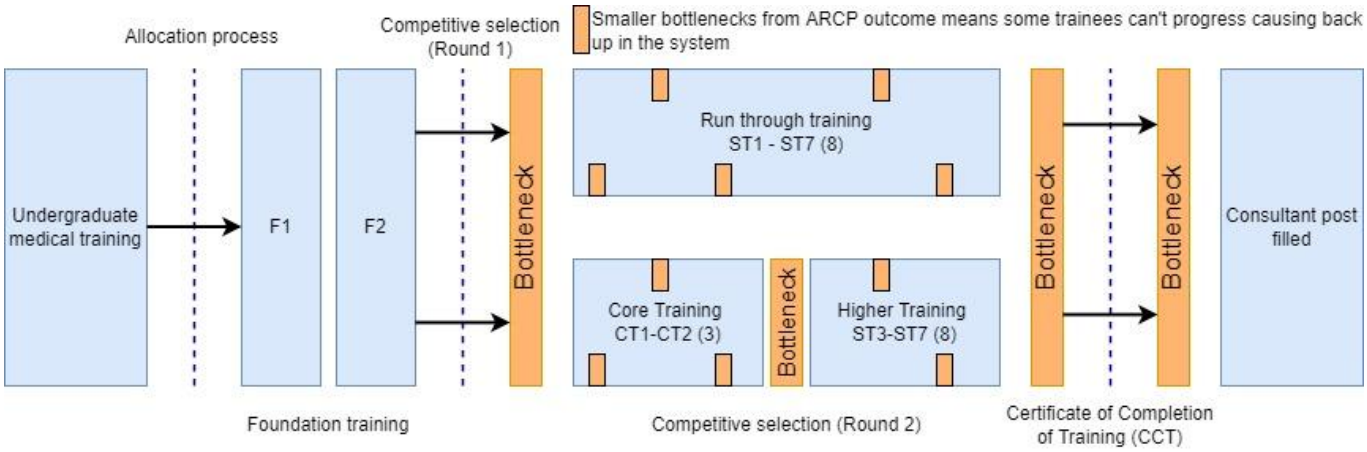

Figure 1. Training recovery to enable service reset and minimise bottlenecks to progression

[3] "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.

6.6 Training extensions have been the traditional way of achieving outstanding curriculum requirements during a set training period. These have been necessary to ensure that DiTs 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.

6.7 Although retention in postgraduate medicine is high, the impact of COVID threatened to affect DiT's progression (as in Figure 1). The numbers affected during the pandemic were such that if every DiT were simply given an extension to cover the period of the pandemic, this would have led 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.

6.8 Without targeted intervention, there was therefore a risk to the supply of consultant, GP and middle grade doctors. These senior decision-makers are essential to the COVID-19 recovery and the NHS backlog. Our Interim Report[4] outlines the approach taken to define, manage and reduce risks to medical workforce wellbeing, numbers and future supply.

Mitigating the length of extension to encourage progression

6.9 During the COVID pandemic, the GMC, the AOMRC and the four UK SEBs agreed college and faculty derogations to curricula and decision aids for Annual Review of Competence Progression (ARCP). These temporary derogations have enabled many DiTs to achieve the required capabilities, progress and where appropriate to achieve Certificate of completion of training (CCT). The GMC anticipates these derogations will be discontinued after 30 September 2023, with the exception of some GMC-approved methods of online training and assessments.

6.10 We are confident that mitigating measures in 2022/23 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 DiTs. HEE estimate there are about 3% of DiT who require additional training time or 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.

Training recovery interventions

6.11 To avoid further extension costs, and to support DiTs who are managing ongoing curriculum gaps, over the past two years we worked with our system partners to maximise training opportunities while supporting service recovery and embed continuous improvements to training structures and delivery. Our focus is to ensure service and training recovery are integrated.

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

6.12 The programme has been investing into PGME training recovery interventions. With support from DHSC, in 2021/22 HEE invested over £26M new funding into PGME training recovery interventions. We have developed principles for managing future cost pressures such as study leave, expanding capacity in the independent sector, development and delivery of training catch-up, support for the educator workforce, extension costs and funding for DiTs who have used curriculum derogations.

6.13 In 2022/23, we secured a further £25M to address the continued impact of the pandemic on doctors in training and their educators. As a result of HEE and partners' interventions, extension rates are lower compared to 2019-2020. To address future extension risk and avoid significant future cost pressures, training recovery interventions have been developed to respond to specialty specific and regional training needs. These interventions have had the dual-focus of both supporting DiT wellbeing and addressing lost training opportunities, enabling DiTs to practice and harness procedural, diagnostic and clinical skills.

6.14 Funding continues to be invested in a range of initiatives, including Simulation and Technology Enhanced Learning (TEL) initiatives, training workshops, bootcamps and courses, additional supervision, exam and wellbeing support. Evaluation of interventions has shown that simulation has enabled DiTs to meet competency requirements, while increased supervision and training courses have improved their confidence and capability in performing skills as well as exam success rates.

Identifying individualised training needs and recovery options

6.15 The COVID-19 pandemic caused significant training disruption, anxiety and distress to both DiTs 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.

6.16 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 DiT 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 DiT's learning needs.

6.17 The training recovery conversations are an opportunity for DiTs 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 DiTs are offered a one-to-one training recovery discussion.

Ensuring wellbeing for training recovery and future resilience

6.18 HEE has worked closely with national, regional and local partners to ensure that the health and wellbeing of students and DiTs 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 DiTs.

6.19 We have encouraged DiTs and educators to consider HEE's enhanced flexibility offer to promote recuperation and wellbeing, reduce burnout, and support DiTs 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 Less than Full Time are important (Section 5). HEE will continue to extend its flexible offers for DiTs in England and will conduct a full impact analysis and evaluation of the flexible training offer, working with system partners to resolve any issues.

6.20 Doctors in training who are disabled, or have a disability, learning difference, or long-term health condition (including long-term effects of COVID-19 and mental health conditions) may be able to access additional support that will enable them to equitably access their education and employment in healthcare. An evaluation of the Training Recovery Programme highlighted that the key impacts of the interventions were increased DiT wellbeing and morale.

Ongoing monitoring and mitigating against further disruption

6.21 Recognising the impact of earlier waves on the pandemic on the education and training of health and care DiTs, we have refreshed HEE's guidance on managing the training workforce[5].

6.22 HEE regularly monitors DiT progression and 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 DiT'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 DiTs, training programme directors (TPDs) and Heads of Schools (HoS); and
- actual impacts on DiT progression, including extensions, as identified by the ARCP process.

6.23 Taken together, these datasets allow postgraduate deans to monitor and identify developing risks to DiT 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.

6.24 Since the start of the pandemic, the programme has mitigated against and minimised the risk of further disruption to PGME Education. As the pandemic resulted in a diminished training experience, up to 50% of trainees' progression was identified as being at risk in 2020. At the start of the 2021/22 academic year, 14% of trainees were identified at risk

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

which by 2022/23 this figure is estimated at 3% of trainees identified at risk of COVID dependent delay.

6.25 The potential impact to postgraduate medical extensions based on 2021/22 ARCP data is higher compared to pre-pandemic numbers but significantly lower than in previous pandemic years:

- The number of DiT at high risk of extensions due to the pandemic (ARCP COVID outcome 10.2 and outcome 3 where development and additional time is required) is 1869 or 4%, of which 438 or 1% are COVID outcome 10.2 derogations. The number of DiT at medium risk of derogations (COVID outcome 10.1) is 1321 or 3%.[6]
- The number of DiT on developmental outcomes, at high or medium risk of additional training time in a 'normal' year not affected by the pandemic (outcomes 2 and 3) was around 6-7%. Currently, the total number of DiT requiring additional training time or at risk of additional time (ARCP outcomes 2, 3, 10.1 and 10.2) is approximately 10.5%.
- In 2022/23 about 3-4% of high and medium risk to DiT's progression is due to the impact of the pandemic on PGME. This data excludes dentistry specialties.

[6] During the COVID pandemic, the GMC, the AOMRC and the four UK SEBs agreed derogations to curricula and decision aids for ARCPs facilitated by the development of the "no fault" COVID Outcomes 10s (10.1 & 10.2) which could be applied in place of Outcome 2 and 3 respectively where the training had been disrupted.

7. The Dental Workforce

Dentistry workforce

7.1 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.

7.2 There were 43,944 UK dentists registered with the dental workforce regulator, the General Dental Council (GDC) as October 2022. The total number of dentists registered in England was 34,859 October 2022[7]. Although some might not be practising, working instead in research or overseas.

7.3 During 2021-22, 24,272 dentists were practising under NHS GDS, Mixed, PDS and TDS contracts in primary care[8]. This equates to 72% of all registrants.

7.4 Dentists working to the GDS contract are 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.

7.5 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 delivering NHS care 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. NHS England announced reforms to the dental contract in July 2022 which are designed to improve access to dental care.

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[9] students are capped by government; more than 800 places are available each year in England (see **Table 4**).

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. In 2022, intake targets reverted to pre-pandemic levels, and provisional data suggest these have been adhered to.

[7] GDC, Registration Report – 17 October 2022
[8] NHS Dental Statistics for England, 2021-22, Annual Report
[9] Applicants who are from countries outside of the European Economic Area are defined as international students.

Applicants and Entrants to Dentistry Courses at English Providers (2018-2023)					
Year of Entry	**2018-19**	**2019-20**	**2020-21**	**2021-22**	**2022-23 (provisional)**
UK Applicants	2,365	2,765	2,860	3,185	3,440
Intake	808	811	898	980	795

Table 4: Dentistry undergraduate intake numbers[10] [11]

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 eight 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[12] (DST; 3-5 years)

7.9 Appendix C presents recruitment data for DCT and ST1/4 posts in 2022 and 2021. 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[13] has fallen, there are very few paediatric posts in some regions. 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.19 new posts were funded for 22/23 in Oral Surgery, Special Care and Paediatric Dentistry.

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 2004/38/EC, or a select number of recognised overseas qualifications.[14] Dentists from outside the EEA whose qualifications are not recognised for full registration

[10] *Source:* 28 days after A level results day *In-Cycle Date*
[11] *OFS, Medical and Dental Intakes, https://www.officeforstudents.org.uk/advice-and-guidance/funding-for-providers/health-education-funding/medical-and-dental-intakes/*
[12] Specialist Lists, GDC. https://www.gdc-uk.org/registration/your-registration/specialist-lists
[13] Additional Dental Specialties includes Dental and Maxillofacial Radiology, Oral and Maxillofacial Pathology, and Oral Medicine.
[14] Apply for registration, GDC. https://www.gdc-uk.org/registration/join-the-register/how-to-join-the-register

with the GDC need to take the overseas registration examination (ORE) and obtain the necessary permits/visas to stay and work in the UK. [15] Temporary registration is available allowing 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.[16]

7.12 As shown in Table 5, 61% of new dentists joining the register in 2021 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.

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. These arrangements will be reviewed by the Government in the first half of 2023. Registration data shows the number of new registrants coming from the EEA has increased from 22% of total registrants in 2020 to 29.5% in 2021.

New additions to the dentist register in 2020 and 2021, by region of qualification

	2020		2021	
Regions of Qualification	Registrants	% of total	Registrants	% of total
UK Qualified	1,070	66%	912	61%
EEA Qualified	357	22%	446	29.5%
ORE (UK overseas registration exam)	106	7%	5	0.5%
Overseas Qualified	94	6%	137	9%
TOTAL	**1,627**	**100%**	**1500**	**100%**

Table 5: New additions to the register in 2020 & 2021 by region of qualification[17]

Dentistry education and training reform: Advancing Dental Care

7.14 HEE's Advancing Dental Care (ADC) Review[18] 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 fell into two phases with the final report published in September 2021[19]. The report built on successful pilots and evidence gathered in 2018-2021 to provide 20 recommendations that would develop more flexible training experiences in varied settings and considered the importance of building better training pathways for both dentists and DCPs. Furthermore, the 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

[15] Ibid
[16] Temporary registration, GDC.
[17] Registration statistical report 2021 (gdc-uk.org)
[18] Advancing Dental Care Review: Final Report, HEE.
[19] ibid

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.

7.16 The benefits of education reform and workforce transformation identified 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;
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.

7.17 HEE established the Dental Education Reform Programme to deliver the recommendations of the ADC Review. The 4-year programme established governance, stakeholder engagement and delivery plans in 2021/22 with implementation commencing in 2022.

7.18 Key projects in 2022/23 included:

- Procurement and implementation of a Lead Employer model for Dental Foundation Training
- Review of Early Years Dental Training established programmes and pilots, with commencement of procurement of new curricula. Early Years Dental Training is a longitudinal programme covering Dental Foundation Training and Dental Core Training Year 1, designed to provide trainees with a wider breadth of experience across sectors within an Integrated Care System(s) to enhance skills and knowledge for delivery of dental services
- Review of Dental Therapist Foundation Training education and funding model
- Initial development of guided distribution models for Dental Foundation Training and Dental Specialty Training across three prioritised specialties – Special Care Dentistry, Paediatric Dentistry and Oral Surgery – to inform HEE's distribution of training investment
- 19 new Dental Specialty Training posts, in the three priority specialties, supported to commence in 2022/23

7.19 As part of the Programme, 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.

Impact of COVID-19

Undergraduate Dental Students

7.20 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.

7.21 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 and 2022 was £32m.

7.22 97% of dental students graduated with the required competencies to begin Dental Foundation training from September 2022 (98% 2021). Without the additional revenue funding made available, there would have been very few Undergraduate Dental students graduating in England in summer 2021 and 2022, having a subsequent impact on progress onto the dental foundation programme. Further extensions may be needed for some dental schools due to the teaching deficit. As the impact has been dependent upon the dental estate and air flow restricting the ability to perform aerosol generating procedures. Progression of students continues to be monitored closely by the Dental Schools Council (DSC) and other stakeholders including HEE.

7.23 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. Numbers of Dental Undergraduates in 2022/23 have returned to the capped level.

Postgraduate

Dental Foundation Training (DFT).

7.24 No Covid outcomes have been required in DFT for the last 2 cohorts (20/21 and 21/22). The number of extensions to training nationally are 1%. This is in line with pre covid extensions of between 1-3%.

7.25 Some HEE regions have had difficulty recruiting Educational Supervisors and Training practices for the 2022 cohort, with the number leaving DFT training greater than the recruitment of new trainers. Several reasons for leaving training have been cited, workload of training, payment for the service component of training not having been increased since 2013, HEE is working to address those issues identified within its control.

Dental Core Training (DCT).

7.26 Dental Core Training (DCT) has not been adversely affected by Covid. The option to extend training for DCTs was introduced this year with only 7 (1.3%) DCTs nationally receiving a developmental RCP outcome.

Dental Specialty Training (DST).

7.27 There was some variation on the impact of COVID on trainee progression dependent upon specialty.

7.28 ARCP outcomes as of December 2021

- 85% of trainees received standard ARCP outcomes (18% completed training).
- 13% received COVID outcomes of these approximately one third (16) required extensions to training. Of those requiring extensions to training 62% were in orthodontics and 25% were in oral surgery.
- 1.6% of trainees received a non-COVID related extension to training.

7.29 The above figures were from 2021, 2022 figures are not yet available.

Health Education England
January 2023

Appendix A

Recruitment into specialty – fill rates 2021/22

Training Programme	Level	Posts	Accepts	Fill Rate
Anaesthesia/Intensive Care Medicine				
ACCS Anaesthetics/Core Anaesthetics	1	488	488	100.00%
Anaesthetics	4	141	141	100.00%
Intensive Care Medicine	3	184	175	95.11%
Diagnostics				
Clinical Oncology	3	143	94	65.73%
Clinical Radiology	1	308	308	100.00%
Diagnostic neuropathology	3	16	3	18.75%
Histopathology	1	97	97	100.00%
Paediatric and perinatal pathology	3	9	1	11.11%
Emergency Medicine				
ACCS Emergency Medicine	1	321	321	100.00%
Emergency Medicine	4	51	50	98.04%
GP/PH/OccMed				
General Practice	1	4000	4032	100.80%
Occupational Medicine	3	6	4	66.67%
Public Health Medicine	1	86	86	100.00%
Medicine				
ACCS Internal Medicine/Internal Medicine Training	1	1381	1381	100.00%
Acute Internal Medicine	4	96	85	88.54%
Allergy	3	3	3	100.00%
Audio vestibular Medicine	3	7	4	57.14%
Cardiology	4	102	102	100.00%
Chemical Pathology	3	8	7	87.50%
Clinical Genetics	3	8	8	100.00%
Clinical Neurophysiology	3	11	11	100.00%
Clinical Pharmacology and Therapeutics	4	11	4	36.36%
Combined Infection Training	3	36	33	91.67%
Combined Infection Training	4	22	18	81.82%
Dermatology	3	48	48	100.00%
Endocrinology and Diabetes Mellitus	4	86	86	100.00%
Gastroenterology	4	90	90	100.00%
General (Internal) Medicine	4	16	13	81.25%
Genito-urinary Medicine	4	50	4	8.00%
Geriatric Medicine	4	157	121	77.07%
Haematology	3	98	95	96.94%
Immunology	3	2	2	100.00%
Medical Oncology	3	90	72	80.00%
Medical Ophthalmology	3	4	2	50.00%
Neurology	4	72	54	75.00%
Nuclear Medicine	3	2	2	100.00%
Paediatric Cardiology	4	6	5	83.33%

Palliative Medicine	4	54	16	29.63%
Rehabilitation Medicine	3	14	9	64.29%
Renal Medicine	4	83	83	100.00%
Respiratory Medicine	4	169	169	100.00%
Rheumatology	4	78	73	93.59%
Sport and Exercise Medicine	3	5	5	100.00%
Mental Health				
Core Psychiatry Training	1	554	554	100.00%
Core Psychiatry Training	1	14	14	100.00%
Child and Adolescent Psychiatry	4	70	57	81.43%
Forensic Psychiatry	4	32	31	96.88%
General Psychiatry	4	268	240	89.55%
Medical Psychotherapy	4	2	2	100.00%
Old Age Psychiatry	4	52	36	69.23%
Psychiatry of Learning Disability	4	55	20	36.36%
O&G				
Community Sexual and Reproductive Health	1	10	10	100.00%
Obstetrics and Gynaecology	1	255	242	94.90%
Obstetrics and Gynaecology	3	57	57	100.00%
Ophthalmology				
Ophthalmology	1	65	65	100.00%
Ophthalmology	3	12	12	100.00%
Paeds				
Paediatrics	1	388	381	98.20%
Paediatrics	3	17	17	100.00%
Paediatrics	4	69	69	100.00%
Surgery				
Cardio-thoracic surgery	1	4	4	100.00%
Cardio-thoracic surgery	3	2	2	100.00%
Cardio-thoracic surgery	4	3	3	100.00%
Core Surgical Training	1	524	524	100.00%
General Surgery	3	112	112	100.00%
Neurosurgery	1	14	14	100.00%
Oral and Maxillo-facial Surgery	1	9	8	88.89%
Oral and Maxillo-facial Surgery	3	33	19	57.58%
Otolaryngology	3	42	42	100.00%
Paediatric Surgery	3	11	11	100.00%
Plastic Surgery	3	37	37	100.00%
Trauma and Orthopaedic Surgery	3	133	133	100.00%
Urology	3	47	47	100.00%
Vascular Surgery	3	20	20	100.00%

DATA CORRECT AS AT 16/11/2022 - Source: www.oriel.nhs.uk

Appendix B

2022 – GP Target Enhanced Recruitment Scheme (TERS)[20]

Region	Advertised	Filled	Fill rate
East of England	115	118	103%
London	77	75	97%
East Midlands	81	81	100%
West Midlands	79	70	89%
North East and North Cumbria	99	99	100%
Yorkshire and Humber	88	83	94%
North West	86	75	87%
Kent Surrey Sussex	27	27	100%
Wessex	62	59	95%
South West	82	81	99%
TOTAL	**796**	**768**	**96%**

Appendix C
Dental Core and Specialty Training Recruitment

Dental Core & Specialty	Level	Post Type	2022				2021		
			Posts	Accepts	Fill Rate %	Trend	Posts	Accepts	Fill Rate %
Dental Core Training Year 1	1	Dental	361	325	90.03	↓	336	317	94.35
Dental Core Training Year 2	2	Dental	227	206	90.75	↓	255	240	94.12
Dental Core Training Year 3	3	Dental	81	62	76.54	↑	102	75	73.53
Dental & Maxillofacial Radiology	1	ST	1	1	100%	=	1	1	100%
Oral and Maxillofacial Pathology	1	ST	4	2	50.00	↑	1	0	0.00
Oral Medicine	1	ST	1	1	100.00	=	2	2	100.00
Oral Surgery	1	ST	14	14	100.00	=	13	13	100.00
Orthodontics	1	ST	33	33	100.00	=	16	16	100.00
Orthodontics	4	ST	27	13	48.15	↓	13	13	100.00
Paediatric Dentistry	1	ST	11	11	100.00	=	14	14	100.00
Paediatric Dentistry	4	ST	8	6	75.00	↓	8	7	87.50
Public Health Dental	1	ST	3	1	33.33	↓	4	4	100.00
Restorative Dentistry	1	ST	4	4	100.00	=	4	4	100.00
Special Care Dentistry	1	ST	9	9	100.00	↓	15	15	100.00
			1943	1844	94.90		1678	1616	96.31

Acceptance of dental core year 1 and 2 training posts showed a downward trend with only London reporting a 100% fill rate.

The recruitment included the additional 19 Dental specialty posts in Oral Surgery, Special Care and Paediatric Dentistry. Only 1 of these posts was filled in Special Care in a second round of recruitment.

The fill rate for Oral & Maxillofacial Pathology was only 50%, with only 2 applicants being deemed appointable following interview.