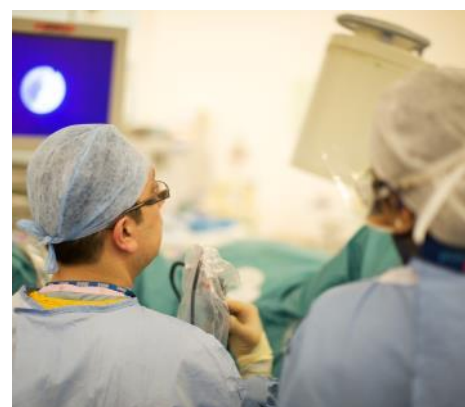


Doctors' and Dentists' Review Body

Health Education England's written evidence for 2017/18



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Background

- i. Health Education England (HEE) welcomes the opportunity to once again submit evidence to the Doctors and Dentists Review Body (DDRB) as part of its national process of gathering evidence from interested parties to inform the recommendations for 2017/18.
- ii. We greatly appreciated the opportunity to meet to review and discuss the handling of the evidence round for 2016 with the Review Body Secretariat earlier in the year. It was also helpful that Ffiona Hesketh, Deputy Director, Office of Manpower Economics, was able to meet with HEE's Chief Executive, Ian Cumming, to discuss HEE's role in supporting the pay review bodies, and the particular value that HEE can add. The session proved helpful in enabling us to reflect further on how we can best support the work of the review bodies going forward.

Health Education England's role

- iii. HEE exists for one reason only: to help improve the quality of care by ensuring our workforce has the right numbers, skills, values and behaviours to meet the needs of patients. In 2013, we took over the functions of the former strategic health authorities (SHAs) and their Deaneries for workforce planning, education commissioning and education provision. It is the first time that responsibility for all of these functions are within the same body, and by doing so, we aim to improve both national consistency and standards and local leadership and decisions. We recruit doctors and dentists into training and we fund and support the training of a range of multi-professional staff and apprentices. We are also responsible for supporting the NHS Constitution and helping to embed the NHS Values into everyday activity in the NHS.
- iv. We are now in our fourth year as HEE, providing the NHS with a single national body with a ring-fenced budget for commissioning education and training places to secure the future workforce. Our four local education and training boards (LETBs), regionally based and employer-led, provide a single strategic forum for their region in which health care economies can come together to discuss and agree plans and actions on the local workforce.
- v. We operate a single system of dispersed leadership, working together to deliver both local and nationwide success. To achieve this we are proud to also work with:
 - The providers of NHS services who are ultimately responsible for employing, maintaining and developing their staff and the quality of care they provide; and
 - Other organisations such as commissioners, local authorities and higher education providers.

- vi. We also have a wider role on the national stage working with the Department of Health (DH) and other health Arms-Length Bodies (ALBs) and Non-Departmental Public Bodies, including NHS England, NHS Improvement, the Care Quality Commission and Public Health England. Together, HEE and these organisations have developed the NHS Five Year Forward View¹. The purpose of the Five Year Forward View is to articulate why change is needed, what that change might look like and how we can achieve it together.
- vii. HEE has now established, for the first time ever in the NHS, a workforce planning process that brings together into one place decisions about:
- Planning the future medical workforce;
 - Planning the future non-medical workforce;
 - Investment in the education and training of existing staff;
 - Local needs and national priorities; and
 - National workforce priorities alongside wider system/strategic goals.
- viii. Earlier this year we published our third Workforce Plan for England², which set out the investment we are making in education and training programmes for 2016/17. In line with the previous two versions, it sets out the £5bn worth of investment we will make in education and training programmes for the following year. These investments are primarily (though not exclusively) focussed on our core role of ensuring secure future supply.
- ix. This year we have again increased the overall volume of education and training with in excess of 38,000 new training opportunities for nurses, scientists, and therapists, and over 50,000 doctors and dentists in training. We have targeted increases on critical areas such as adult and mental health nursing, paramedics, and physician's associates, whilst in postgraduate medicine there are increases to training posts in General Practice, Emergency Medicine and Clinical Radiology. This training supports continuing strong growth in the number of clinical professional staff both within the NHS and the total number of registered clinical professionals in England. HEE forecasts that as result of this training between 24,000 and 82,000 additional staff could be available to the NHS or other employers by 2020, depending on the extent to which service providers' act to employ output from our programmes and work to retain their existing staff.
- x. The Plan also starts to address the full range of workforce issues facing the Health and Care system, regardless of HEE's own specific responsibilities. In doing so it aims to address the important issues raised in both the National Audit Office and Public

¹ The NHS Five Year Forward View, NHS ALBs: <https://www.england.nhs.uk/ourwork/futurenhs/>

² Investing in People, HEE 2016:

<https://www.hee.nhs.uk/sites/default/files/documents/Workforce%20Plan%20for%20England%202016-17.pdf>

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Accounts Committee reports on 'Managing the supply of NHS clinical staff in England', and will also reflect on the observations made in the Health Foundation's recent report on workforce policy in the English NHS. In addition to future workforce supply the Plan also therefore considers current workforce shortages and how they may be addressed and also builds on the opportunities presented by the Shared Delivery Plan and the new Sustainability and Transformation Plans (STPs) to outline the critical service and workforce transformation agenda.

Evidence to the Doctors and Dentists Review Body on behalf of Health Education England

1. Introduction

- 1.1 The NHS in England employs directly of the order of 110,000 doctors in 105,000 whole time equivalent (WTE) posts. Within this total, there are around 44,000 (41,500 WTE) consultants, 19,000 (18,000 WTE) 'non consultant non training' (NCNT) staff and 44,000 (42,500 WTE) trainees. Note, there are around 50,500 trainees in total – the remainder are in GP Registrar training programmes, (and thus not captured on the Electronic Staff Record), 'Out of Programme' and on maternity/other leave.
- 1.2 In primary care, the published data indicates of the order of 41,000 GPs and 5,000 registrars. However, in practice, the numbers are less certain; changes in the way primary care staff are classified and coded means there is a break in the time series.
- 1.3 Health Education England's (HEE) role regarding the medical workforce is to ensure that there is a sufficient on-going supply through the planning and commissioning of post graduate medical education programmes. This is a complex activity which requires HEE to work with the wider NHS system to forecast long term demand and supply, and to seek to resolve these in the context of a process which takes a newly graduated medical student through a multi-stage process that can *notionally* be as long as 10 years (in paediatrics for example), but often far longer.
- 1.4 HEE has no specific formal remit in the area of pay, although pay and contracts of medical staff will impact on recruitment and retention and labour market behaviour. However, the workforce and labour market intelligence that HEE is developing (to use in making its post graduate medical education commissioning decisions) has a clear overlap with the intelligence the Doctors and Dentists Review Body (DDRB) requires for its deliberations. Hence, HEE is pleased to submit this evidence to the DDRB. Our evidence, and the data supplied, is structured around a specific brief provided by the DDRB Secretariat. It addresses explicitly the points the Review Body asked us to address and the data we were asked to supply. Within this context, at the request of the DDRB, we have been as concise as we think possible, while conveying the key points we understand the members of the DDRB are interested in. We will, of course, be happy to respond in the form of answers to further written questions and in our oral evidence on 28 November 2016.
- 1.5 Our written evidence is structured as follows:
 - Section 2 summarises the HEE approach to medical workforce analysis;

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- Section 3 discusses current supply of consultants including an analysis of 'shortfall from demand' by specialty and geography, and commentary on the proportion of doctors with 'non UK' Primary Medical Qualifications;
- Section 4 is concerned with supply into post graduate medical education, and identifies the fundamental constraint: the number of opportunities available to doctors on completion of Foundation training is far in excess of the numbers emerging from Foundation training who are seeking such opportunities. The section shows how this plays out in terms of fill rates in specialities and geographies. The section also comments specifically on recruitment in to general practice; and
- Section 6 looks ahead at future supply prospects, noting the overall projection of sustained growth in available CCT holders.

- 1.6 As noted above, HEE has no formal role in determining the pay of doctors. However, our comment is that overall we suggest that, at this stage, there is little evidence to demonstrate that differential pay awards for Consultants will necessarily resolve current or future shortages. The supply of consultants is the outcome of a process of PGME training of, at a minimum, seven years and generally longer. If supplementation has a place, it might be in incentivising doctors to choose *between* specialties and geographies. At this stage, the use of recruitment incentives in General Practice training has yet to be evaluated and while the Psychiatry Taskforce is currently considering introducing incentives to attract doctors into core and specialty training it has not yet done so.
- 1.7 We look forward to the opportunity to address further specific questions at the forthcoming oral evidence session on 28 November 2016.

2. The HEE Approach to medical workforce analysis

2.1 HEE took over some of the functions, and some of the resource, from the Centre for Workforce Intelligence in April 2016. We are currently refining our approach to medical workforce analysis into the following core components as follows:

- 'Short run' *supply* forecasts which will set out forecasts of supply for the coming five years at the level of medical specialty. This data will be further analysed by HEE Region where the numbers involved allow, and, for the very largest specialties, by HEE local area. Aggregation 'sets' of grouped specialties will also be available at 'Sustainable Transformation Planning' (STP) footprint level. This data is currently being prepared and will not be available to the system in time for the Review Body submission, but may be available ahead of the DDRB report;
- 'Short run' *provider expressed* demand forecasts. In 2015, HEE collected from providers current (2015) demand and forecast demand for each of the subsequent five years (i.e. to 2020). In 2016, to date, HEE has collected from providers their current (2016) demand and an *initial* 2017 demand forecast. This later data collection clearly precedes the submission of the outcome from the pan-ALB Sustainable Transformation Planning (STP) process (due in late 2016). HEE is currently analysing the 2016 data and awaiting a decision by the collective Arm's Length Bodies (ALBs) as to whether there will be a further collection of future demand data. Hence, at this stage, HEE cannot provide general comment on future workforce risks within a demand context defined by the wider system planning process. We intend to be in a position to do so early in 2017; and
- More detailed assessment of long term supply and demand to support HEE's PGME commissioning decisions. A process for these reviews has been developed and the first specialties to be considered through this process will be considered by the HEE Board in due course. HEE's approach will develop further as the data improves and techniques to explore and contextualise the sometimes very different perspectives on the drivers of long term demand also develop.

3. Current workforce supply

- 3.1 The DDRB asked HEE specifically to supply data and commentary on 'vacancy rates'. This section addresses that through a 'proxy' measure, described below.
- 3.2 For the reasons set out above, at this stage the summary analysis here is based on 2015 data.
- 3.3 There are over 60 medical specialties ranging in size³ from several thousands to just tens.
- 3.4 Providers were asked to supply information on:
- The number of consultants in post by speciality expressed in whole-time equivalent (WTE). These numbers did **not** include agency doctors temporarily filling substantive posts; and
 - The demand for consultants in that speciality expressed in WTE.
- 3.5 Figure 1 groups specialties into categories (some of which relate to 'feeder' routes and some of which are broadly grouped into the service areas where they are concentrated) and then within each category expands the data for *some* specialties.
- 3.6 The difference is construed as 'shortfall from demand'. HEE is cautious not to use the term 'vacancy' as the collection neither defined nor explicitly sought vacancy data. The purpose is to provide a general sense of 'unmet demand' which we can then position against future supply in our more detailed work. (See Appendix B)
- 3.7 The table shows:
- The number of consultants (WTE) in each specialty in 2015. The blue bar indicates the relative scale of the specialty;
 - The overall England wide 'shortfall' as a percentage of total demand in 2015; and
 - The corresponding shortfall in each of the four HEE regions.
- 3.8 Shortfall, which is highlighted below, of 6% or less is coloured green, which is not to say it does not present a problem for providers. It is rather that an element of 'labour market friction' is to be expected as staff leave (e.g. retire) and are recruited (from, for example, new CCT holders). Shortfalls of between 6% and 10% are coloured amber and those of 10% or more are red. It is important to appreciate that March is likely to be the 'high

³ Expressed in this case as the number of NHS employed consultants.

point' for shortages as 'establishment' is set for financial purposes in March and supply tends to grow incrementally throughout the year with a jump in the summer as new CCT holders emerge in volume. Clearly trend data would be of more value but, at this stage, we do not have reliable trend data for the HEE measure.

3.9 **Figure 1: Current provider expressed shortfall from demand for Consultants at March 2015**

	Scale (Staff in Post)	England	North	East & Mids	London and SE	South
SMALL SPECIALTIES	508	13%	14%	9%	16%	9%
ACCIDENT AND EMERGENCY	1,509	13%	13%	15%	11%	10%
ACUTE TAKE	4,087	10%	12%	14%	8%	6%
Acute medicine	182	33%	29%	28%	20%	15%
Gastroenterology	1,029	7%	11%	9%	3%	2%
General Internal Medicine	815	15%	9%	20%	21%	8%
Geriatric Medicine	1,195	9%	12%	12%	4%	6%
Respiratory Medicine	867	7%	8%	8%	4%	6%
PATH & LAB	1,917	10%	16%	9%	6%	8%
Histopathology	1,208	10%	15%	8%	5%	8%
PSYCHIATRY	3,963	8%	13%	7%	3%	9%
CANCER SERVICES	4,724	8%	11%	9%	6%	4%
Clinical Radiology	2,714	9%	12%	11%	6%	5%
Ophthalmology (inc. medical)	1,026	7%	10%	5%	10%	2%
OTHER MEDICINE	4,393	6%	8%	7%	3%	6%
SURGERY	7,302	6%	8%	5%	4%	4%
Anaesthetics & ICM	6,533	5%	5%	4%	8%	1%
Obsterics & Gynaecology	2,069	4%	4%	3%	5%	1%
Paeds & Paed Cardio	2,977	4%	8%	4%	3%	2%
All	41,557	8%	9%	7%	6%	5%

Source: HEE Workforce returns from providers relating to March 2015

Colleagues from the EU and wider overseas

3.10 The 2016 DDRB report noted (2.86)

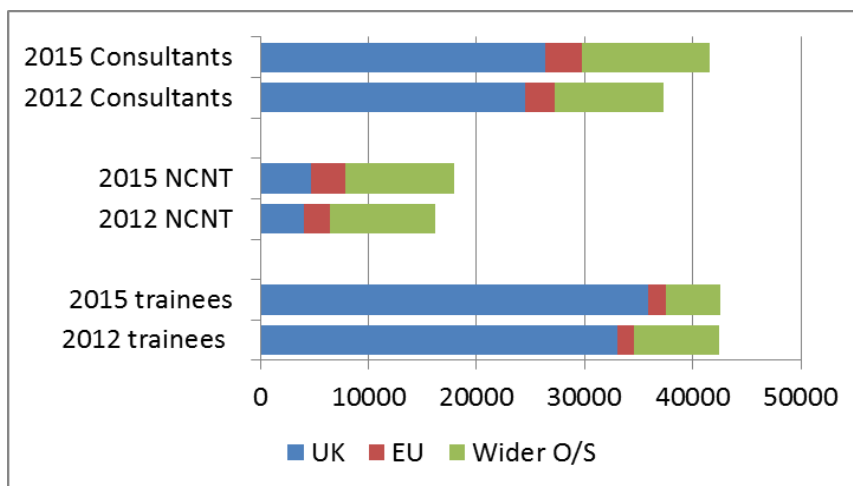
3.11 ***“Whilst we do not see any sign of the UK’s historical reliance upon overseas doctors reducing, we note the aspiration of the Department of Health for England to become self-sufficient and the recent publication of Health Education England’s third workforce plan in December 2015.”***

3.12 HEE concurs that reliance on overseas doctors will not reduce rapidly. The Electronic Staff Record (ESR) and the GMC Register both have nationality fields in their data sets but in both cases the data are only partially populated. However, the GMC register holds information on the institution – thus the country – where all doctors gained their Primary Medical Qualification, or ‘PMQ’ (i.e. medical degree or equivalent). While a small number of UK citizens have studied undergraduate medicine abroad it understood that, historically, numbers have been small (they are currently increasing but this will not

feed through to workforce for some time). An advantage of using PMQ is that for an individual nationality may change, but PMQ does not. It is thus assumed that 'PMQ' is a reasonable *proxy* for nationality.

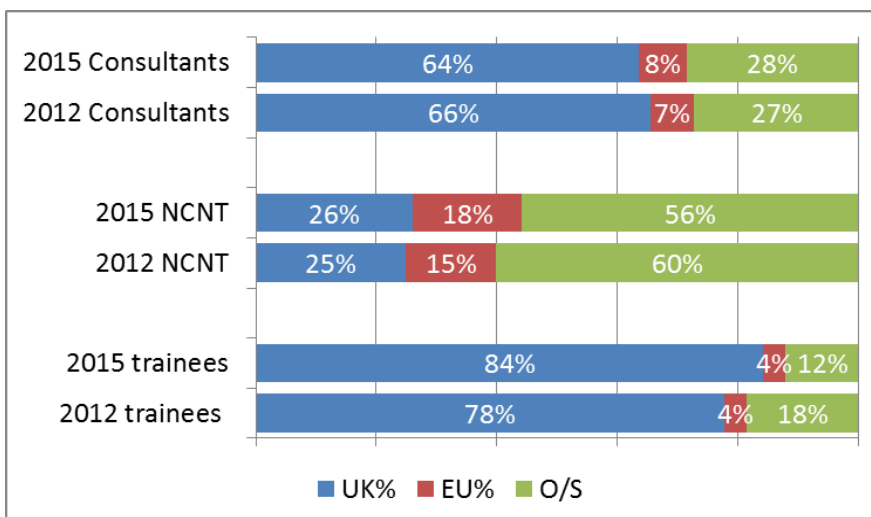
3.13 Figures 2 and 3 below summarises the proportion of Consultants and NCNT staff recorded in ESR who had gained their PMQ outside the UK in 2012 and 2015, and the proportion of doctors in training in England with non-UK PMQs.

3.14 **Figure 2: Components of the medical workforce and world region of Primary Medical Qualification – whole time equivalents**



Source ESR and GMC matched data

3.15 **Figure 3: Components of the medical workforce and world region of Primary Medical Qualification whole time equivalents as a percentage of the total**



Source ESR and GMC matched data

3.16 The proportion of the medical workforce from the EU and wider overseas will shift as the current workforce retires and the growing proportion of doctors in training with UK PMQs move into Consultant and NCNT roles. However, this will be a long process.

'SAS' Grades

- 3.17 The 2016 DDRB report noted (also 2.86)
- 3.18 ***“HEE’s third Workforce Plan for England] noted HEE was considering the part played in delivering services by SAS and trust grade doctors as well as doctors in training. HEE said that only by openly and explicitly acknowledging the whole medical workforce and their supporting multi-professional teams would it be able to make sensible decisions on the levels of structured post-graduate medical education to commission for future consultant and GMP supply.”***
- 3.19 And also (4.50):
- 3.20 ***“Given the BMA’s survey results, we welcome the action taken in both England and Scotland via the Charter for SAS doctors and the SAS Doctors Development Fund. We have long championed the importance of funding for SAS doctors to support career development. We ask all of the parties to update us on any issues impacting SAS career development for our next review and to learn of the effects of the Charter and any other actions impacting SAS grades. As we noted last year, SAS doctors are an important part of the NHS workforce and continue to play a pivotal role in the provision of services. We would like to see this group of doctors given equal consideration and reflected more in the quality and quantity of evidence we receive.”***
- 3.21 HEE is considering the part the part played in delivering services by ‘SAS’ and trust grade doctors and other ‘NCNT staff, as well as doctors in training. At the time of writing HEE is preparing guidance on this.

4 Supply in to post graduate medical education (PGME)

- 4.1 Medical undergraduate programmes are generally five years in duration, but there are variations. HEE funds the placement costs of medical undergraduates. On successful completion of a medical degree, UK graduates who wish to pursue medicine as a career are entered into a two year Foundation training programme, during which they receive GMC Registration. On successful completion of Foundation training, doctors who intend to continue their training compete (either immediately or after a period out of training for a variety of reasons) for 'core' or 'common stem' training, or apply in to 'run through' programmes. Data from successive cohorts of the GMC/HEE trainee census indicate that approximately four in five trainees transition from Foundation to further training (See Appendix A).
- 4.2 HEE is responsible for commissioning post-graduate medical training programmes for 60+ medical specialties and relevant 'feeder' training programmes. Programmes vary in notional length from two years (for example core surgery) to eight years (paediatrics) although in practice many trainees spend longer in training as they undertake 'out of programme' activities, and/or take maternity and other leave, and/or work part time for part of their programme.
- 4.3 HEE funds the training infrastructure and 50% of salary costs of commissioned programmes. NHS provider bodies (and some others) also fund programmes where HEE makes no contribution to salary costs. These are termed 'Trust Funded' posts. Further academic posts are funded by the National Institute for Health Research (NIHR), and a small number by the defence services.
- 4.4 When a programme is commissioned by HEE – irrespective of the funding source - there is thus a commitment to maintain a number of posts into the future while trainees move through these programmes. So, for example, when HEE, or the wider system, commissions a programme in paediatrics, it is committing to eight years of funding and support. Moreover, those who enter higher specialty training expect (and are led to expect) that they will ultimately move into a consultant post. HEE exerts control over the overall number of programmes and posts in each specialty in each HEE geography through the annual Investment Planning process.
- 4.5 Doctors in training contribute directly to service delivery. The extent of this varies by the level of training and specialty but many services *rely* on trainees to fill medical staffing rotas. The corollary is that reduction in the number of trainees (through either directly decommissioning training programmes, interventions aimed at diverting trainees between specialties or geographies, or an actual reduction in applicants from home or overseas) has a direct impact on service.

The underlying supply constraint

4.6 The 2016 DDRB report noted (4.21)

4.7 ***“For our next round, we ask the parties to provide a more detailed analysis of the causes of hard-to-fill specialties, broken down by region in each country, and evidence on how the gaps from low fill rates are covered, including by adjustments to pay. We would also welcome evidence on whether it is actually the case that junior doctors are choosing location over specialty, and if so, the reasons for this.”***

4.8 Nationally, HEE manages annual recruitment to medical training posts for core, run-through and higher training. Close to 10,000 posts ‘turn over’ each year. Currently, there are more opportunities post-Foundation than there are trainees completing Foundation training and seeking a career in medicine. That is, in the context of current ‘demand’ for trainees there is a fundamental supply constraint limiting the NHS’ ability to recruit to training posts.

4.9 This results in:

- A continued (but diminishing) reliance on recruitment from outside the UK; and
- Less than 100% fill in geographies and specialties considered ‘less popular.’

4.10 In making its annual decision about the overall number of posts and programmes to commission (including Trust funded programmes), HEE has to take into account and seek to balance a range of factors:

- Considerations of future demand for CCT holders (who are then eligible to apply for consultant posts);
- The overall supply of trainees available (the output from Foundation training);
- The overall funds available;
- Relative priorities as expressed by the Government and NHS England; and
- The impact on service of any changes. That is explicit intentions to regulate supply of future CCT holders may implicitly impact on service delivery now. The overwhelming pressure is for HEE has to stay its hand as, understandably, near term priorities trump the longer term interests of future patients and future taxpayers.

- 4.11 As a result of the supply constraints above, it is not possible to fill all posts in all specialties in all areas. Figures 4 and 5 show comparative recruitment 'fill' rates for each specialty. These are averaged over two years -2015 and 2016 - and the data included here only covers fill as at the end of August 2016. Recruitment continues into October as in some specialties there is a February intake.
- 4.12 The figures show the number of posts advertised and filled at 'post Foundation' level - that is 'core' and 'run-through' programmes (figure 4) and the number of posts advertised and filled at 'higher' level only for *grouped* specialties (shown in block capitals below) and some specific specialties (shown in lower case below) (figure 5), open only to doctors who have completed core or common stem training or can demonstrate equivalence can apply into these posts.
- 4.13 The left hand block provides a sense of scale - so for instance, Clinical Radiology posts represent around 3% of posts advertised and those filled while General Practice represents 43% of advertised posts and 40% of filled posts.
- 4.14 The table shows vertically that programmes fill differentially: the programmes at the top fill completely and thus in all areas, while those towards the bottom fill less well.
- 4.15 The table shows horizontally that areas to the left fill less well overall (bottom row) with fill increasing moving to the right.
- 4.16 The data indicates that the more significant 'under-fill' problems at ST/1 and CT1 (i.e. posts in 'core' and run-through' training) are in General Practice and Psychiatry outside of London and the South East (Kent Surrey and Sussex) and the more significant problems at higher level (i.e. those specialty training programmes which can only be accessed after successful completion of core or common stem training) are the smaller pathology specialties, psychiatry, and those specialties associated with the 'undifferentiated acute take'. Again, the areas outside London are most affected, although Acute Medicine struggles in London.
- 4.17 The blue bar in the final column shows the proportion of trainees in each programme at the entry level⁴ with a non UK PMQ at two data points - 2012 and 2016. The data indicate that the proportion of trainees with UK PMQS has increased.
- 4.18 The specialties most reliant on recruitment of staff from the EU and wider overseas are pathology, psychiatry, and acute medicine.

⁴ Note these data include a proportion of staff who have not been recruited in the year (ie some be will less than full time trainees, trainees who are 'out o programme or on maternity/other leavers, and trainees who may not have progressed to the next level for a variety of reasons. However it is a reasonable proxy for the proportion of new recruits by PMQ.

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4.19 **Figure 4 : Posts advertised and filled at Core (CT1) and Run-through (ST1) levels in 2015 and 2016 at end August each year, averaged over two years**

	Scale -two year averages 2015 and 2016				Fill rate -two year averages 2015 and 2016							
	Numbers		As % total		Fill rate (2 year average)						UKPMQ	
	Advertised	Filled	Advertised	Filled	England	North	E. & Mids.	South	Lon/KSS	LONDON	2012	2016
Clinical Radiology	212	212	2.9%	3.2%	100%	100%	100%	100%	100%	100%	75%	85%
Ophthalmology	68	68	0.9%	1.0%	100%	100%	100%	100%	100%	100%	86%	90%
Public Health Medicine	68	68	0.9%	1.0%	100%	100%	100%	100%	100%	100%	93%	94%
Neurosurgery	26	26	0.3%	0.4%	100%	100%	100%	100%	100%	100%	83%	88%
Cardiothoracic surgery	6	6	0.1%	0.1%	100%	100%	100%	100%	N/A	N/A		
Oral and Maxillo-facial Surgery	4	4	0.1%	0.1%	100%	100%	N/A	100%	N/A	N/A		
Community Sexual and Reproductive Health	4	4	0.0%	0.1%	100%	100%	100%	100%	100%	100%		
ACCS Anaesthetics/Core Anaesthetics	503	501	6.8%	7.5%	100%	100%	100%	99%	100%	100%	95%	93%
Obstetrics and Gynaecology	218	217	3.0%	3.3%	100%	99%	99%	100%	100%	100%	87%	91%
Histopathology	77	76	1.0%	1.1%	99%	98%	100%	100%	100%	100%	64%	74%
Core Surgical Training	508	504	6.9%	7.6%	99%	99%	99%	100%	100%	99%	90%	94%
Acute Care Common Stem - Emergency Medicine	324	320	4.4%	4.8%	99%	97%	100%	98%	100%	98%	95%	93%
ACCS Acute Medicine/Core Medical Training	1372	1327	18.7%	20.0%	97%	92%	98%	98%	100%	100%	85%	84%
Paediatrics	376	356	5.1%	5.4%	95%	88%	94%	100%	99%	100%	86%	89%
General Practice	3184	2628	43.3%	39.6%	83%	70%	78%	91%	99%	99%	80%	81%
Core Psychiatry Training	411	326	5.6%	4.9%	79%	66%	73%	78%	99%	100%	65%	73%
All recruited at CT/ST1	7357	6639			90%	83%	88%	94%	99%	100%	83%	85%

4.20 **Figure 5 : Posts advertised and filled at Higher levels in 2015 and 2016 at end August each year, averaged over two years**

	Scale -two year averages 2015 and 2016				Fill rate -two year averages 2015 and 2016							
	Numbers		As % total		Fill rate (2 year average)							
	Advertised	Filled	Advertised	Filled	England	North	E. & Mids.	South	Lon/KSS	LONDON	2012	2016
Anaesthetics	304	282	12.0%	13.7%	92.6%	83.2%	90.1%	97.6%	100.0%	100.0%	73.0%	90.0%
SURGERY (10 SPECIALTIES)	484	473	19.1%	23.0%	97.7%	95.7%	97.8%	98.2%	99.6%	100.0%	73.0%	85.0%
CANCER RELATED	171	154	6.7%	7.5%	90.3%	81.8%	85.3%	95.4%	97.3%	97.3%	75.0%	85.0%
ACUTE TAKE	368	323	14.5%	15.7%	87.6%	89.9%	84.1%	81.8%	94.4%	95.6%	68.0%	77.0%
Intensive Care Medicine	132	116	5.2%	5.6%	88.2%	77.2%	92.1%	94.5%	97.1%	100.0%		
PATH (NB shisto and chemical recruit at ST1)	91	61	3.6%	2.9%	66.5%	54.8%	63.0%	62.5%	82.8%	85.5%	92.0%	76.0%
PSYHIATRY (6 SPECIALTIES)	345	202	13.6%	9.8%	58.4%	52.3%	47.6%	49.0%	78.6%	78.8%	42.0%	61.0%
Gastroenterology	81	80	3.2%	3.9%	98.8%	97.9%	100.0%	95.7%	100.0%	100.0%	68.0%	71.0%
Geriatric Medicine	111	103	4.4%	5.0%	92.8%	97.1%	87.0%	89.1%	96.2%	95.0%	75.0%	82.0%
Respiratory Medicine	94	82	3.7%	4.0%	87.2%	90.2%	78.1%	86.8%	100.0%	100.0%	73.0%	80.0%
Acute Internal Medicine	83	59	3.3%	2.8%	70.5%	75.0%	69.4%	61.0%	75.9%	84.2%	53.0%	67.0%
All	2541	2058			81.0%	76.1%	76.4%	81.6%	90.2%	91.4%	68.0%	80.0%

Recruiting to General Practice

- 4.21 The DDRB in its 2016 report (3.46) noted
- 4.22 ***“HEE told us filling GMP training posts was its highest priority, and it said that recruitment premia were needed for some hard-to-fill locations, but that others including Kent, Surrey and Sussex needed no further incentive.”***
- 4.23 And (3.25)
- 4.24 ***“We note the impact that perceived excessive workload is having on motivation and the potential for this to create a negative image of general practice, especially for trainees, which will not help with recruitment and retention”***
- 4.25 In 2016, NHS England made available funds to support one-off payments of £20,000.00 to 109 General Practice training programmes in geographical areas where historically it has been hardest to fill. At the time of writing 99 of the posts covered by this 'Targeting Enhanced Recruitment Scheme' (or TERS) have been filled. The scheme is yet to be fully evaluated but has increased recruitment in these areas, to the extent that HEE is replicating the scheme in other areas. However, there is some evidence that this has 'pulled' trainees from adjacent programmes which are thus finding it harder to fill than in past years.
- 4.26 HEE is also supporting GP recruitment through a range of other initiatives including greater flexibility in the selection process, deferral for non-statutory reasons, Global Health Fellowships and Post CCT Fellowships. These developments are in the context of NHSE commitment to the development of primary care including significant additional investment in the comprehensive policy document 'General Practice Forward View' produced with the original '10 point plan' partners; RCGP, BMA, and HEE. The report builds on previous work but goes further to include areas such as ambitious international recruitment plans and fleshing out plans for other clinical professionals such as mental health therapists.⁵
- 4.27 The DDRB in 2016 also asked (3.16):
- 4.28 ***“We would be interested in any analysis by the parties of why a greater proportion of trainees in some foundation schools than others choose a career in general practice.”***
- 4.29 At this stage, HEE has no further data or information on this, but is building trend analysis over a number of years. This will enable further analysis on foundation doctor career destinations.

⁵See General Practice Forward View (April 2016) developed in partnership between NHS England, Health Education England, and the Royal College of General Practitioners <https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf>

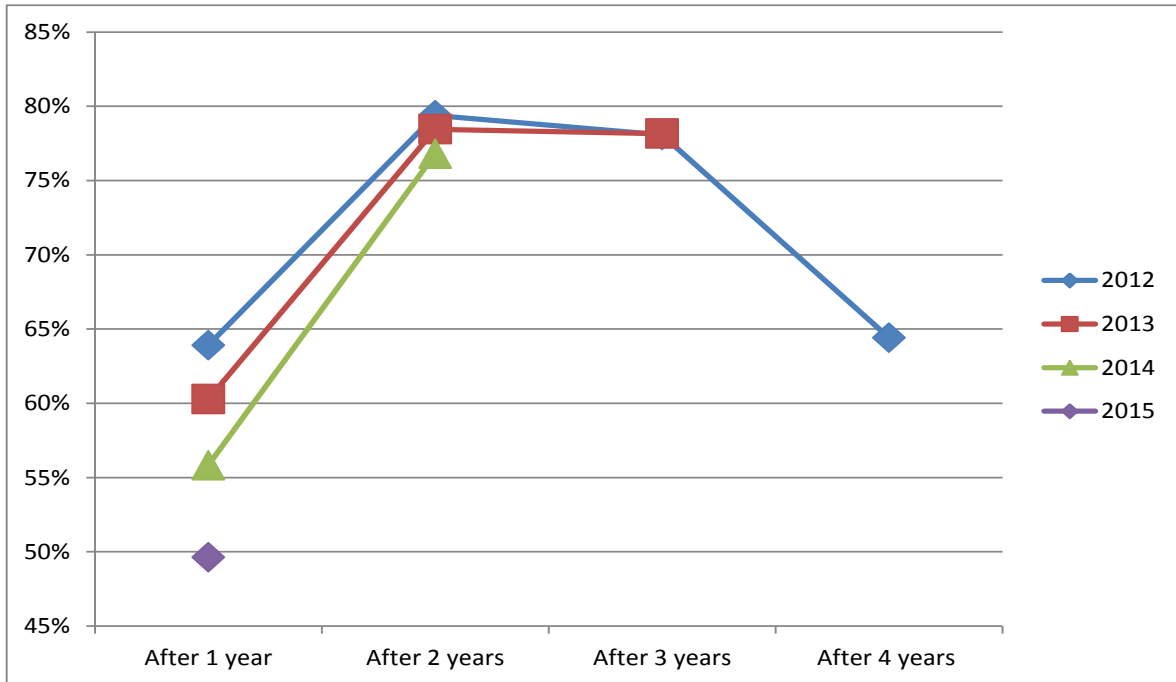
5 Supply prospects

- 5.1 In terms of 'HCHS' staff, at the time of writing, HEE does not have available 'short-run' supply forecasts for every specialty. These are in development and will be available in 2017. However we can make some general comments:
- The overall forecast is for sustained growth in CCT holder supply of 3-4% per year. This is unsurprising: it is the continuation of a long term trend fuelled by historic expansion in the number of training posts and trainees. The system produces of the order of an average of 2,500-2,800 new CCT holders each year (excluding GPs) and there are less than 1,000 annual consultant retirements forecast (based on historic age and gender related historic patterns);
 - In some specialities growth is forecast to exceed latest (2015) estimates of provider expressed demand over the next few years, and in others it will fall significantly short. This will impact differentially in different areas reflecting the current balance of trainees which in turn reflects historic differential rates of fill;
 - The STP process, once concluded, may imply quite different demand for consultants than some recent forecasts. This too will impact differentially in different areas;
 - Our observation in those specialties we have explored to date is that historically patterns of migration on gaining a CCT are limited. Staff do migrate to and from London and the East of England and the South East (Kent Surrey and Sussex) in considerable numbers, but no further. *Generally* other regions are largely 'self-contained' in terms of migration. The factors that limit migration are to do with life events : by the time a doctor has completed their training that will be in their middle to late thirties and may well be 'settled' with families and thus less inclined to uproot;
- 5.2 In respect of primary care, the limitations of the data available to HEE means it is not feasible to set out forecasts of the future stock of GPs with the same confidence. While HEE has data on how many trainees there are and can observe outturn from training, HEE does not have access to the 'line level' data we need to observe turnover, patterns of transition from training to the workforce, and patterns of working of newer GPs. There is moreover no data available on current shortages (or a vacancy proxy) for GPs. HEE and NHS England are in discussion with NHS Digital regarding access to such data. We regard such access as imperative to support not only the work of the Review Body, but also the development of plans for the future of primary care.

Appendix A: Transition from Foundation to further PGME training

- 1.1 The GMC census frame is the basis for the survey which is sent to doctors in training in the UK. The GMC, working with local teams in England and Deaneries in the rest of the UK go to considerable lengths to ensure that the data set captures all trainees and is accurate in respect of training level, training programme, and demographic information. The GMC makes the data available to HEE at individual level for the purposes of workforce planning. (Note that we cannot go back beyond 2012).
- 1.2 The chart shown draws on the data from the four successive cohorts of the GMC Training survey census frame -2012 to 2016. It shows the proportion that was at F2 in a given year, who are still in training in each of the subsequent years for which data are available. For example, for the 2012 cohort we have data for four subsequent years: 2013, 2014, 2015 and 2016. For the 2015 cohort, there is only one data point, which is 2016. Clearly, we cannot know if the low initial transition of the 2015 cohort will recover after the second year.
- 1.3 The chart shows that the proportion of F2s moving into further training after one year has varied between 64% (2012) and 50% (2015). However, by the second year the proportion has recovered to close to 80% for each of the three cohorts for which data is available. By the third year (based on only two cohorts), the chart indicated a very small drop as a proportion of those who return subsequently leave. The single cohort for which we have four years data shows a marked drop. It is hypothesised that this results from some of the cohort who have completed core training taking time out of training for a variety of reasons, including awaiting training opportunities in their preferred specialty or geography. We will not know whether this 'recovers' until we have more longitudinal data from further cohorts.
- 1.4 Kindly note that this analysis does not look at retention in the *workforce*: further analysis can be conducted to identify former trainees in ESR. This indicates that of the 2012 cohort of F2 trainees in the English training system in 2012, in 2015 79% were in training and a further 8% were in 'NCNT' roles.

1.5 **Figure 5: Proportion of trainees at F2 in given cohort appearing in training in subsequent years (UK data)**



Source: GMC /HEE National Trainee Census data

Appendix B:

- 1.1 It is important to note that the data set, developed 'bottom up' from 400 NHS provider bodies is far from perfect. For example:
- In some cases the provider reported Staff in Post was markedly different from that recorded in ESR. This can arise for various reasons including genuine error, movements in staff numbers between the ESR 'cut' and the submission to HEE, and coding of staff differently in ESR and in finance systems, 'split' posts which are coded wholly to one specialty in ESR, and genuine mapping constrains (for example paediatricians can 'specialise' pre-CCT in one of 17 specialties - such as paediatric emergency medicine - and may be coded on ESR to paediatrics or the service they work in); and
 - Some providers did not return demand data and in these cases the demand was assumed equal to the supply. Some providers returned neither supply nor demand data in which case ESR was assumed to represent both the supply and demand figures.