

Doctors' and Dentists' Review Body

**Health Education England's written
evidence for 2019/20**

1 Introduction

- 1.1 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 2019/20.

2 Health Education England

- 2.1 HEE was created by the NHS reforms of 2012 which abolished Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs). The functions of these organisations were given to new bodies including the NHS Commissioning Board, Clinical Commissioning Groups, The Trust Development Authority, and to HEE. HEE was originally created as a Special Health Authority in 2013 and was formalised by the Care Act 2014 as a statutory Arm's Length Body of the Department of Health and Social Care.

- 2.2 HEE has identified its purpose as:

'HEE exists for one reason only: to support the delivery of excellent healthcare and health improvement to the patients and public of England by ensuring that the workforce of today and tomorrow has the right numbers, skills, values and behaviours, at the right time and in the right place.'

- 2.3 HEE has identified its core roles and deliverables in its 2018/19 Business Plan as:

- **Medical and Dental Education:** HEE will ensure the planning, management, delivery and quality assurance of education and training to the highest standards.
- **Education of Clinical Professions:** HEE will act to enable a sufficient, high quality and well-functioning market for these education programmes.
- **Quality and Patient Safety:** With partners, HEE will improve the overall quality of the learning environment for all learners and will improve education and training for patient safety.
- **Workforce Planning and Intelligence:** With partners, HEE will secure the right supply of skilled staff across priority areas to meet patterns of demand.
- **Workforce Transformation:** With partners, HEE will build and develop a workforce that drives innovation and improvement.
- **Leadership Services:** HEE, through the NHS Leadership Academy and partners, will develop the leaders required to deal effectively with the healthcare challenges of today and tomorrow.

- 2.4 We are also responsible for supporting the NHS Constitution and helping to embed the NHS Values into everyday activity in the NHS. We are now in our sixth 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.

- 2.5 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
 - Sustainable Transformation partnerships (STPs) and Local workforce Advisory Boards (LWABs); and
 - Other organisations such as commissioners, local authorities and higher education providers.
- 2.6 We also have a wider role working nationally with the Department of Health & Social Care (DHSC) 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 developed the [NHS Five Year Forward View](#) in October 2014. The Five Year Forward View was refreshed in March 2017 with the publication of the [Next Steps On The Five Year Forward View](#) which acknowledged the progress that had been made but highlighted the emerging pressures within the service and refocused the Five Year Forward View priorities in the light of this.
- 2.8 In October 2017, HEE led the development of the first NHS Workforce Strategy for over 25 years, [Facing the Facts, Shaping the Future](#) in recognition of the need for further co-ordination at national level to ensure that the issues facing the NHS with regard to the supply and development of staff were discussed, and actions agreed, with a broad range of national, regional and local stakeholders. The strategy said that the Department of Health and Social Care (DHSC), working with HEE and other partners, would review national organisational roles and responsibilities to ensure that the national workforce system is well aligned.
- 2.9 The announcement of a long-term funding settlement in 2018 alongside the work to develop the NHS Long Term Plan has further reinforced the importance of ensuring that national, regional and local organisations are working effectively together to address workforce priorities. In light of this, and building on recent constructive joint work to develop the workforce priorities for the Long Term Plan, HEE, NHS Improvement, NHS England and DHSC agreed the following measures in October 2018 to improve how we work together:
- HEE will work jointly with NHS Improvement to develop its mandate for 2019/20 onwards. HEE's Board will continue to sign-off the draft mandate, but, as a new step, the mandate will then be approved by the NHS Improvement Board to ensure it meets service requirements, before approval by the Secretary of State. This will ensure that workforce plans are more closely aligned with NHS service plans.

- The NHS Leadership Academy will transfer from HEE to the new NHS Improvement and NHS England People function from 1 April 2019, maximising the natural fit between the work of the NHS Leadership Academy and the People function's responsibility for executive and non-executive leadership and talent across the NHS.
- HEE will identify opportunities for its regional teams to align with NHS Improvement/ NHS England's integrated regional teams to continue to build on the strong collaborative working that already exists across the country in support of local health systems.

2.10 These changes will help ensure that our organisations work much more closely together to support local health systems to recruit, train, develop and retain the staff the NHS depends upon, and in enhancing leadership across the service.

3 Facing the Facts, Shaping the Future

3.1 [Facing the Facts, Shaping the Future](#) was a whole national system consultation document, produced by HEE with content from NHS England, NHS Improvement, Public Health England, the Care Quality Commission, National Institute for Clinical Excellence and the Department of Health. The document was published in December 2017.

3.2 The draft strategy looked at the challenges faced by the health and care system, charting the growth in the NHS workforce over the previous five years while also setting out the critical workforce challenges that will be faced over the next decade.

3.3 While the NHS is employing more staff now than at any time in its history, with significant growth in newly-qualified staff from 2012 across the majority of professional groups, the report concluded that more must be done to keep up with increased demand as the population expands and grows older. It responded by setting out a range of measures to improve productivity, boost training and retention, open up new routes into nursing and prepare the future workforce for technological advances such as genomics, artificial intelligence and digital robotics, which are poised to transform modern medicine.

3.4 Among the specific measures were:

- targeted retention schemes to encourage staff to continue working in healthcare, including support for local NHS organisations on how to improve retention rates, an expansion of the nursing Return to Practice scheme and efforts to encourage European nationals to stay by ensuring a streamlined, user-friendly service for obtaining settled status
- improvements to medical training and how junior doctors are supported in their careers, with a greater emphasis on producing more doctors in areas where there are the biggest shortfalls, including general practice and psychiatry, and on-going efforts to improve the working practices of

doctors in training, such as improving access to training opportunities and better communication around rotations and shift patterns

- a far-reaching technology review across England, led by Professor Eric Topol to look at how advances in genomics, pharmaceuticals, artificial intelligence and robotics will change the roles and functions of clinical staff over the next two decades and what this will mean for future skills and training needs
- making the NHS a more inclusive, ‘family-friendly’ employer – the strategy also acknowledged the changing shape and expectations of the NHS workforce, with more people wanting flexible working practices to enable them to balance work and family life. It concluded that NHS organisations will need to develop an employment offer that remains attractive for all staff.
- the draft strategy looked at the major workforce plans for the Five Year Forward View priorities: cancer; mental health; maternity; primary and community care; and urgent and emergency care.

3.5 HEE proposed a set of six principles for future NHS workforce decisions, which aim to mitigate the risks associated with workforce planning.

- i. Securing the supply of staff that the health and care system needs to deliver high quality care in the future.
- ii. Enabling a flexible and adaptable workforce through our investment in educating and training new and current staff.
- iii. Providing broad pathways for careers in the NHS, and the opportunity for staff to contribute more, and earn more, by developing their skills and experience.
- iv. Widening participation in NHS jobs so that people from all backgrounds have the opportunity to contribute and benefit from public investment in our healthcare.
- v. Ensuring the NHS and other employers in the system are inclusive modern model employers with flexible working patterns, career structures and rewards.
- vi. Ensuring that service, financial and workforce planning are intertwined, so that every significant policy change has workforce implications thought through and tested.

3.6 Consultation outcomes

Formal consultation on the draft strategy began in December 2017 and ran until the end of March 2018. 101 people completed the on-line survey, and 1,185 participated in the online workshop that ran throughout the consultation period, including 143 organisations. Feedback was captured from 32 events held across the country and from the 195 organisations that also submitted direct responses as part of the consultation process. The consultation feedback demonstrated good support for the six principles set out above. In addition, there were five key priority areas that emerged:

3.7 Attracting People – which highlighted the need to;

- Address public perceptions of careers in health and care
- Introduce new qualifications and routes to employment
- Ensure roles allow for future development
- Protect funding for health services
- Promote careers through school outreach

3.8 Modern, model employers – where the feedback was to;

- Protect time and funding for CPD and other development activities
- Enable health and care organisations to support flexible working
- Ensure staff are paid fairly
- Create opportunities through apprenticeships

3.9 Fitness for the Future – where there is a need to;

- Ensure health and care systems work together effectively
- Enable health and care staff to embrace the potential of technology
- Develop new roles and specialities
- Value carers and volunteers
- Empower staff to improve outcomes

3.10 Social Care – where the feedback highlighted;

- The need for financial investment into the social care workforce to reflect the growing demand
- The need to recognise that the profile, pay and reputation of the social care workforce all impact on recruitment and retention
- That there is support for national standards for registration of social care workers.

3.11 Technology

The [Topol Review](#) has been exploring how to prepare the healthcare workforce, through education and training, to deliver the digital future, to enable us to make the most of technologies such as genomics, digital medicine, artificial intelligence and robotics to improve services and help ensure a sustainable NHS. The [Interim Report](#) was published in June 2018 and the final report is due to be published later this month.

4 The NHS Long Term Plan

4.1 The [NHS Long Term Plan](#) was published on 7 January 2019.

To ensure that the NHS can achieve the ambitious improvements we want to see for patients over the next ten years, the NHS Long Term Plan sets out the challenges that the NHS currently faces can be overcome, such as staff shortages and growing demand for services, by:

- **Doing things differently:** we will give people more control over their own health and the care they receive, encourage more collaboration between GPs, their teams and community services, as ‘primary care networks’, to increase the services they can provide jointly, and increase the focus on NHS organisations working with their local partners, as ‘Integrated Care Systems’, to plan and deliver services which meet the needs of their communities.
- **Preventing illness and tackling health inequalities:** the NHS will increase its contribution to tackling some of the most significant causes of ill health, including new action to help people stop smoking, overcome drinking problems and avoid Type 2 diabetes, with a particular focus on the communities and groups of people most affected by these problems.
- **Backing our workforce:** we will continue to increase the NHS workforce, training and recruiting more professionals – including thousands more clinical placements for undergraduate nurses, hundreds more medical school places, and more routes into the NHS such as apprenticeships. We will also make the NHS a better place to work, so more staff stay in the NHS and feel able to make better use of their skills and experience for patients.
- **Making better use of data and digital technology:** we will provide more convenient access to services and health information for patients, with the new NHS App as a digital ‘front door’, better access to digital tools and patient records for staff, and improvements to the planning and delivery of services based on the analysis of patient and population data.
- **Getting the most out of taxpayers’ investment in the NHS:** we will continue working with doctors and other health professionals to identify ways to reduce duplication in how clinical services are delivered, make better use of the NHS’ combined buying power to get commonly used products for cheaper, and reduce spend on administration

4.2 The NHS Workforce is a key component of the plan, and eight areas are discussed:

1. A comprehensive new workforce implementation plan
2. Expanding the number of nurses, midwives, AHPs and other staff
3. Growing the medical workforce
4. International Recruitment
5. Supporting our current NHS staff
6. Enabling productive working
7. Leadership and talent management
8. Volunteers

4.3 The Long Term Plan recognises that:

- The performance of any healthcare system ultimately depends on its people – and the NHS is no exception
- NHS staff are feeling the strain due, in part, to the number of vacancies across many roles and in many parts of England
- To make the Long Term Plan a reality, the NHS will need more staff, working in rewarding jobs and a more supportive culture

- New NHS roles and careers will be shaped to reflect the future needs and priorities set out in the rest of the Plan
- More people want to train to join the NHS than are currently in education or training. Many of those leaving the NHS would remain if they were offered improved development opportunities and more control over their working lives
- The plan sets out specific workforce actions that can have a positive impact now. It also sets out wider reforms for the NHS workforce which will be finalised when the education and training budget for HEE is set later on in 2019.

A summary of the Workforce Section of the Plan is attached as Appendix A.

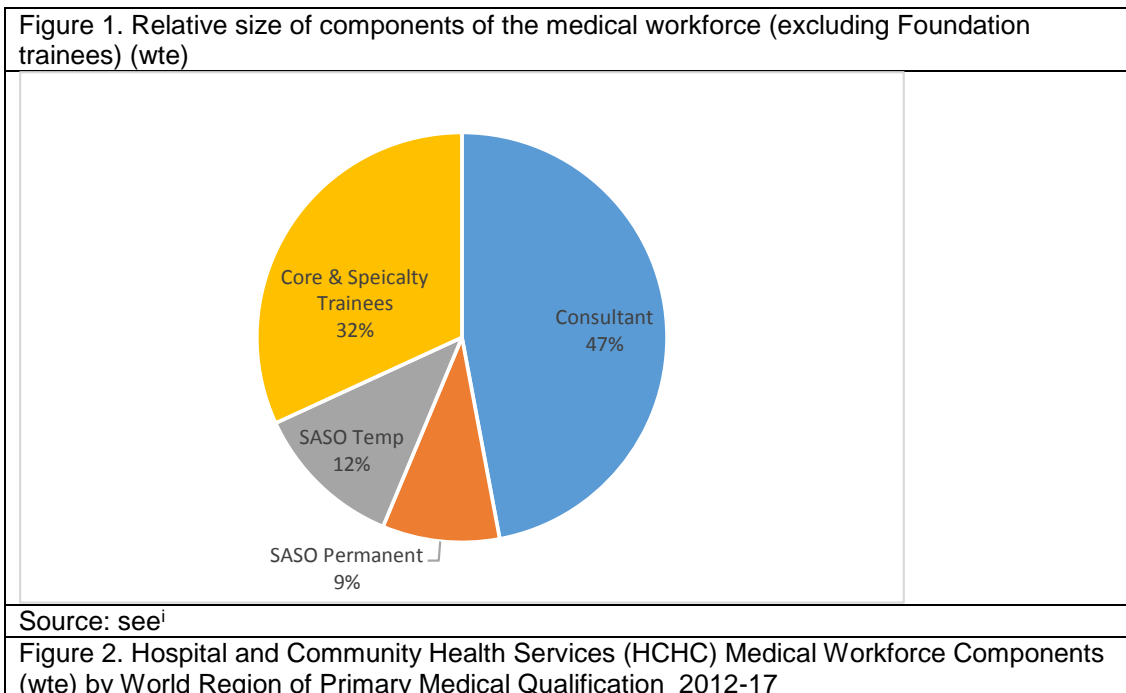
- 4.4 Building on [Facing the Facts, Shaping the Future](#) and the responses received during the consultation (see section 2 above) workforce plans need to work locally and add up nationally – they need to be adaptive and attentive to detail and wider context. The overall aim is to ensure a sustainable overall balance between supply and demand across all staff groups. For doctors, there will be a focus on reducing geographical and specialty imbalances. For the wider workforce, the aim is to ensure sufficient supply of nurses and to address specific shortages for AHPs and other key groups.
- 4.5 A final workforce implementation plan will be published later in 2019. NHS Improvement, HEE and NHS England will establish a national workforce group to ensure workforce actions agreed are delivered quickly. This will include the new NHS Chief People Officer, the NHS National Medical Director and the Chief Nursing Officers, and other Chief Professions Officers. We will ensure that the plan is shared with the Review Body members at the earliest possible opportunity.
- 4.6 Our intention in the submission of this year’s evidence is to focus on key areas of interest highlighted by the DDRB and discussed with colleagues from DHSC and other stakeholders since last year’s evidence round. The following sections address, in turn; Improving the experience of work for post graduate doctors through the Enhancing Junior Doctors’ Working Lives project; Flexible pay premia for doctors and dentists in training (including specialty and geographical issues); and supporting SAS Doctors.

5 The Medical Workforce

- 5.1 From a planning and supply perspective the ‘medical workforce’ can be partitioned into four components:
- Consultants (in general a very stable workforce)
 - Doctors who are following training programmes intended to lead untimely to a Certificate of Consultant Training. This workforce turns over rapidly by design as training entails rotation through multiple employers, and has competitive recruitment points between Foundation and Core/Run-Through, and between Core and Higher.

- Those employed as Specialty and Associate Specialists and ‘others’ on permanent contracts who are a *relatively* stable workforce (yet still exhibit high turnover)
- Those employed as above on non-permanent contracts who are in general a mix of:
 - ‘former’ trainees who are ‘between’ training programmes (that is, they have completed one stage of training and are pending selection into further training)
 - Doctors between training and consultant roles (that is, they have completed CCT training and are pending consultant opportunities, or undertaking further experiential training such as fellowships)
 - those recruited specifically to short term roles, often from overseas. This workforce turns over extremely rapidly.

5.2 Figure 1 overleaf shows the overall proportion of the medical workforce (excluding Foundation trainees) each component represented in 2017. Figures 2 and 3 summarise aggregate national level workforce stock values and proportions Consultants and SASO staff for the period 2012-17 by world region of Primary Medical Qualification¹. The figures demonstrate the extent to which the NHS is currently reliant on recruitment of doctors from overseas.



¹ The 2018 data based set is in preparation.

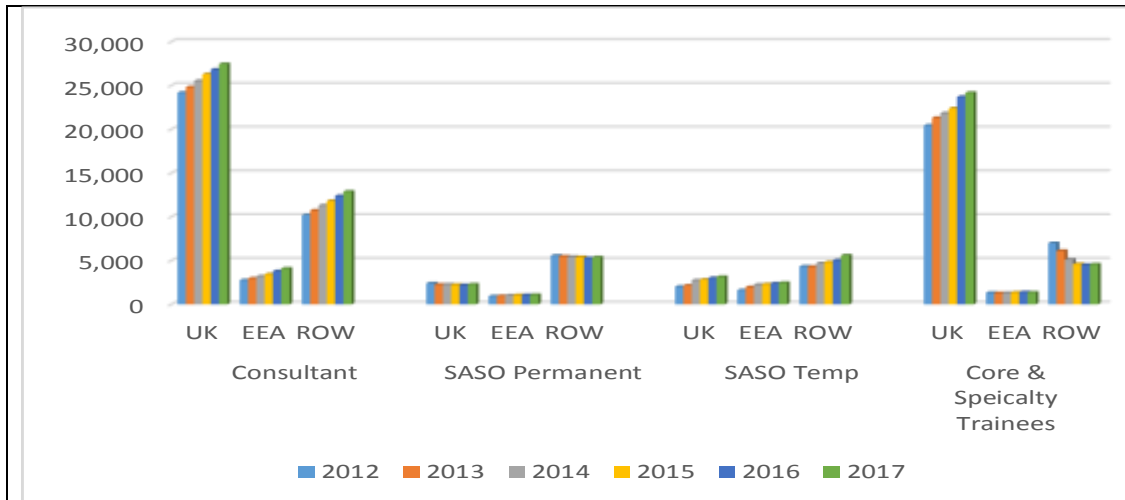
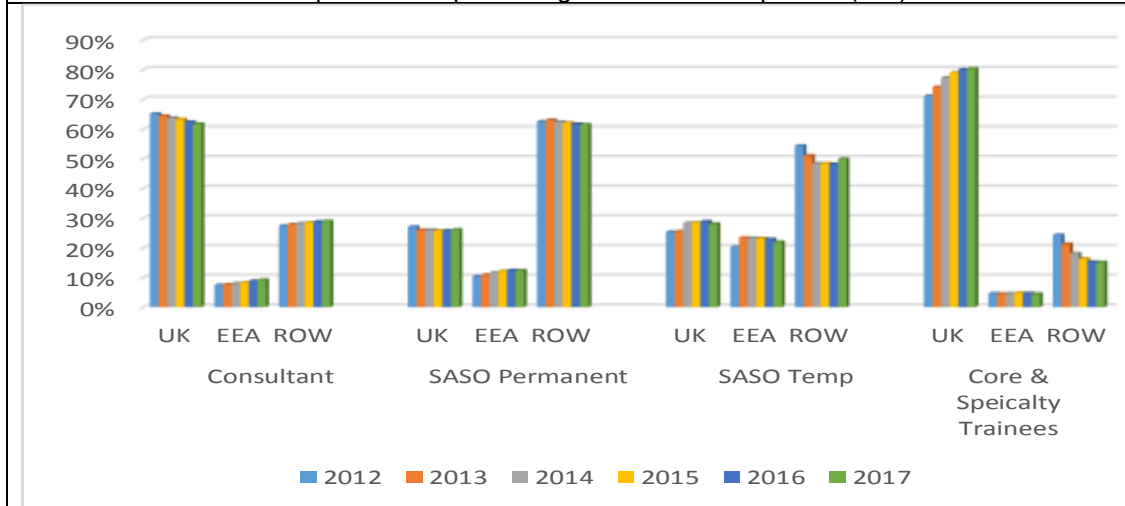


Figure 3. HCHS Medical Workforce Components: World Region of Primary Medical Qualification 2012-17 expressed as percentage of total in component (wte)



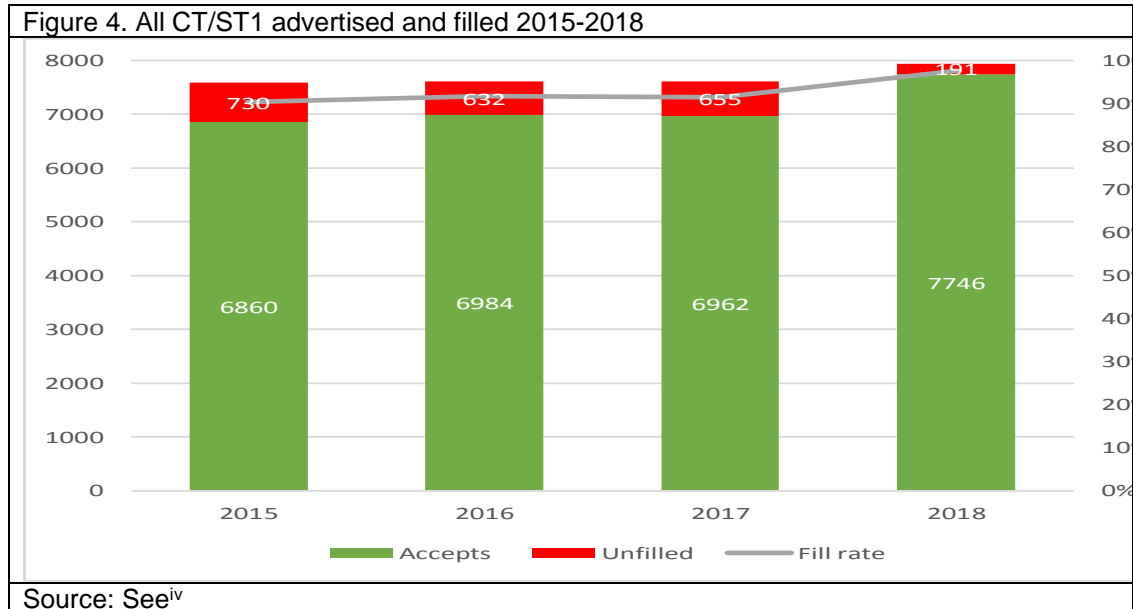
Source: Seeⁱⁱ

5.3 Recruitment into specialty at CT/ST1ⁱⁱⁱ

HEE, on behalf of the NHS, recruits annually to training programmes at ‘CT1’ (Core training first level) and ‘ST1’ (Specialty training first level where such training is a ‘run through’ programme). Recruitment levels fluctuate each year but are of the order of 7,000 annually. Recruitment to higher specialty training (that is, at ST3 for the majority of ‘non-run-through’ specialities, and at ST4 for psychiatry) is *principally* determined by the available supply completing core training. Thus, examining recruitment at CT1 and ST1 is a key indicator not only of the extent to which the NHS is reliant on ‘non UK’ trainees now, but the extent to which the NHS will be reliant on non-UK supply of higher trainees, and ultimately of Consultants, in future.

5.4 The majority of applicants to CT1/ST1 emerge though the UK training system, and thus completed Foundation training in the UK. The vast majority of those previously in Foundation Training will have gained their ‘Primary Medical

Qualification' (PMQ) in the UK². Thus an assessment of the proportion of trainees at or recruited to CT/ST1 each year³ provides an indication of the extent to which recruitment to each programme is currently dependent on non-UK supply⁴. Figure 4 shows that, over the period 2015-2017 there was little variation in the numbers advertised and filled. However, in 2018 more posts were advertised, and more filled, with the fill rate (at the time of writing) moving from an average of 91% to 98%.



- 5.5 At the time of writing we do not have available the PMQ of recruits for 2015-17. We create a 'proxy' by identifying the numbers at CT/ST1 in the General Medical Council National Trainee Survey (NTS) census frame at a given point who were not in the same specialty in the previous year. This is not the *same* as the number recruited as:
- there may be some drop off from recruitment levels as some recruits may have withdrawn since the recruitment data was last 'cut';
 - there may have been some early attrition post recruitment;
 - there may be some (relatively small) subsidiary recruitment determined by local factors.

5.6 Figure 5 below sets out:

The average fill rate at level 1 for the period 2016-18⁵;

² A relatively small number of UK citizens undertake their undergraduate medicine degree in non-UK universities and a small number of non-UK PMQ doctors undertake Foundation training in the UK. Hence PMQ is a *proxy* for nationality at the time of recruitment.

³ This is the number in the system at these levels at a census point in spring. Thus it is not precisely the same as the proportion recruited in the previous year. We use this technique as, for now, we do not have *historic* recruitment data by either PMQ or nationality.

⁴ In more detailed analysis scheduled for 2019 we will build in analysis of nationality as well as PMQ.

⁵ The source for 'fill' is HEE recruitment data which includes 2018 recruitment. These data indicated a marked increase in recruitment in 2018 compared to previous years. We will know the extent to which this has translated into a similarly marked increase in numbers on programmes at the next census

The average (2016-8) proportion of trainees at CT/ST1 with a UK PMQ in each of four geographical areas and at the 'all-England' level;
 The relative scale of recruitment (thus by far the largest single specialty into which HEE recruits at level 1 is General Practice, with a target level of 3,250 annually).

Figure 5: Recruitment and fill at CT/ST1

		England	North	Mids&East	London	South	Scale of recruitment (average recruited 2016-18)
Ave. fill 2016-18 - All CT/ST1 recruitment - all PMQ		94%	87%	94%	100%	97%	
Analysis by specialty	Ave fill 2016-18	Trainees with UK PMQ at CT/ST1 - average 2016-18					
Public Health	100%	95%	93%	97%	97%	95%	72
Ophthalmology	100%	95%	92%	98%	96%	93%	64
Core Surg	100%	93%	90%	94%	96%	94%	505
Neurosurgery	100%	90%	77%	100%	96%	94%	28
Clinical Radiology	100%	88%	84%	87%	94%	91%	228
O&G	99%	87%	84%	79%	98%	90%	232
ACCS Ana/Core Ana	98%	95%	95%	92%	99%	97%	537
ACCS EM/EM RT	96%	83%	89%	62%	94%	88%	302
General Practice	96%	74%	73%	62%	94%	78%	
ACCS Acute/Core Med	94%	82%	74%	73%	98%	86%	1340
Paediatrics	88%	89%	86%	80%	96%	95%	367
Histopathology	82%	78%	88%	72%	69%	82%	61
Core Psych	68%	72%	63%	57%	82%	82%	376
All ST/CT1	94%	81%	78%	71%	94%	84%	

Source: HEE Recruitment Team (from Oriel recruitment system)

- 5.7 The figures show:
- some specialties fill wherever they are;
 - London fills whatever the specialty;
 - the extent to which specialties are filled from non-UK sources varies, with London least reliant on non-UK sources, and Midlands and East most reliant.

5.8 Consultant shortfall

The data in this section are drawn from the HEE/NHSI 2017 'Joint Collection' and are concerned only with Consultants. At September 2017, providers reported a total consultant establishment of 48,531 and a total shortfall of 3,756 (7.7%). Reporting such numbers at the level of specialty and geography inevitably means the actual numbers involved become very small. Thus figure 6 below focuses on those specialties where:

- the total shortfall identified was equal to or exceeded 50 wte **and**
- the vacancy rate was equal to or exceeded 7%.

The table is ordered by the total volume of shortfall.

point in spring 2019. Future analysis will explore the demographic characteristics of this recruitment 'bump'

Figure 6: Provider expressed shortfall from establishment, September 2017

	Establishment wte	Shortfall wte	Shortfall as percent of establishment				
			England	North	Mids&East	London	South
General and Acute Medicine	1455	330	23%	30%	28%	12%	14%
Clinical Radiology	3224	341	11%	12%	13%	11%	6%
Emergency Medicine	2045	340	17%	12%	20%	21%	15%
Psychiatry - General & Adult	2774	301	11%	14%	12%	11%	7%
Geriatric Medicine	1483	197	13%	14%	17%	9%	13%
Histopathology	1398	174	12%	16%	12%	11%	10%
Gastroenterology	1320	132	10%	10%	8%	12%	10%
Respiratory Medicine	1104	104	9%	10%	9%	2%	14%
Dermatology	648	98	15%	19%	12%	12%	19%
Neurology	853	87	10%	15%	8%	6%	11%
Intensive Care Medicine	608	52	9%	16%	3%	10%	4%
Psychiatry - Child & Adolescent	680	62	9%	11%	9%	7%	9%
Endocrinology	723	51	7%	7%	9%	4%	6%

See ^v

5.9 CCT holder supply prospects

HEE projects the available supply of CCT holders (i.e. those eligible for Consultant roles) by analysing historic flows to and from the workforce, and projecting outturn from specialty training.

First order priorities

General and acute medicine serve the general acute take. Hence the significant shortfall constrains the ability of the NHS to ‘process’ patients. While CCT output will fuel steady growth, supply projections indicate the current shortage will not be significantly mitigated by ‘domestic’ supply in the next two years.

Clinical Radiology is integral to the delivery of the Government’s cancer strategy. CCT output will fuel steady growth, but supply projections indicate the current shortage will not be mitigated by ‘domestic’ supply in the next two years. Moreover, the projected growth is contingent on maintaining historic levels of overseas recruitment.

General (adult) Psychiatry is integral to the delivery of the Government’s Mental Health Strategy. CCT output is projected to *broadly* maintain current numbers of psychiatrists and is not expected to reduce the current shortfall.

Histopathology is key to diagnostics. CCT output is projected to broadly maintain current numbers of consultants and is not expected to mitigate the current shortfall.

Emergency Medicine consultant numbers have grown at an average of around 6% per annum. CCT will support sustained growth as a result of recent investment in training. However, that accelerated growth is not projected to meet current provides expressed demand in the next two years.

5.10 Specialty and associate specialist doctors and others (SAS or SASO)

This group comprises those who are neither Consultants nor in training, previously referred to as ‘Non-Training, Non-Consultant’ medical staff. (See also section 6.17 below). There is strong anecdotal evidence of shortages in

what is referred to as ‘middle grades’ resulting in ‘rota gaps’. While these shortages are undoubtedly real, the terms are loosely defined and often refer to both trainees and SASOs, reflecting the fact that trainees provide service.

5.11 While we can quantify SASO doctors at the level of specialty, and we observe the high turnover, there is no reliable data on shortfall. Thus, we are unable at this stage to directly quantify rota gaps and/or shortages of middle grades, and/or shortages of SASO staff. It is clear (section 5.1 above) that the NHS is heavily reliant on overseas doctors in SASO grades. It is equally clear that, hitherto, the NHS has been able to attract non-UK doctors into these grades.

5.12 Maintaining Medical Workforce Supply in the medium term

The available domestic supply is constrained by output from medical schools. The system has prioritised growth in training for GPs, Clinical Radiology and Emergency Medicine within this constraint. Growth in a priority specialty provided by attracting more domestic trainees means fewer domestic trainees are available to other specialties. The recent expansion in students will not *begin* to flow into the workforce until 2023 (Foundation), into PGME until 2025 (post Foundation) and into the consultant workforce until the early to mid-2030s.

5.13 The analysis suggests the most practical way to maintain and grow the total available medical workforce in any significant volume for the decade ahead is through international recruitment. Other measures that will support this include:

- Encouraging/ incentivising a higher proportion of trainees to remain in training (or in the workforce but not in training) post Foundation. Further analysis in 2019 will quantify the potential of this approach.
- delaying ‘final’ retirement and encouraging more post-retirement return for consultants. The yield from this will be relatively minor.
- There may be some marginal gains from reducing the ‘outflow’ of consultants under 55. However, net inflows and outflows to and from consultants effectively balance and since some of the outflow in one year become inflow in subsequent years the effect will be limited.
- Development of support workforces to free up doctor time and thus resource.

6 The Medical Education Reform Programme

6.1 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

6.2 The result of the programmes within MERP will be a radical change in how Medical Education is delivered. To ensure successful delivery, the programme is therefore designed to work in partnership with national stakeholders, including system and professional regulators, the British Medical Association (BMA), medical Royal Colleges, provider organisations and most importantly educators and doctors in training themselves. 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.

6.3 Expansion in medical student numbers

HEE worked with the Higher Education Funding Council for England (HEFCE) to increase the number of medical students by 1,500 across three years from Autumn 2018. As a part of the assessment process, new medical schools were expected to:

- Ensure access and successful participation for students from under-represented backgrounds
- Be located in geographically under-doctored areas
- Ensure high-quality training placements to support provision
- Focus on the prioritised specialties of general practice, psychiatry and any other shortage specialties.

HEE will be working closely with all medical schools to help the Office for Students ensure the above ambitions are realised.

6.4 Review of the Foundation Programme

The review of the Foundation Programme aims to ensure that it aligns with new medical school places and supports better transition between medical school and specialty training. The review will ensure that we are maximising the capability of future doctors and addressing issues around both specialties and geographies such as training in rural and remote localities. It will also strengthen the links between medical schools and the Foundation programme to enable better transition for graduates entering their careers in the NHS.

6.5 Building the generalist skills of the medical workforce

The medical workforce has become increasingly specialised while the population is aging with complex co-morbidities which require much more generalist care. HEE is working with the medical Royal Colleges, General Medical Council (GMC) and the BMA to increase the numbers of doctors with broad clinical and professional competencies that can be adapted to meet current patient needs. While there will always be a need for specialised

medical training, this greater focus on generalist skills is critical if we are to urgently address the challenges in providing acute care, as well as enabling doctors to work across a range of settings.

6.6 Internal Medicine Training (IMT)

Following work with the Joint Royal College of Physicians Training Board (JRCPTB) and the GMC, there will be a rebalancing in the majority of physician specialty training pathways to provide generalist focussed training. This rebalancing will mean that from 2019 the training for over 700 physician trainees per annum will include an extra year of general medical training and a commitment to help manage the unselected take in their subsequent higher specialist training and consultant careers.

6.7 Specific outcomes of the programme include:

- Greater numbers in a future skilled generalist consultant medical workforce who can be employed to manage the acute unselected take plus provide specialist skills;
- A skilled generalist workforce at registrar 'decision making' level within five years of qualification;
- An increase in junior medical staff on rotas, sucking trust grades into training, reducing rota gaps and the reliance (and cost) of locums, and;
- Improved training with a greater focus on gaining the skills of a medical registrar.

6.8 Improving Surgical Training (IST)

HEE has worked with the Royal College of Surgeons to pilot new competence-based, run through surgical training programmes in several surgical specialties. To facilitate this, there has been a focus on developing members of the team from other professional backgrounds to work alongside surgical trainees to improve patient care. The Improving Surgical Training programme will:

- Provide trainees with a better balance between training and service delivery;
- Enable surgeons to develop generalist skills within a more focussed training pathway which will allow highly skilled trainees to progress faster;
- Improve the quality of training posts by enhancing the role of trainers to enable them to dedicate more time to deliver training;
- Develop surgical skills earlier through focused training opportunities, simulation etc. so that time is not wasted, particularly in the early years of surgical training;
- Train and develop a workforce from other professions (the wider surgical team) to support trainees to help deliver better patient care and free up their time for more training.

6.9 From 2019/20, HEE and the RCS will work to roll out the IST programme further and use the learning from the programme to enhance surgical training for all trainees, improve patient care and continue to build effective multi-professional surgical teams.

6.10 Credentialing

Credentialing is a mechanism to formally recognise professionals with skills, expertise and competencies in certain areas of practice. By enabling professionals to expand their scope of practice to undertake new or additional roles and responsibilities, deliver different procedures, types of service, and work more flexibly, moving into different specialty areas and services, credentialing can:

- Ensure quality and patient safety in the development of advanced practice and enabling flexible training throughout professional careers;
- Ensure the workforce can respond to evolving service needs;
- Upskill the workforce and enable multidisciplinary working and more flexible reallocation of workload across teams;
- Enable staff to be more flexibly deployed in different service areas, helping reduce the impact of workforce shortages.

6.11 Developing credentialing across the professions is progressing in line with HEE's framework for Advanced Clinical Practice. Credentials for ACPs will enable Advanced Practitioners to develop and be recognised for new skills and capabilities through post ACP training modules such as frailty.

6.12 Flexible Training Pathways and the 'Blue Triangle'

We are moving away from prescriptive, and restrictive, time-based models of postgraduate training to recognise that all our trainees progress at different rates. Instead, we will place far greater emphasis on the acquisition of skills and competences at the pace of the individual doctor, allowing them to step off training pathways and spend longer undertaking service delivery consolidating training, or to progress faster when they are rapidly gaining competencies and experience.

6.13 Flexible Training Pathways

The aligned initiatives that enable a more effective approach to supporting doctors in training include (see figure 1 below);

- [Enhancing training and the support for learners](#), the recent review of the Annual Review of Competence Progression (ARCP)
- Supported Return to Training (SuppoRTT)
- Proposals to enable stepping in and out of training including an 'Out of Programme Pause' (OOPP) in service posts.

6.14 Trainees feel they are on a ‘production line’ and discouraged from taking time out of training, despite feeling that this would have positive benefits for their personal development and/or well-being. Trainees also feel frustrated about the inability to count competencies gained in non-training posts, when they return to training. In response to this, the Medical Education Reform Programme with the support of the Academy of Medical Royal Colleges (AoMRC) flexibility group has developed proposals for stepping on and off training.

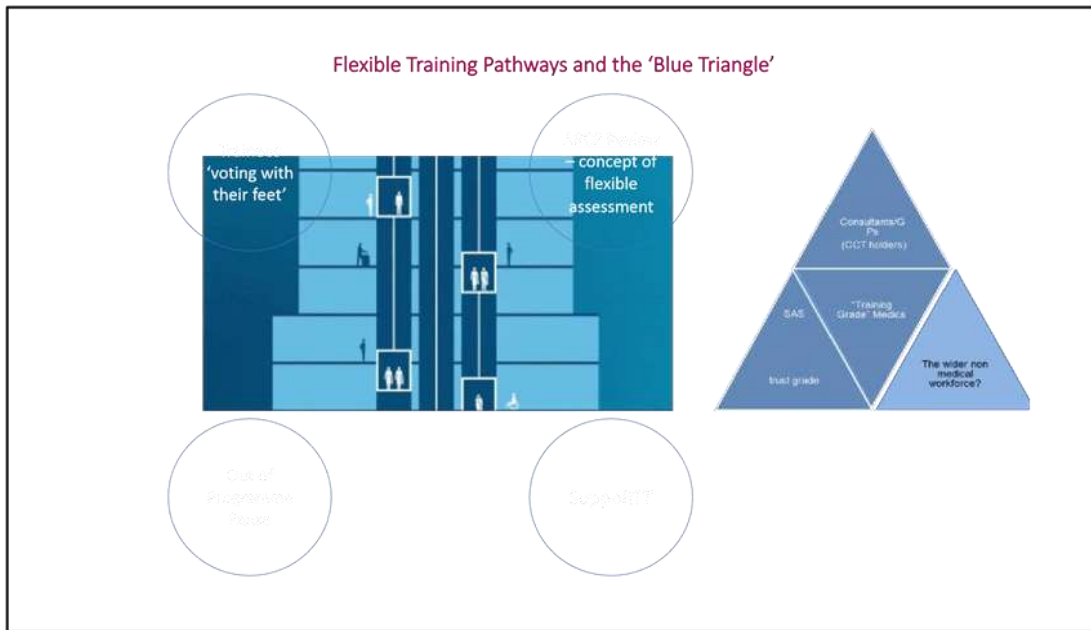


Figure 7: Flexible Training Pathways and the ‘Blue Triangle’

6.15 These proposals recognise the need for flexibility in training and a more individualised approach to medical careers and aim to improve medical staff retention within the NHS in England and boost wellbeing and productivity. The Supported Return to Training (SuppoRTT) process will support trainees on their return to training.

6.14 The ‘Blue Triangle’

An evolved ARCP process, which enables a robust assessment of competency at different stages, could facilitate junior doctors exiting and re-entering training programmes more flexibly, by defining the competence of the trainee at the exit point and validating the competencies gained for re-entry. It could also be the mechanism for recognising that those who are excelling are capable of either progressing faster or doing more within their training pathway.

6.15 For those outside the traditional CCT route, such as SAS or Trust Grade doctors, the ARCP could be broadened to allow them to gain recognition for competencies gained and either enter training at different stages or make it easier to collect the parallel evidence needed for the alternative route to the

specialist register through the Certificate of Eligibility for Specialist Registration (CESR).

6.16 Having defined the competencies required at any particular stage that could be validated through an assessment process, these competencies could be formally signed off or 'credentialed', for other professionals, allowing the multi-professional workforce to access development and assessments traditionally afforded to the medical workforce. In this way the ARCP review has enabled HEE to offer the 'blue triangle'.

6.17 SAS Doctors

HEE acknowledges many doctors choose a career as a SAS doctor. Given this career choice and their significant contribution to patient care and service delivery, HEE is committed to increasing opportunities for, and enhancing the development, of SAS doctors. HEE has led a multi-agency group including representation from NHSI, the AoMRC, the GMC and the BMA to explore how best SAS doctors can be supported and developed within their role to provide high quality patient care, the report of which will be published shortly.

6.18 However, it is equally important that SAS doctor roles are not necessarily seen as a separate career pathway. Doctors increasingly stress they require greater flexibility in the career structure, so that a typical career pathway could involve moving in and out of training and spending valuable time in SAS grade roles. In the NHS Long Term Plan, HEE is committed to enabling this greater flexibility by promoting opportunities to pursue individualised career pathways and "step off and step on" training. This will also benefit the service, helping increase retention and providing the middle grade workforce to deliver front line care. Consequently, our focus is as much on SAS doctors as it is on doctors in training and we welcome DDRB initiatives to ensure the reward system supports these workforce aims.

6.19 HEE's work on SAS doctors derived from;

- A commitment in the ARCP Review, [Enhancing Training and the Support for Learners](#), where it stated, "there should be a more flexible, evolving approach to supporting the professional development for SAS grade and trust grade doctors".
- A commitment in the [Facing the Facts, Shaping the Future - A draft health and care workforce strategy for England to 2027](#), where it stated, "a genuine focus on recruiting, investing, supporting rewarding and recognising SASG doctors can significantly help deliver medical rotas. We need more discussions and ideas about what re could be done to support and value the SASG workforce".

6.20 In response, HEE led work with NHS Improvement, the BMA, the GMC, the AoMRC, NHS Employers and the Royal College of Surgeons to develop a strategy for the support and development of SAS doctors. [Maximising the Potential – a system-wide strategy to support and progress the careers of](#)

[SAS Doctors](#) makes a number of recommendations to support a strategic approach to:

- The support of SAS doctors
- The development of SAS doctors
- Raising Awareness of SAS doctors and their key role in the NHS
- Facilitating and Enabling doctors

6.21 To ensure that the recommendations are implemented, each contributing organisation will be asked to develop a plan to take forward their areas of responsibility. The multi-partner working group that has informed the development of this strategy will continue to meet on a quarterly basis and will monitor progress and provide a forum for discussing the impact and learning as it emerges.

6.22 Quality Context

All programmes are predicated on a desire to improve the quality and efficiency of training. HEE's Quality Framework is a key vehicle via which we can ensure that initiatives are implemented, and outcomes monitored so that we can be assured that real improvements are being delivered.

6.23 Enhancing Junior Doctors Working Lives

The 'Enhancing Junior Doctors Working Lives' initiative, was born out of the junior doctors dispute in 2015. Requested by NHS Employers, the BMA and the DHSC, it aims to improve the morale and training of doctors by addressing areas identified as negatively impacting upon their training and working lives. A summary report of activity is published annually (the last published in [Spring 2018](#)) to update on progress against the component workstreams of the programme. These include:

- Deployment: ending fixed leave and ensuring trainees have timely notification of placements and rotas
- Increasing retention in front line specialties and reducing burnout; by increasing the opportunities for less than full time or portfolio careers
- Improving the Recruitment processes to allow pre-allocation of places for doctors with special circumstances and to improve the process for doctors wishing to work in the same location as their partners.
- Working with the Academy of Medical Royal Colleges to ensure doctors in training to not incur unnecessary costs
- Reforming the allocation of study budget to ensure an equitable approach across trainees.

6.24 Supported Return to Training (SuppoRTT)

During the last five years, at any given time, there were approximately 5,000 (or 10%) of postgraduate doctors taking approved time out of programme. To help facilitate these doctors returning to training, an annual fund of £10 million

has allocated by the DHSC, including an educational support fund of £6 million, that has been made available to individual trainees to access through an education support fund.

6.25 Enhancing Supervision

Educational supervision is being increasingly squeezed by service pressure, yet it is essential to high quality training, high quality care and patient safety. Supervision has been consistently raised as an area where improvements could make a significant impact on the morale, motivation and effectiveness of trainees.

6.26 The MERP programme on supervision will;

- Ensure clarity on the various roles of all those involved in the supervisory process, including the wider multi-professional team.
- Set out what good and poor practice looks like, highlighting examples of how supervision can be done effectively to enable trusts to make improvements and regulators to see where there are issues.
- Make clear the responsibilities and expectations of supervisors and employers in delivering high quality supervision.
- Strengthen HEE's levers, such as the Quality Framework and LDA to improve supervision, in tandem with system partners including the CQC and NHS Improvement through vehicles such as the Joint Strategic Oversight Groups at national, regional and local levels.

6.27 Summary and Next Steps

The Medical Education Reform Programme has built momentum and shared ownership across the educational system over the last 12 – 18 months, particularly with Royal Colleges and the GMC. Its foundations form the basis of how HEE will respond to the NHS Long Term Plan and core strands of the programme such as flexible training, expanding the generalist skills of doctors and supporting SAS doctors will be a key component of shaping the future of medical education.

7 Flexible pay

7.1 For the 2019/20 pay round, HEE has been asked to submit any further proposals for targeting through the application of Flexible Pay Premia, informed by supply data (increases in training numbers/expansion of medical schools), geographical data (under-doctored areas), application and fill rates for training programmes, available data on consultant vacancies and agency spend, and workforce planning. HEE has also been asked to include information on the effectiveness of the GP Targeted Enhanced Recruitment Scheme.

7.2 The pay premia for hard-to-fill training programmes and GP specialty training that were part of the 2016 contract from its introduction were designed to

ensure that there are no pay disincentives that would deter trainees from entering these programmes. One way of assessing whether that has had the intended impact is to look at application and fill rates, which is set out in more detail at Appendix A.

7.3 General Practice Targeted Enhanced Recruitment Scheme (TERS)

The new Targeted Enhanced Recruitment Scheme (TERS) is an initiative that offers a one-off payment of £20,000 to GP trainees committed to working in a select number of training places in England that have been hard to recruit to for the past three years. The scheme has been running since 2016. The sum is repayable if trainees leave the programme during the training period and is taxable.

7.4 The areas targeted by TERS were those with 50% or below fill rate, on average, between 2013 and 2016. Subsequent rounds of TERS use the same principle of the previous three years rolling average fill rate. The primary care programme, which includes TERS, is funded through the infrastructure fund and TERS is a commitment by both Health Education England (HEE) and NHS England (NHSE) in partnership.

7.5 The fill rate for TERS funded posts are set out below:

Year	Posts	Filled posts	Fill Rate %
2016/17	143	122	86%
2017/18	143	133	93%
2018/19	265	236	89%

7.6 Locations identified by HEE and NHSE for posts commencing in February 2019 are listed [here](#). Following an independent review of the scheme, recommendations were made to improve the methods for measuring the retention of doctors post-qualification in TERS and non-TERS areas in 2019. HEE is of the view that TERS has helped to increase the number of trainees in posts in hard to fill areas.

7.7 Impact of TERS on fill rates in North Cumbria

There are many areas in England which struggle to recruit staff and concerns were so considerable that HEE produced a report ‘Training in Smaller Places’⁶, which recognises the challenges of recruitment for hospitals in remote and rural locations. The report suggests considering “the use of preferential fees and placement rates to encourage training in smaller places”. The HEE North East GP Postgraduate School has evidence that TERS incentives have led to an increase in trainee numbers in the areas where the financial incentives were offered. This is illustrated in figure 8 below:

⁶<https://madeinheene.hee.nhs.uk/Portals/0/Policies/overarching/Training%20in%20Smaller%20Places%20June%202016.pdf>

Year	Round	North Cumbria	NGPTP	DTV
2015	1 and R1 Re-advert	7	63	27
2015	2	0	12	11
2015	Total/places	7/24	75/96	38/72
2016	1 and R1 Re-advert	15	72	28
2016	2	5	14	16
2016	Total/places	20/24	86/96	44/72
2017	1 and R1 Re-advert	15	84	25
2017	2	Opens 20/7/17	Opens 20/7/17	Opens 20/7/17
2017		15/24 + Round 2	84/96 + Round 2	25/72 + Round 2

Figure 8: Impact of National TERS on GP Recruitment

- 7.9 Following the success of the GP scheme, the HEE North East GP Postgraduate School offered a TERS payment of £7,000 for doctors in training taking up a 12-month Specialty Training or Foundation Post in North Cumbria University Hospital (NCUH) and Cumbria Partnership Trusts, who are now working as an Integrated Care System (ICS). The NCUH Trust is the only part of the North East and North Cumbria which is more than one hour's drive from the other NHS Trusts. This means that the NCUH Trust is in a different geographical location to the remaining Trusts.
- 7.10 The £20,000 TERS payment for GP trainees was an incentive to attract them for a 3-year period. The majority of doctors in training spend one year at NCUH, and Foundation doctors spend two years. It is believed that an incentive of £7,000 for a 12-month placement should serve as an effective inducement to Specialty Training and Foundation doctors as this is similar to the GP TERS incentive. In the unusual situation that a trainee is placed for less than 12 months the payment could be reduced pro rata. If a trainee were placed for a second year, then a further TERS payment of £7,000 could be considered.
- 7.11 If a trainee leaves the post before completion of the placement then they would be obligated by contract to repay a proportion of the TERS payment as outlined in Figure 9 below.

Time in training	% of payment to be repaid
0-3 months	100%
3-6 months	75%
6-9 months	50%
9-12 months	25%

Figure 9: Proposed scale for North Cumbria TERS

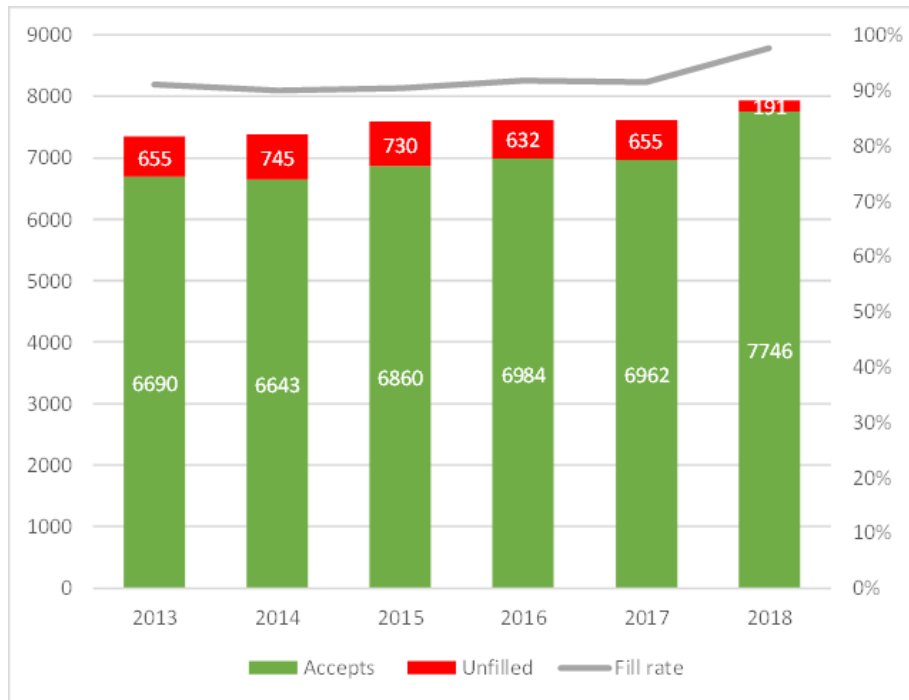
7.12 The results to date appear favourable. We are awaiting the final round for GP recruitment.

Programme	2017 Fill Rate %	2018 Fill Rate %
Foundation	80%	100%
Specialty	81.5%	90%
GP	75%	13/24 round 1 + R1R, awaiting rd2 Currently 54%

Figure 10: Effects of TERS on recruitment in North Cumbria

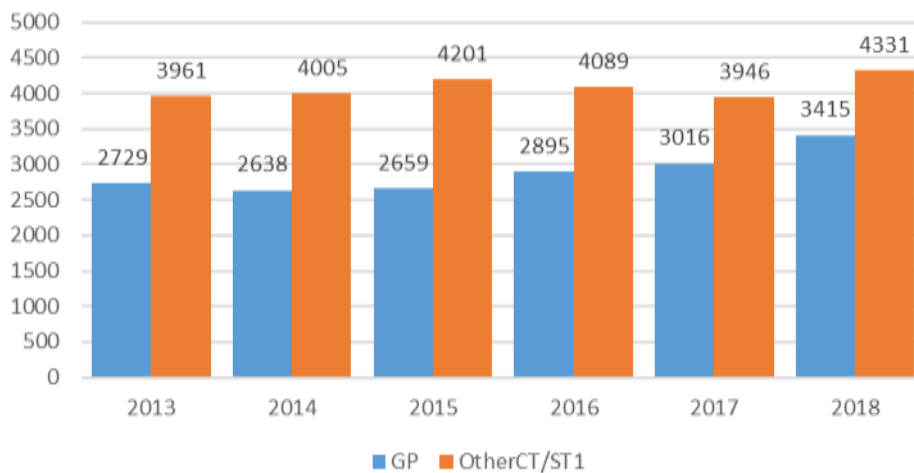
Appendix A

Overall recruitment to PGME training 2013-2018



Total recruitment at CT/ST1 was steady at approximately 7,000 from 2015 to 2017. In 2018 both the number of posts advertised and the number recruited to increased. The full rate jumped in 2018.

Recruitment at CT/ST1 : GP and other



Within this overall growth the number of GPs recruited and the number of 'others' recruited grew by similar amounts.

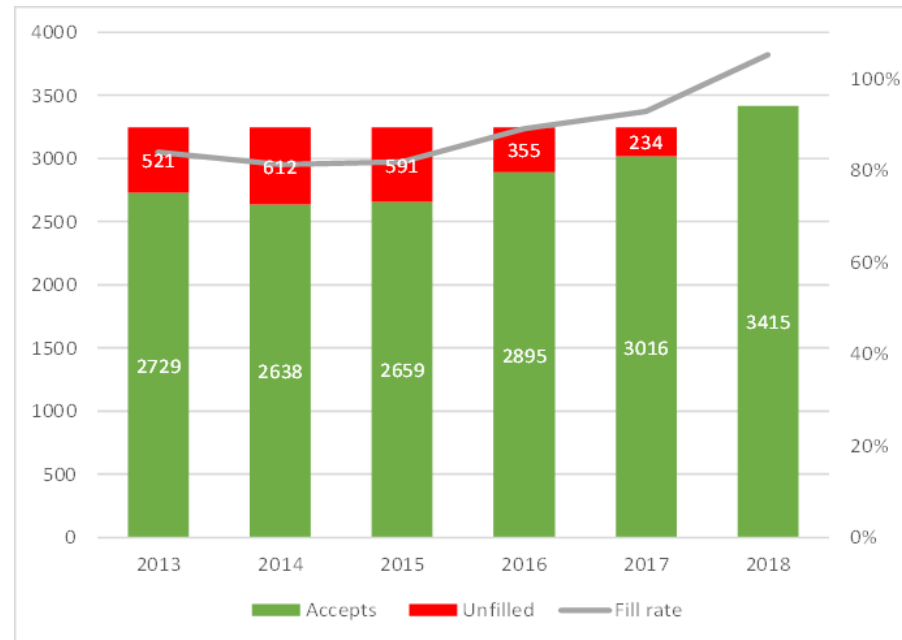
2018 recruitment in context

In 2018 CT/ST1 recruitment rose to the highest level in recent years. A total of 7,746 were recruited to commence in Autumn 2018, 900 more than the 2013-17 five-year average. General practice recruited 399 more than in 2017, and 628 more than the long-term average. All core and run-through programmes recruited more than the previous year, and more than their five-year average with the exception of Histopathology recruited ten fewer than in 2017, and only maintained the five-year average (and also O&G but this is not significant). Core psychiatry recruited 97 more than the previous year, and 51 more than the 5-year average.

	Fill rate	5 year average	2017	2018	2018 relative to			
					2017		Average	
					No.	%	No.	%
General Practice		2787.4	3016	3415	399	13%	628	23%
Ophthalmology	100%	62.4	55	72	17	31%	10	15%
ACCS Emergency Medicine	97%	285.4	279	325	46	16%	40	14%
Core Psychiatry	79%	372.6	327	424	97	30%	51	14%
Clinical Radiology	100%	203.8	226	229	3	1%	25	12%
Paediatrics	95%	354.8	336	397	61	18%	42	12%
Public Health Medicine	99%	68.2	69	75	6	9%	7	10%
Core Medicine + ACCS Acute	96%	1296.8	1281	1398	117	9%	101	8%
Obstetrics & Gynaecology	100%	216.2	237	232	-5	-2%	16	7%
Neurosurgery	96%	26.4	27	28	1	4%	2	6%
Core Anaesthetics + ACCS	98%	523	532	541	9	2%	18	3%
Core Surgery	99%	511.2	500	510	10	2%	-1	0%
Histopathology	85%	72.2	60	62	2	3%	-10	-14%

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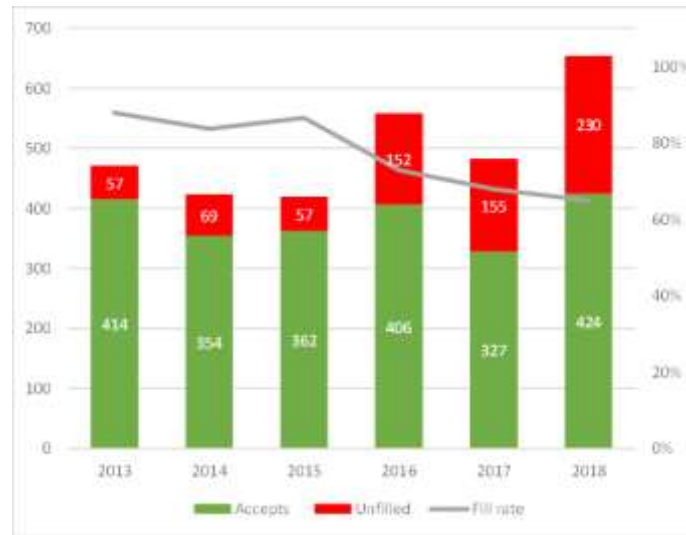
General Practice



Accepts	NE	NW	YH	WM	EM	EoE	LON	KSS	TV	WSX	SW	North	Mids&E	London	South	England
2013	154	388	260	307	237	271	405	236	102	133	236	802	815	405	707	2729
2014	124	356	238	330	171	282	421	233	105	133	245	718	783	421	716	2638
2015	115	376	242	262	176	311	433	239	117	129	259	733	749	433	744	2659
2016	150	386	274	297	261	311	455	251	128	146	236	810	869	455	761	2895
2017	147	413	295	329	254	322	480	226	131	153	266	855	905	480	776	3016
2018	193	512	320	427	290	348	498	270	157	154	246	1025	1065	498	827	3415
Ave17+18	170	463	308	378	272	335	489	248	144	154	256	940	985	489	802	3216
Fill rate																
2013	80%	80%	74%	86%	85%	87%	87%	96%	78%	89%	89%	78%	84%	87%	89%	84%
2014	65%	74%	68%	92%	61%	85%	91%	94%	81%	89%	93%	70%	81%	91%	91%	81%
2015	60%	78%	69%	73%	63%	94%	93%	97%	90%	87%	98%	71%	77%	93%	94%	82%
2016	78%	80%	78%	83%	93%	94%	98%	102%	98%	98%	89%	79%	90%	98%	96%	89%
2017	77%	86%	84%	92%	91%	98%	103%	91%	101%	103%	101%	83%	93%	103%	98%	93%
2018	101%	106%	91%	119%	104%	105%	107%	109%	121%	103%	93%	100%	110%	107%	105%	105%
Ave17+18	89%	96%	88%	105%	97%	102%	105%	100%	111%	103%	97%	92%	102%	105%	101%	99%

Health Education England

Core Psychiatry



Accepts	NE	NW	YH	WM	EM	EoE	LON	KSS	TV	WSX	SW	North	Mids&E	London	South	England
2013	16	63	49	32	24	44	117	15	15	14	25	128	100	117	69	414
2014	22	45	21	32	17	32	121	19	9	10	26	88	81	121	64	354
2015	20	41	39	34	18	27	116	18	18	8	23	100	79	116	67	362
2016	22	54	33	29	17	40	137	15	16	15	28	109	86	137	74	406
2017	10	36	28	23	19	18	118	17	16	17	25	74	60	118	75	327
2018	25	61	44	34	17	35	135	22	14	10	27	130	86	135	73	424
Ave17+18	18	49	36	29	18	27	127	20	15	14	26	102	73	127	74	376
Fill rate																
2013	73%	98%	66%	78%	83%	98%	99%	83%	100%	88%	86%	80%	87%	99%	88%	88%
2014	67%	83%	68%	73%	77%	80%	100%	86%	100%	63%	84%	75%	76%	100%	82%	84%
2015	57%	84%	78%	94%	82%	55%	121%	90%	95%	50%	85%	75%	74%	121%	82%	86%
2016	85%	51%	37%	74%	71%	80%	100%	71%	94%	100%	80%	50%	76%	100%	84%	73%
2017	28%	59%	47%	82%	70%	40%	97%	74%	62%	94%	69%	47%	60%	97%	73%	68%
2018	38%	59%	50%	92%	74%	40%	92%	81%	54%	59%	79%	51%	59%	92%	70%	65%
Ave17+18	35%	59%	49%	88%	72%	40%	94%	78%	58%	77%	74%	49%	59%	94%	71%	66%

Health Education England

Histopathology



Accepts	NE	NW	YH	WM	EM	EoE	LON	KSS	TV	WSX	SW	North	Mids&E	London	South	England
2013	2	9	10	6	6	6	18	0	4	4	8	21	18	18	16	73
2014	6	11	8	5	5	4	21	0	4	6	4	25	14	21	14	74
2015	6	10	7	6	4	6	24	0	4	3	6	23	16	24	13	76
2016	5	11	8	6	10	7	22	0	4	3	2	24	23	22	9	78
2017	3	11	5	3	5	1	19	0	4	3	6	19	9	19	13	60
2018	4	9	6	4	7	7	13	4	3	4	1	19	18	13	12	62
Ave17+18	4	10	6	4	6	4	16	2	4	4	4	19	14	16	13	61
Fill rate																
2013	14%	64%	53%	100%	100%	67%	86%		80%	100%	80%	45%	86%	86%	84%	68%
2014	75%	100%	89%	100%	125%	100%	95%		100%	100%	80%	89%	108%	95%	93%	95%
2015	100%	111%	117%	100%	100%	100%	100%		100%	100%	100%	110%	100%	100%	100%	103%
2016	100%	92%	100%	100%	100%	100%	100%		100%	100%	100%	96%	100%	100%	100%	99%
2017	60%	100%	71%	50%	63%	10%	76%		100%	100%	100%	83%	38%	76%	100%	71%
2018	67%	90%	43%	80%	70%	88%	100%	67%	100%	80%	100%	63%	78%	100%	80%	77%
Ave17+18	64%	95%	52%	64%	67%	44%	84%	67%	100%	88%	100%	72%	57%	84%	89%	73%

Health Education England

Other specialties



Other specialties (continued)



Recruitment at CT/ST1 by HEE Region 2013-2018

