NHS
Health Education England

Review Body on Doctors' and Dentists' Remuneration

Health Education England's written evidence for 2021/22

1. Introduction

1.1. Health Education England (HEE) welcomes the opportunity to submit evidence to The Review Body on Doctors' and Dentists' Remuneration (DDRB) as part of its national process of gathering evidence from interested parties to inform the recommendations for 2021/22.

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

1.3. Our evidence has been provided in the light of the broad strategy outlined in the NHS Long Term Plan and *We are the NHS: People Plan for 2020/21*. Further publications aligned to the NHS People Plan will confirm the strategic aims and inform the more detailed aspects of HEE's work going forward. Our June 2020 publication, *The Future Doctor* report, sets out HEE's co-created vision for the reforms of medical education and training in the next stage of this strategy[1]:

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 is the NHS body that works with others to plan, educate and train the health workforce. To deliver this purpose, HEE:

- seeks out, invests in and quality assures the best education and training for trainees, new roles and current professionals; intervening where quality, environment or supply are not meeting the needs of learners or the NHS;
- ensures new evidence-based science, digital technology, skills and knowledge enhance both individual staff and multi-professional teams;
- co-operates and collaborates with partners across health and education, respecting each other's roles, expertise and responsibilities. HEE brings workforce data, intelligence and analysis, policy proposals, practical transformation and development tools and resources, both financial and people, to shared issues.

2.3. HEE has identified its core roles as:

- Workforce design and analysis
- Medical and Dental education

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

- Clinical education and training
- Quality of education and training
- Workforce transformation and skills development
- Developing global partnerships

2.4. While HEE will continue to deliver its statutory responsibilities to secure sufficient and high quality education and training for the NHS workforce, HEE recognises the importance of working collaboratively with the Department of Health and Social Care (DHSC), NHS England / Improvement (NHSE/I), and other health system stakeholders to tackle the issues facing the NHS and its workforce as a whole. This view is shared by HEE's partners, who are committed to working together using the different levers each has available.

2.5. Similarly, there is mutual agreement that there must be better alignment of service, workforce, and financial planning at a national, regional, and local levels - in particular to support the delivery of the NHS Long Term Plan published in January 2019 and the People Plan for 2020/21 published in July 2020.

2.6. To reinforce the desire to work more collaboratively, HEE worked with NHSE/I to ensure HEE's mandate for 2020/21 aligned with national service plans, before it was finalised and published by the Department. HEE and NHSE/I have also agreed a reciprocal arrangement where one Board member from each organisation will sit as an Associate Non-Executive Director on the Board of the other.

2.7. Most importantly, and to ensure the NHS has the workforce it needs to deliver the service ambitions for patients set out in the Long Term Plan, HEE and NHSE/I worked together to lead the development of the NHS People Plan, with a continued focus on:

- **make the NHS the best place to work,** improving staff experience and retention
- **improve the leadership culture**, with an emphasis on compassionate, inclusive and collaborative leadership behaviours
- **transform and grow the workforce** ('more staff, working differently') in support of Long Term Plan service priorities by:
    - **releasing more time for care**, supported by systematic use of digital technology
    - **supporting and enabling workforce redesign** through better use of clinical and non-clinical roles to support registered professions, extended and advanced roles, and helping established professions work in multidisciplinary teams across different settings including primary care
    - **growing the future workforce** and **reforming education and training** to ensure the right number and mix of staff – with the right skills – able to join our workforce in the short, medium and longer term

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

3. The Medical Workforce

Workforce Context

3.1. HEE undertook a process of data collection by requesting information from each NHS Provider regarding current consultant staff in posts and funded establishment. HEE received a high response rate to enable data to be converted into a standard measure of staff in post. Estimated vacancy rate data from this collection are set out in the table below.

	North East & Yorkshire	North West	Midlands	East of England	London	South East	South West	All	Aggregate shortfall all England
Emergency Medicine	15%	7%	23%	15%	16%	27%		16.0%	366
Psychiatry	23%	26%	15%	5%	9%	9%	12%	15.0%	806
Acute take	14%	14%	18%	12%	11%	13%	9%	13.0%	914
Pathology	14%	14%	9%	9%	8%	13%	10%	11.0%	177
Clinical Radiology	9%	12%	11%	13%	12%	6%	5%	10.0%	352
Wider medical	6%	12%	9%	13%	5%	9%	5%	8.0%	539
Oncology	11%	14%	8%	2%	1%	11%	5%	7.0%	97
Ophthalmology	13%	8%	7%	10%	5%	11%	1%	8.0%	116
Infectious diseases	10%	12%	16%	3%	1%	-	11%	7.0%	43
Surgery	9%	6%	6%	9%	5%	7%	6%	7.0%	610
Anaesthetics and ICM	2%	4%	5%	9%	6%	5%	1%	5.0%	362
Obstetrics & gynaecology+CSRH	9%		5%	6%	7%	6%	1%	5.0%	140
Paediatrics	1%	0%	6%	6%	5%	2%		3.0%	103

Aggregate across specialties	10%	10%	10%	9%	7%	9%	5%	9%
Shortfall from establishment	812	696	967	478	782	647	242	4,628

3.2. The data confirm:

- Emergency Medicine and the Psychiatry specialties are in the shortest supply.
- The 'acute take' specialties are also in significant shortage – the data mask notable variations between specialties in this grouping. Wider medicine also indicates considerable shortages, and again the aggregate masks variation.
- Histopathology, Clinical Radiology – both central to diagnostics and the treatment of cancer - exhibit marked shortage as do the oncology specialties.

- Specialties where there is less concern are surgery (which is ten specialties, again with variation between them), Anesthetics (although Intensive Care Medicine - a small but rapidly growing specialty - exhibits significant shortage), Obstetrics and Gynaecology, and Paediatrics.

- In general terms the north of England has the most significant consultant shortfall, followed by the Midlands and the East of England. Shortages in London are generally comparatively low. Nevertheless, London has significant problems in Emergency Medicine, the Acute Take, and Clinical Radiology.

Recruitment into specialty at CT/ST1

3.3. The data at Appendix A show that recruitment to CT1/ST1 in 2020/21 was successful with all programmes achieving at least a 95% fill rate, and the majority reaching 100%. Particularly noteworthy was the record number of 3,793 applicants that accepted General Practice training, in line with the Government's manifesto target.

3.4. Applications have closed for 2021/2022 recruitment which has seen a 34% increase in applications compared to 2020/2021. This includes an 84% increase in Core Psychiatry applications. The main driver for the increase are applications from international medical graduates.

4. The Medical Education Reform Programme

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

- Issues around recruitment and retention of doctors in training;

- The expectations of doctors in training, both in terms of their careers in medicine and in where, when and how their training is delivered;

- Societal, demographic and workforce changes, placing changing demands upon the medical workforce of the future and offering new challenges and opportunities.

4.2. The 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.

4.3. HEE's medical education reforms are now focused around a number of key and aligned initiatives to produce doctors that better meet the needs of patients and service, address health inequalities and improve the experience of doctors in training. These key initiatives are drawn from **The Future Doctor**, published in July 2020. This co-created vision sets out what is required of the doctors of the future. It sets a clear direction for the next phase

of our reforms for medical education and training so our future doctors are equipped with the right skills to deliver care in an evolving environment. This is focused around six reform pillars set out below:

1. **Enhanced generalism –** ensuring the NHS and patients have the doctors they need to care for patients with multimobidities and disease clusters through enhanced generalist training.

2. **Equality, diversity and inclusion** - widening participation / access, opening new undergraduate routes.

3. **Accelerating undergraduate supply –** getting doctors into the NHS workforce quicker through the introduction of a 6-month undergraduate 'assistantships' and bringing forward the current *Point of Registration.*

4. **Address health inequalities** by ensuring a more even distribution of NHS training posts across the country meaning we better support NHS service priorities across England – this will also tackle remote and rural healthcare challenges.

5. Improve the **wellbeing and experience of doctors** through flexible training opportunities, portfolio careers Enhancing Junior Doctors Working Lives.

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

Specific initiatives relevant to DDRB

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

<u>Future workforce – developing generalist skills</u>

4.5. HEEs recent Future Doctor report defines the generalist skills needed by all doctors to enable them to:

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

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

4.7. This will be delivered by developing and delivering a wraparound professional educational offer to augment current specialty training using innovative educational methods. Generalist Schools will provide the local educational leadership for generalist training, working closely with local employers to organise and deliver training activities and work with local health and care systems to develop training and career pathways within local health and care systems that enable doctors to learn and apply these skills confidently.

4.8. HEE's trailblazer programme will drive this change where there are the best opportunities in the system. It will produce a cohort of trainee doctors with enhanced generalist skills, recognised by a generalist certification. It is planned to have a trailblazer in each of HEE's seven regions with a minimum of 140 trainees nationally, which means these doctors will start to have this enhanced generalist training from August 2021, learning and applying these skills over 3 – 5 years of enhanced training. Further expansion is planned for 2022 and 2023.

Addressing Health Inequalities – distribution of training places

4.9. The NHS Long Term Plan committed to meaningful action to tackle health inequalities. With this fundamental principle in mind, HEE has developed a robust model for guiding the distribution of training posts in three high-fill specialties to better align with patient need. This follows evidence from NHS Improvement showing a correlation between Summary Hospital Mortality Indices and doctors per head of population.

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

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

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

Flexible Pay

4.13. We note the DDRB would welcome evidence or proposals that look at extending the range of pay premia to cover difficult to recruit to specialties and geographies. We suggest this debate should link to HEE's work around the geographical distribution of training places described above, given the potential scope for a complementary approach. HEE officials would welcome the opportunity to discuss this further with a view to aligning policy in this important area.

4.14. In terms of providing evidence, HEE's experience of introducing flexible pay premia is limited to the General Practice Targeted Enhanced Recruitment Scheme (TERS) and a small number of training posts in the North East of England region. The 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.

4.15. The data appear to show this has been successful (see Appendix B), and HEE is therefore considering whether flexible pay premia should also be considered in psychiatry where there is a similar pressing need to increase recruitment to the training grades. However, HEE believes caution should be exercised in extrapolating the TERS results in considering the evidence for flexible pay premia more generally as GP (and psychiatry) trainee recruitment present specific issues and other factors may also have influenced the results.

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

4.17. During 2019/20 and 2020/21 priority programmes will be introduced and evaluated, including the following local financial incentives:

- Trent Foundation School are offering an enhanced salary package in the second year of the programme;
- Northern Foundation School are offering eight five priority programmes with an offering of £7,500 per training year incentive. These programmes also include additional educational support for all F1 and F2 doctors through the F-Docs online education package;
- Wessex Foundation School are offering three programmes, which are located on the Isle of Wight in the second year. Trainees will be given £8,750 in their F2 year to spend on whatever they like.

SAS Doctors

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

4.19 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. 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. HEE has also engaged with colleagues from DHSC and NHS Employers on the development of the 'Senior SAS doctor' role.

5. Impact of COVID-19

Impact of COVID-19 on undergraduate medical education

5.1 COVID-19 inevitably had an impact on undergraduate medical students, due to loss of teaching time and placements. HEE worked with the Medical Schools Council (MSC) to assess this impact and found that medical schools (at the time of writing) had no plans to extend the academic year.

5.2 In order to enable students to "catch-up", some lost placement activity was made good by online learning or considered not essential to re-provide, for example due to spiral curriculum, and alternative methods of delivery were employed (e.g., more use of online teaching and simulation software, remote consultations, changes to clinical assessment, repurposing elective periods). However, the challenges remain, and medical schools and students continue to be monitored to assess whether further mitigating action will be required.

5.3 A second issue was the impact of COVID-19 on the 2020 A-level results that resulted in more applicants achieving the requirements of their conditional offers of a place at medical school and, consequently, a significant over-subscription. The Government committed to ensuring all successful applicants should be provided a place, so HEE supported the MSC in the creation of additional capacity, helping to broker arrangements with individual medical schools and securing funding for the additional places from Government.

5.4 HEE is continuing to work with the DHSC to secure funding for additional places in 2021 for those deferring from 2020 (so as not to disadvantage the cohort of 2021 applicants).

Impact of COVID-19 on postgraduate medical education

5.5 COVID-19 has generated significant disruption to postgraduate medical education, particularly due to the cancellation of high stakes examinations required to complete

training, meet the regulatory education requirements, and enter the professional or specialist register.

5.6 This has the potential to disrupt the consultant and mid-grade doctor supply pipeline, as the "product" of training cannot be achieved, and posts reserved for newly recruited trainees continue to be occupied, causing congestion to the training pipeline at significant cost to HEE.

5.7 To mitigate this issue, alternative approaches to assessment and progression had to satisfy the professional regulators' requirements, as did any steps to bring pre-registration learners into the workforce ahead of the scheduled start date.

5.8 HEE has taken proactive measures with system partners to develop and agree contingencies for recruitment, assessment and progression to mitigate the overall disruption to workforce supply and minimise the potential financial impact posed by training extensions.

Foundation Interim Year 1

5.9 The Foundation Interim Year 1 (FiY1) initiative was launched to help boost the workforce in response to the COVID-19 pandemic. Working with the General Medical Council (GMC) and Medical Schools Council (MSC) HEE and the UK Statutory Education Bodies (SEBs) reached an agreement to allow final year medical students to graduate early and attain provisional registration. These new medical graduates could volunteer to work as Foundation doctors ahead of the usual UK Foundation Programme start date in August.

5.10 The initiative was a success with 5,607 graduates volunteering across the UK and around 3,800 being deployed to Trusts in England. Feedback to date has indicated they provided helpful additional resource and gained valuable experience.

Recruitment

5.11 The emergence of the pandemic necessitated the cancelation of face-to face recruitment in mid-March 2020. This decision was taken due to significant pressures on clinical time, which prevented clinicians from being released for recruitment panels, and social distancing measures introduced by the Government.

5.12 The SEBs determined that recruitment should not be delayed, as this would severely disrupt the continuity of medical and dental trainee progression at a time of acute NHS workforce need.

5.13 A consistent recruitment process based on online testing and self-assessment application forms was negotiated across the majority of specialties. The British Medical Association, Medical Royal Colleges and trainee representatives were involved in this process.

5.14 For the second round of recruitment for February 2021 start dates, HEE conducted online interviews. This was achievable, as this was a small scale recruitment exercise limited to a select number of specialties with a low fill-rate after the August recruitment round or with a high number of vacancies arising mid-year.

5.15 2021 recruitment is now underway, with the application window closing on Thursday 17th December. The following general principles for recruitment have been agreed via the Medical & Dental Recruitment and Selection (MDRS) governance:

- Recruitment plans should be developed with the anticipation of further COVID disruption and therefore should be future proofed, meaning that they are deliverable regardless of social distancing or restrictions in place and will not need to be changed after applicants have applied
- Applicants should be aware of the selection process that they will undertake before they submit an application
- There will be no in person face to face interviews throughout the 2021 recruitment process
- Where self-assessment is used, evidence should be verified, unless an exception has been agreed by the MDRS Board
- Any interview processes should be undertaken digitally as a single panel and not as a multiple mini-interview format
- The interview panel should consist a minimum of two panel members, one of whom must be a consultant. This can be reduced to a single consultant if clinical pressures necessitate it
- Consideration should be given to recording interviews with only one interview panel member
- Lay representatives should be available to undertake quality assurance checks on a proportion of the interviews taking place
- Where applicant numbers exceed interview capacity, shortlisting processes can be adopted.

5.16 To futureproof the recruitment process, each specialty has provided two recruitment plans:

- **Plan A** – Preferred delivery model of recruitment based on the above agreed principles and the known delivery constraints.
- **Plan B** – How recruitment would be delivered if there was a significant 2nd peak of the pandemic which effects clinician or trainee availability or the availability of administrative support. Plan B should be deliverable without the need for clinicians.

Annual Review of Competency Progression (ARCP) and assessments

5.17 HEE has worked with the regulators, professional bodies and Medical Royal Colleges to agree acceptable compensatory evidence for trainees to progress through critical progression points, where COVID-19 has presented a barrier to training.

5.18 We have also identified flexible and technology-supported contingencies for high-stakes assessment; allowing examinations to be replaced with suitable alternatives or to be rescheduled as remote assessments at the earliest possible opportunity.

5.19 Following discussions between the four SEBs and the GMC, in April the Regulator authorised a temporary derogation from the Gold Guide, to introduce a new ARCP Outcome 10 during the COVID-19 emergency. This provides an alternative to Outcome 3, which could be perceived as unfairly penalising trainees. An Outcome 10 indicates that a trainee has been unable to demonstrate all the necessary curriculum requirements due to the pandemic. This "no fault" outcome recognises the exceptional circumstances presented by the emergence of a novel coronavirus.

5.20 The regulator also permitted temporary modifications to ARCP decisions and derogations to curricular requirements based on the principle of a delay in achievement of required standards. Working with the Medical Royal Colleges, HEE and the SEBs were able to secure agreement on the minimum data required to evidence progression at ARCP.

5.21 These mitigating actions have significantly lowered the forecast disruption and extensions requirements.

Evidencing Experience in COVID-19 settings

5.22 Following discussions and endorsement from the four SEBs, HEE has issued guidance to trainees and faculty on recording and recognising trainee experience and competencies gained during the COVID-19 emergency. The guidance offers a light touch approach, recommending that experience is mapped to the GMC General Professional Capabilities, particularly the following domains:

- Domain 1: Professional values and behaviours
- Domain 2: Professional skills
- Domain 3: Professional knowledge
- Domain 5: Capabilities in leadership and team working

Rotations

5.23 When the pandemic first emerged, HEE and the SEBs took the decision to pause April rotations, to support the service with its COVID-19 response.

5.24 For August rotations, and into the resurge phase of the pandemic, scheduled rotations have continued as planned wherever possible, particularly for foundation and core trainees. HEE has permitted regional flexibilities to rotation dates for higher trainees, with a view to balancing regional training and service needs. This flexibility facilitates provision of high quality training posts for trainees to rotate into and support resilience within the system.

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

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

Extensions

5.27 Postgraduate medical and Primary Care deans are engaging with employers across their regions to identify suitable posts for training extensions. These will include use of Period of Grace and Acting Up as a Consultant (AUC) where local opportunities allow; creation of Trust-funded posts; and upscaling HEE's Out of Programme Pause (OOPP) offer to create pre-CCT fellowships.

5.28 OOPP provides up to a 12-month break from training and the opportunity to gain competencies which may have been missed during the pandemic.

5.29 The postgraduate medical deans will use their discretion to liaise with local employers to defer specialty trainee start dates, where possible, or agree to double run for up to six months if necessary.

Ongoing monitoring

5.30 During autumn/winter 2020-21, with the re-emergence of COVID-19, HEE is capturing consistent and accurate data on the pandemic's impact on postgraduate medical education (PGME) at a local office, regional and national level. Data collection broadly falls into three categories:

i. changes to trainee's planned placements that materially affect their access to learning and curriculum opportunities, captured in real time by HEE local offices;

ii. perceived risks to experiential learning and progression, as identified by trainees, training programme directors (TPDs) and Heads of Schools (HoS); and

iii. actual impacts on trainee progression, including extensions, as identified by the ARCP process.

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

Funding implications

5.32 HEE has baseline funding for a finite number of doctors in training and contributes approximately 42%-43% of their basic salary whilst in Secondary Care and 100% salary in Primary Care. There are already pressures emerging from a greater number of doctors that are able to complete training or progress to the next level (foundation > core > higher) because COVID-19 has interrupted their training and they have not attained the required competencies. This is resulting in extensions to training that either need additional funding or it will reduce the number of training posts available for recruitment. It is important to remember that these are qualified doctors who are making a valuable contribution to dealing with COVID-19 at the expense of their training requirements. The future pipeline of trainee doctors into consultant posts will be affected in the longer term, even with the mitigations that HEE is working with the Royal Colleges and others to introduce to minimise the impact.

6. The Dental Workforce

Context – oral and dental health in England

6.1. The nation's oral health has improved significantly in recent decades, despite there being sections of the population – such as those living in deprived areas – who still have significant levels of tooth decay and gum disease. These factors have led to changes in the demand for dental treatment and public health approaches to prevention.

6.2. The most recent survey of adult oral health in England, undertaken in 2009[2], showed that only 6% of adults had no natural teeth at that time, compared with 28% in 1978. Other measures also show a marked improvement in adult oral health over that period, with younger people generally having less tooth decay than older people. However, in recent years, the number of adults seen by an NHS dentist in England has fallen. The latest data on patients seen by an NHS dentist reveals that 22 million adults (50.7%) saw an NHS dentist in the 24 months to 30 June 2018. This figure was 98,445 fewer than the 24-month period to June 2017. This has, in part, been attributed to labour shortages in NHS dentistry.[3]

6.3. Public Health England recently reported[4] that the improvement in the population's oral health in recent decades masks significant inequalities between population groups and geographies. A more recent survey of adult oral health would be valuable, but there appears to be no evidence that the trends observed over recent decades have not continued; therefore, extrapolating from the 2009 results can provide a realistic picture for today. Regional variations are likely to become more acute without any changes in the care systems, given that population increases are forecast in metropolitan areas which already contain areas of high deprivation and that the elderly population in rural areas is expected to grow at a greater rate.

6.4. Access to all types of dental care has been significantly and disproportionately affected by the Covid-19 pandemic due to the issues relating to the use of Aerosol Generating Procedures (AGPs) in dental treatment and the virtual closure of dental practices between mid-March and early July 2020. This has consequences for both service delivery and the provision of dental clinical education and training.

Dentistry workforce

6.5. Dentistry workforce data is limited and there has not been a recent workforce survey to present a comprehensive picture of the composition, spread and hours committed to NHS services by dentists. Disparate workforce data is available and HEE examined some of this as part of an evidence review of dental education and training.[5] There are major variations in the average number of dentists per head of population[6] across England (see **Figure 1**). For example, in 2018, the average population size per NHS dentist in North

[2] https://digital.nhs.uk/data-and-information/publications/statistical/adult-dental-health-survey/adult-dental-health-survey-2009-first-release
[3] NHS Dentistry Services, House of Lords Briefing, 2019. Available here: https://lordslibrary.parliament.uk/research-briefings/lln-2019-0096/
[4] A Summary of Oral Health Data for England, Public Health England, September 2019.
[5] HEE (2020). Advancing Dental Care: Interim Evidence Report.
[6] This data takes account of appointments across all specialities across the whole population

West London was 797 at one end of the scale, while at the other it was 3,853 in Shropshire, Telford, and Wrekin, with a weighted average for England of 1,701.

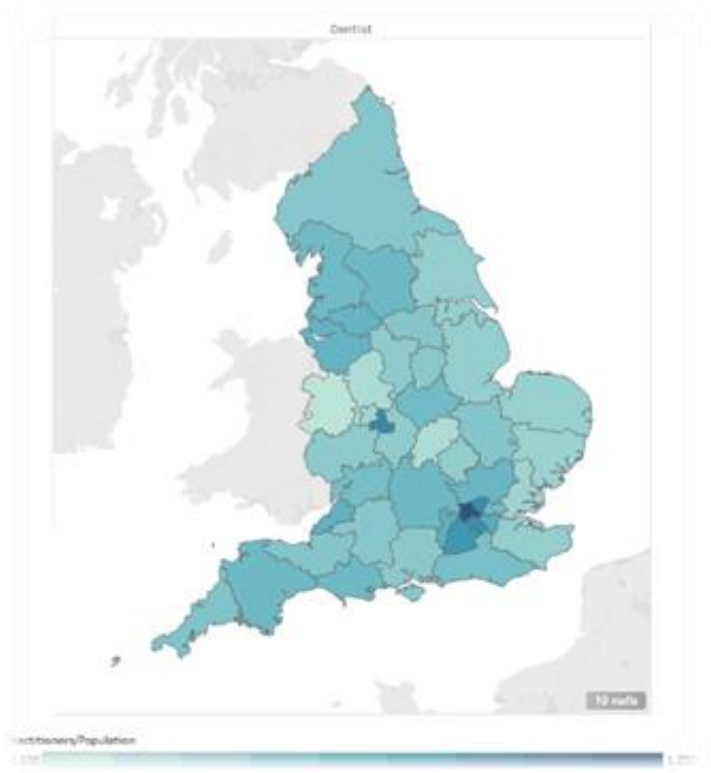

Figure 1: Dentists per 1,000 population (2018)[7]

6.6. There are major variations in the average number of dentists per head of population[8] across England (see Fig.1). In 2018, the average population size per NHS dentist in North West London was 797 at one end of the scale, while at the other it was 3,853 in Shropshire, Telford, and Wrekin, with a weighted average for England of 1,701.

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

6.8. There were 41,705 UK dentists registered with the dental workforce regulator, the General Dental Council (GDC), in 2017. The total number of dentists in England, including NHS primary and secondary care, including SAS[9] dentists, plus 'private-only' dentists, was 32,501 in March 2019. Although some might not be practising, working instead in research or overseas, for example, this equates to 5.8 dentists per 10,000 population.[10] Within England, the number of NHS primary care dentists varies from 12.6 dentists per 10,000 in

[7] Based on ONS population statistics and on GDC registrant data (2019)
[8] This data takes account of appointments across all specialities across the whole population
[9] Along with consultants and auxiliary staff, SAS dentists are a consistent presence in a department. They can establish continuity and stability in teams where the junior workforce frequently moves between posts. SAS dentists experience varies from recent completion of dental core training up to and including senior clinicians involved in senior management and training. As a result, they are uniquely positioned to play an important role in teaching, management and quality improvement.
[10] National Audit Office (2020). Dentistry in England.

Bradford City to 3.4 per 10,000 in West Norfolk and North Lincolnshire.[11] However, these data do not include information on whether or not the dentist is working full or part-time and recent trends indicate a greater move to part-time working.

6.9. In contrast to medicine, there is limited dental workforce data available to draw upon. Data is available from Electronic Staff Record (ESR) that highlights some of the NHS dentistry workforce in secondary care. For example, **Table 1** presents the number of specialist dentist consultants working in the NHS, mostly working in secondary care, with some holding posts community settings. However, HEE have found regionally that the ESR data does not correlate with the numbers of dental consultants known in dental hospitals. Consultants may not be identified as dentists and instead may put in the clinical division dentistry aligns to e.g surgery.

Region	2017 N (per 100k)	2018 N (per 100k)	2019 N (per 100k)
North East and Yorkshire	25.2 (3.0)	28.7 (3.4)	29.3 (3.4)
North West	31.3 (4.5)	30.4 (4.3)	28.8 (4.1)
Midlands	7.6 (0.7)	9.6 (0.9)	13.6 (1.3)
East of England	2.1 (0.3)	2.9 (0.4)	1.7 (0.3)
London	29.9 (3.4)	36.7 (4.1)	50.2 (5.6)
South East	6.2 (0.7)	8.1 (0.9)	5.3 (0.6)
South West	5.3 (1.0)	4.4 (0.8)	5.2 (0.9)
TOTAL	**107.5 (1.9)**	**120.6 (2.2)**	**134.1 (2.4)**

Table 1: Consultant dentists: total number and number per 100,000 population
Notes. Source: ESR; figures have been rounded.

6.10. Primary care workforce data, linked to NHS commissioning, has begun to be collected by NHSE/I and HEE is awaiting sight of this data across England.

6.11. Whilst HEE is not responsible for the recruitment of SAS dentists, the following ESR data in **Table 2**, from 2017-2019 illustrates the number of SAS dentists across England. This data may, however, be inaccurate as SAS dentists working in hospital trusts may not clearly identified as SAS 'dentists' on ESR but rather identified broadly as 'SAS'. SAS dentists may go on to undertake further postgraduate training at some stage in the career and a number of them have already completed some. This existing workforce may, therefore, move into new roles through further training.

Region	2017	2018	2019
North East and Yorkshire	24.0	36.6	52.8
North West	20.8	22.0	26.0
Midlands	8.3	10.1	18.7
East of England	0	1	1
London	39.8	50.9	55.2
South East	1	2	4
South West	18.5	20.7	18.6
TOTAL	**113**	**144**	**177**

Table 2: SAS dentists *Notes. Source: ESR; figures have been rounded.*

[11] National Audit Office (2020). Dentistry in England.

6.12. Dentists are working slightly fewer hours in the NHS than 10 years earlier: 25.7 hours in 2017/18 compared with 26.1 hours in 2006/7 in England.[12] Access to NHS dental services remains an ongoing issue for patients and access varies across the country. These differences are likely to be explained by many factors, including in some cases a shortage of dentists overall and in some cases the availability of private dental care to meet local needs. The lack of access to dentists offering NHS dental services in parts of England has often left patients with no access to an NHS dental practice, consequently leading to patients having to visit hospitals, general medical practitioners or perform their own treatments to manage dental pain.[13]

Workforce supply – postgraduate training

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

- One year of Dental Foundation Training (DFT)
- Dental Core Training (DCT; years 1, 2, 3)
- Dental Specialty Training[14] (DST; 3-5 years)

6.14. Appendix C presents recruitment data for ST1/4 posts in 2020/21; trainee numbers overall in 2020/21 are being reconciled in an exercise being completed by the end November 2020. Appendices D and E present trainee numbers and overall fill rates across England for these three postgraduate training programmes managed by HEE. Posts have consistently been filled, or close to filled, across all training programmes.

6.15. One workforce issue related to supply through postgraduate training we are aware of is the numbers of dentists on speciality lists, particularly in Oral Surgery / Special Care Dentistry and Additional Dental Specialities[15] has fallen. The number of trainees in training does not match those retiring from posts, the majority of which had been grandfathered onto these lists.

Workforce supply - undergraduate

6.16. HEE supports in the quality management of undergraduate dentistry clinical placements and provides placement funding across years 2-5 of the five-year degree. As with medicine, undergraduate dentistry student intake numbers for home and international[16] students are capped by government; more than 800 places are available each year in England (see **Table 3**).

[12] ADC calculations based on data from NHS Digital - https://digital.nhs.uk/data-and-information/publications/statistical/dental-working-hours
[13] NHS Dentistry Services, House of Lords Briefing, 2019. Available here: https://lordslibrary.parliament.uk/research-briefings/lln-2019-0096/
[14] https://www.gdc-uk.org/registration/your-registration/specialist-lists
[15] Additional Dental Specialties includes Dental and Maxillofacial Radiology, Oral and Maxillofacial Pathology, and Oral Medicine.
[16] Applicants who are from countries outside of the European Economic Area are defined as international students.

6.17. The 2020-21 data has not been released yet but the ratio of applicants to acceptances is anticipated to be the same at over 3:1. In 2020/21 intake, the cap was lifted, leading to additional places in universities. This, however, may not translate to additional dentists graduating in 2025.

Year	Graduation	Applicants	Acceptances
2017/18	2022	2620	840
2018/19	2023	2780	835
2019/20	2024	3175	825

Table 3: Dentistry undergraduate intake numbers[17]

Immigration changes and EU Exit

Overview

6.18. Individuals can register as a dentist with the GDC if they possess a recognised qualification from a UK institution, an EEA/Switzerland qualification as part of EU directive 2004/38/EC, or a select number of recognised overseas qualifications.[18] Dentists from outside the EEA whose qualifications are not recognised for full registration with the GDC need to take the overseas registration examination (ORE) and obtain the necessary permits/visas to stay and work in the UK. [19] Temporary registration is available allows dentists who are not eligible for full registration to practise dentistry in the UK in secondary care if they have had the offer of a supervised post for training, teaching, or research purposes only, for a limited period.[20]

6.19. As shown in **Table 4**, two-thirds of new dentists joining the register in 2019 were from the UK, with the remainder coming from the European Economic Area (EEA) and from other areas beyond the EEA, entering the register either via the GDC's ORE or directly as a result of the recognition of their home country qualification. It is notable that 32% of EEA-qualified dental registrants surveyed by the GDC are considering leaving the UK in the next few years.[21]

Regions of Qualification	Registrants	% of total
UK Qualified	1,131	65%
EEA Qualified	398	23%
ORE (UK overseas registration exam)	195	11%
Overseas Qualified	13	1%
TOTAL	**1,737**	

Table 4: New additions to the register in 2019 by region of qualification

[17] Source: *HEE data programmes team and OfS: https://www.officeforstudents.org.uk/advice-and-guidance/funding-for-providers/health-education-funding/medical-and-dental-intakes/;*
[18] https://www.gdc-uk.org/registration/join-the-register/how-to-join-the-register
[19] https://www.gdc-uk.org/registration/join-the-register/how-to-join-the-register
[20] https://www.gdc-uk.org/registration/join-the-register/temporary-registration
[21] Survey of European Qualified Dental Professionals, General Dental Council, January 2019.

6.20. The UK left the European Union on 31 January 2020 and the transition period ended on 31 December 2020. Registration arrangements after 31 December 2020 will depend on the outcome of negotiations that took place over the course of the transition period. Dentists are not on the shortage occupation list compiled by the Migration Advisory Committee.[22]

Dentistry education and training reform: Advancing Dental Care

6.21. HEE's Advancing Dental Care (ADC) Education & Training Review[23] was commissioned in 2017 to develop a dental education and training infrastructure that supplies a dental workforce, consisting of dentists and dental care professionals (DCPs), with the skills to respond to the changing oral health needs of patients and services.

6.22. The Review's first phase concluded in 2018 with the ADC Report, setting out 21 recommendations for further developing HEE's evidence-base and understanding of the dental workforce required for the future NHS, with the aim of safeguarding dental workforce sustainability and supply.[24]

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

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

6.24. Findings from evidence gathering in 2018-2020 demonstrated the need to consider alternative models of training that were more flexible and training experiences in varied settings. The importance of building better training pathways for the whole workforce, for both dentists and DCPs, was clear. This included opportunities to carry out academic training pathways and learn and develop leadership skills. Furthermore, our Review suggests that, in keeping with the direction of travel indicated by the NHS Long Term Plan and Interim People Plan, more multi-disciplinary working will be desirable in future. There is evidence to suggest that dentists could be released for more complex work if other members of the dental team (DCPs) were working to the limit of their full scope of practice.

6.25. 2020-21 is the final year of the review and workstreams are focusing on developing education and training models for the whole dental workforce including two-year longitudinal foundation training and two-year broad based training (combining two years of current DCT training). This builds on successful pilot programmes that have been carried out in a similar format, in contrast to the one year DFT and DCT posts that are commonly available. Further work is focused on developing career pathways in primary care for

[22] https://www.gov.uk/government/publications/review-of-the-shortage-occupation-list-2020
[23] https://www.hee.nhs.uk/our-work/advancing-dental-care
[24] https://www.hee.nhs.uk/our-work/advancing-dental-care

dentists and DCPs and exploring credentials for the dental workforce. The benefits of workforce transformation identified so far by the ADC Review include:

I. improving the skills and competencies of dental professionals to support them to carry out future roles in line with their full scope of practice and capabilities;
II. improved flexibility within individual training pathways and between other training pathways (as stated in Interim NHS People Plan);
III. improved training quality and learner experiences compared to existing models;
IV. establishing new and effective training models that can be delivered to more learners across HEE regions;
V. improved retention of the NHS dental workforce.

6.26. Another strand of the ADC Review programme is focused on building models and options for the re-distribution of postgraduate training posts (DFT, DCT, DST) more equitably across the country to meet local service and population needs.

6.27. HEE continues to engage closely with key stakeholders across the systems, including NHSE/I, Royal Colleges, GDC, BDA, DCP representative groups, members of the profession and patients and public in developing models of training and examining options for the redistribution of training posts. The Review is also taking account of the impact of COVID-19 on education and training and opportunities for modifying training programmes as a result, such as the utility of virtual training sessions and streamlined recruitment. The Review will culminate in a report in Spring 2021 to HEE Executive presenting recommendations on the future direction of HEE training programmes and commissioning.

Impact of COVID-19

Implications of first wave (approximately March 2020 onwards)

Postgraduate

6.28. **Dental Foundation Training (DFT).** For trainees completing training in 19/20 whose training had been significantly interrupted, a new Outcome ('Outcome 6C'[25]) was developed to manage dental foundation trainees (known as Foundation Dentists) that were judged to be able to work independently in NHS primary dental care services but required focussed development and support in identified competency elements to demonstrate proficiency in those areas that would lead to satisfactory completion of training (Outcome 6). The majority of Foundation Dentists achieved an Outcome 6, with only 23% (approximately 110) receiving an Outcome 6C confirmed by the Final Review of Competency Progression (FRCP). The 20/21 cohort are being monitored closely to consider progress in the context of further impacts of COVID-19 and whether similar arrangements may need to be put in place.

6.29. **Dental Core Training (DCT).** DCT trainees were not impacted as badly as Foundation Dentists as they were able to be redeployed in some areas and continue elements of training, albeit in an adapted way. FRCPs have been completed for DCT trainees. Of 531

[25] https://www.copdend.org/wp-content/uploads/2020/07/Blue-Guide-Supplement-5-v1.4.docx

Dental Core Trainee in England, 521 (98%) received a satisfactory outcome at FRCP (Outcome 1). Nine trainees received an Outcome 10 (Covid-19 related) and one trainee received an Outcome 2 (further development required).

6.30. **Dental Specialty Training (DST).** The impact of COVID-19 on DST will not be clear until specialty examination results are known and ARCPs have been completed.

Undergraduate

6.31. COVID-19 has impacted on clinical training opportunities due to the use of aerosol generating procedures potentially spreading the virus. This may affect students graduating on time and with the required competencies to practice as a safe beginner in Foundation training from September 2021.

6.32. Progression of students in being monitored closely by the Dental Schools Council (DSC) and other stakeholders including HEE. A statement from the DSC[26] laid out potential scenarios for the 20/21 cohort of dentistry undergraduates including students graduating on time, extending their study and delaying entry into the workforce, and putting in place provisional registration. The first scenario most preferred, whereby personal development plans would be used for students who had met the GDC learning outcomes, but who, in the opinion of the dental school would benefit from further targeted experience prior to independent practice.

6.33. Finally, following the problems encountered with the scoring of A-level and equivalents earlier in the year, there has been an increase in 20/21 dental undergraduate places by approximately 100. This will have an affect on HEE's business in five years when this larger than average cohort will graduate and move on to foundation training.

<u>Mitigating implications of second wave (approximately September 2020 onwards)</u>

Postgraduate

6.34. **DFT**. Due to the COVID-19 and ongoing restrictions, it has been decided to make changes to the DFT national recruitment system for this year in England, Wales and Northern Ireland. The main change is that the application process will consist of the Situational Judgement Test (SJT) only. Further information is on the COPDEND website, including some practice SJTs.

6.35. Placement of Dental Foundation trainees to other roles and workplaces across primary and secondary care will be approved by the Associate Postgraduate Dental Dean and Postgraduate Dental Dean and the employer of the trainee.

6.36. Outcome 6C may be retained for Foundation Dentists who have been unable to demonstrate all curriculum requirements due to the pandemic but are safe to successfully exit the programme. In these cases, the outcome will outline the outstanding requirements and provide the dentists with a personal development plan for obtaining

these competencies. The COVID-19 outcome 10 will remain an option to use for speciality and core training ARCP outcomes.

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

6.38. Further guidance can be accessed here: https://www.hee.nhs.uk/coronavirus-information-trainees

Undergraduate

6.39. All undergraduate dental students will continue their academic learning, restart placements that were paused during the first wave and commence scheduled clinical placements as part of their programme. There are no plans for redeployment. Dental Schools Council (DSC) and the Association of Dental Hospitals (ADH) have published a new report outlining a set of guiding principles to support all UK and Irish dental hospitals and schools towards the safe return to educational placement provision within open plan clinics. This can be accessed here: https://www.dentalschoolscouncil.ac.uk/wp-content/uploads/2020/09/COVID-19-Planning-return-to-Open-Plan-Clinics-Guiding-Principles-to-mitigate-risk.pdf

6.40. HEE are working closely with DSC, ADH and the GDC to monitor undergraduate progression, it is likely that there will be a reduced number of UK dental undergraduates , graduating by Sept 2021 , which may impact on Dental Foundation Training numbers in 2021.

Health Education England
January 2021

Appendix A

Recruitment into specialty at CT/ST1 – 2020/21

Specialty	Level	Posts	Accepts	Fill Rate
Acute Internal Medicine	3	113	98	86.73%
Allergy	3	4	4	100.00%
Audio vestibular Medicine	3	9	6	66.67%
Cardiology	3	102	102	100.00%
Clinical Genetics	3	9	9	100.00%
Clinical Neurophysiology	3	10	10	100.00%
Clinical Oncology	3	55	55	100.00%
Clinical Pharmacology and Therapeutics	3	13	7	53.85%
Dermatology	3	42	42	100.00%
Endocrinology and Diabetes Mellitus	3	75	75	100.00%
Gastroenterology	3	76	76	100.00%
Genito-urinary Medicine	3	56	25	44.64%
Geriatric Medicine	3	200	159	79.50%
Haematology	3	85	85	100.00%
Immunology	3	12	11	91.67%
Medical Oncology	3	30	30	100.00%
Medical Ophthalmology	3	1	0	0.00%
Metabolic Medicine	3	12	9	75.00%
Neurology	3	61	58	95.08%
Nuclear Medicine	3	0	0	0.00%
Occupational Medicine	3	14	12	85.71%
Palliative Medicine	3	53	53	100.00%
Paediatric Cardiology	4	7	7	100.00%
Rehabilitation Medicine	3	30	22	73.33%
Renal Medicine	3	70	70	100.00%
Respiratory Medicine	3	83	83	100.00%
Rheumatology	3	38	38	100.00%
Sport and Exercise Medicine	3	11	11	100.00%
Ophthalmology	3	16	16	100.00%
Obstetrics and Gynaecology	3	34	34	100.00%
Paediatrics	3	38	38	100.00%
Paediatrics	4	83	79	95.18%
Child and Adolescent Psychiatry	4	74	55	74.32%
Forensic Psychiatry	4	43	36	83.72%
Forensic & Child & Adol Psychiatry	4	5	1	20.00%
General Psychiatry	4	221	120	54.30%
General & Forensic Psychiatry	4	3	3	100.00%
General Psychiatry & Med Psychotherapy	4	11	11	100.00%
General Psychiatry & Old Age Psychiatry	4	95	62	65.26%
Medical Psychotherapy	4	2	2	100.00%
Old Age Psychiatry	4	75	30	40.00%
Psychiatry of Learning Disability	4	60	14	23.33%
Learning Disability & Child & Adolescent Psy	4	8	6	75.00%
Forensic Psy & Medical Psychotherapy	4	2	2	100.00%

Combined Infection Training	3	58	58	100.00%
Diagnostic neuropathology	3	2	0	0.00%
Paediatric and perinatal pathology	3	9	7	77.78%
Cardio-thoracic surgery	3	6	5	83.33%
Neurosurgery	3	1	1	100.00%
General and Vascular Surgery	3	94	94	100.00%
Oral and Maxillo-facial Surgery	3	20	11	55.00%
Otolaryngology	3	17	17	100.00%
Paediatric Surgery	3	5	5	100.00%
Plastic Surgery	3	38	38	100.00%
Trauma and Orthopaedic Surgery	3	125	96	76.80%
Urology	3	44	44	100.00%
Anaesthetics	3	411	411	100.00%
Intensive Care Medicine	3	249	240	96.39%
Emergency Medicine	3	46	33	71.74%
Emergency Medicine	4	46	39	84.78%
General Practice	1	3,750	3,793	101.15%

Appendix B

2020/2021 – GP Target Enhanced Recruitment Scheme (TERS)

Programme	Places	Accept	Fill
East Midlands – Boston	11	11	100%
East Midlands – Lincoln	7	7	100%
East Midlands - Sherwood Forest	12	12	100%
East of England - Colchester & Ipswich	6	6	100%
East of England - Great Yarmouth	6	6	100%
East of England - King's Lynn	6	6	100%
North East - North Cumbria	20	20	100%
North East - Rural Coastal County Durham & North Yorkshire	33	33	100%
North West – Blackpool	19	19	100%
North West – Lancaster	12	12	100%
North West - South Cumbria	5	5	100%
South West - North Devon	6	6	100%
South West – Plymouth	25	25	100%
South West – Somerset	13	13	100%
South West – Swindon	12	12	100%
Wessex - Isle of Wight	9	9	100%
West Midlands – Hereford	6	6	100%
West Midlands – Shropshire	7	5	100%
West Midlands - Staffordshire (East)	2	2	100%
West Midlands - Staffordshire (North)	7	7	100%
West Midlands - Staffordshire (South)	2	2	100%
Yorkshire and the Humber - Hull GP Scheme	32	32	100%
Yorkshire and the Humber – Scarborough	9	9	100%
Totals	**267**	**259**	**100%**

Appendix C

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

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

*Regional data is unavailable as currently being reconciled.

Appendix D

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

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

Appendix E

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

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