NHS England

Addressing Health Inequalities: Distribution of Medical Specialty Training Programme – London region

Distribution of Medical Specialty Training Programme was formerly known as Medical Specialty Distribution Programme.

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Contents

Frequently asked questions (FAQs)

The questions and comments included here are based on feedback we have received via our stakeholder engagement work and the London Programme mailbox: londonmedicaldistribution@hee.nhs.uk

We have grouped questions and comments under common themes. We will be updating this document and sharing it with stakeholders as the programme progresses, so please email the team with your questions.

Programme objectives / drivers

1. Is funding the only driver for this programme?

The main purpose of the programme is to ensure that there is equitable distribution of Health Education England (HEE)-funded (tariff) specialty training posts and related funding so that it aligns with population need. This is to help address health inequalities across England. This is a cost neutral programme, but equitable allocation of funding is a driver. HEE (now part of NHS England) has a budget which we are required to fairly allocate across the country.

Funding is a key consideration along with others, including training capacity and where services are delivered nationally. The modelling shows there is a current imbalance between HEE (now NHS England) funding and service demand. The result with be an evidenced-based distribution to deprived rural, remote, and coastal areas.

The programme aims to distribute trainees more evenly across England, in other, historically less well served places outside London. London is one region that will be providing posts for distribution. There is evidence that trainees tend to stay in the areas in which they train. By training in these less well served areas, where future consultants will be needed, we expect to see improved local population healthcare outcomes through more robust local service provision.

2. We can all buy-in to the idea of improving health outcomes across England but saying you want to decrease variation will just make it a bit worse in one place and a bit better in another. The real problem is not that London is overstaffed, it's that there are not enough staff across England.

NHS England (NHSE) acknowledges many services are under pressure. Nevertheless, significant health care inequalities exist across England, and we need to develop services within the current Department of Health and Social Care's (DHSC) financial parameters. It offers an opportunity for us to review training and staffing in London and look at other models in which we may deliver services.

3. Have the drivers for trainees, selecting a location for training, been investigated as this may ultimately impact on selection of consultant post?

The remit of this programme relates to the locality of doctors in training posts across England. Fill rates of posts as they move will be closely monitored. Data shows that people are most likely to stay in close proximity to where they train and this programme aims to help future trained workforce supply in these areas.

As part of this, Inter Deanery Transfer requests and approvals will also be monitored for impact alongside fill rates.

4. Does a provision of Ockenden posts not indicate that there was assessment that more trainees were needed in London?

The Ockenden Report has highlighted the requirement for additional Obstetrics and Gynaecology training posts across the country with time-limited expansions currently in many regions.

5. It would help, from an administrative aspect, to make HEE (now NHS England) approval for trust-funded posts easy. Can this be looked at please?

The existing process for approval for trust-funded training posts will be modified to include recommendations arising from the Maximising Training Opportunities process.

6. If the programme is about moving funding, why are we not allowed to create more trust-funded posts to fill the gaps created?

As mentioned in the answer to question 1, funding is not the only driver for the programme. Creating trust-funded posts to replace the HEE-funded posts would undermine the premise of distributing HEE-funded training opportunities more equitably.

7. Shouldn't redistribution focus on trusts with a higher proportion of HEE-funded posts? There is enormous inequity in this proportion between trusts.

   The decision to move posts is based on advice from specialty training leads and heads of school to ensure programmes remain balanced and curriculum opportunities in London are maintained. As part of this process, we are looking at the intra-London distribution of posts; both at ICB and trust level, and are including HEE and trust-funded posts. Modelling is being done at a national level to support this.

Programme decision-making

1. How will Training Programme Directors (TPDs) play a role in helping to shape the programme in its ongoing development and implementation?

   National task and finish groups exist for each forerunner specialty and include input from a variety of stakeholders. TPDs will be pivotal in creating the plans for London as the programme develops. Our preferred approach is undertaking Maximising Training Opportunities (MTO) evaluation to ensure that the best possible training programmes, taking account of health inequalities, are the outcome.

2. How will TPDs and other leads be supported to undertake this work on top of their current workload?

   We acknowledge that the Distribution programme is going to require engagement and dedicated input from our specialty schools and leads. As each specialty undertakes this work, NHS England (NHSE) colleagues will be working with Heads of Schools and clinical leads, throughout the lifespan of the programme, to support them to deliver this programme. Where there is additional resource available to support implementation, this will be discussed with schools.

3. How will decisions be made on where posts in London will be removed and at what pace?

   Once the overall agreement on numbers and sequence of specialties has been reached, we will use the national modelling framework and the MTO process to identify which sites are affected. This is complicated for London as we will need to consider trust-funded training posts and overall training capacity. There is a London oversight group with representation from NHSE and the educator network. In addition, each specialty will be drawing up a proposed implementation plan for approval by the oversight group.

4. Does the redistribution take into account attrition rates of trainees?
   No, the specialty task and finish groups for the initial three specialties did consider this but it was deemed to be a Local Office operational aspect and out of scope of the programme.

5. This is going to be a huge work undertaking. Is HEE (now NHS England) paying for the extra work we will have to do on this project?
   This will be looked at on a school-by-school basis, both from a Training Programme Director and potential fellow perspective.

6. Can HEE approve the creation of trust-funded posts to promote local trust level solutions to attract good international candidates?
   The Medical Training Initiative (MTI) is a national scheme designed to allow a small number of doctors to enter the UK from overseas for a maximum of 24 months, so that they can benefit from training and development in NHS services before returning to their home countries. You can find more information on the MTI process on the Academy of Medical Royal Colleges website.

7. What is the strategy for increasing the number of trainers and the training infrastructure in 'rural and coastal areas' where currently there are no training facilities?
   There are national projects for both enhanced remote and rural educational resources and remote supervision; these projects are currently underway. Before any post is moved, there will be assurance from the local Postgraduate Dean that there is capacity for training at the receiving site. The programme will also take into account the developing educators' strategy. You can also find more information on the rural and coastal work underway.

Chosen specialties

1. Why have these three specialities (Obstetrics and Gynaecology, Cardiology and Haematology) specifically been chosen as programme forerunners?
   These three specialties have been chosen because there was already evidence that the distribution of posts across the country does not match local patient need and they are also popular choices for doctors, with high fill rates.

Data

1. Will both the national and regional modelling data be made available?

An intra-regional distribution tool is in development which will show, at a granular level, the most equitable distribution of training posts within each region based on information available and included in the modelling.

This will be made available as a guide for local systems to use when commissioning and decommissioning posts. Data will be discussed with Heads of Schools and their faculty at the appropriate time. More granular detail will be available at Integrated Care Board (ICB) level in due course.

2. Is the calculation about training numbers related to population?

Over the last 30 years, the NHS has developed sophisticated modelling techniques to guide the allocation of resources against current need. The current model takes into account over 150 separate factors to determine population-weighted healthcare need.

This is combined with NHSE's demand forecasting model that utilises Hospital Episode Statistics alongside Office for National Statistics population projections to understand growth in demand for key hospital services in the future, and gives weighting based on regional deprivation.

This provides a robust method for understanding the distribution of future healthcare demand on the medical workforce. The model provides a reliable and transparent methodology on which to base the distribution of trainee posts across regions which can be revisited if changes occur.

Regions receiving posts will only be able to accept these placements if they can meet training quality standards and have sufficient training capacity.

More information on the modelling will be made available from the national team. The modelling details the variance across regions as well as funding sources.

3. Why are none of the attrition post numbers divisible by 7 which is the number of years of training? How does the methodology for this work then?

Each phase (A,B,C) is expected to last for approximately 5 years. We are, therefore, working to this timeline. It is also worth noting that not all programmes are 7 years in length and the pace of change will be informed by a variety of factors.

4. Is this modelling data available to TPDs for our specialties?

The data will be made available to anyone with a HEE email address via Tableau; this will include all TPDs. However, the data is not yet available on this platform due to ongoing work in the National team to ensure this is accurate before sharing more widely. It is worth noting that the data can change and is refreshed once any expansion numbers are confirmed. Once this is available, we will provide guidance on how to access the platform.

Programme exclusions

1. Will current trainees be required to move programmes?

The programme is looking at training posts not trainees. Trainees will remain within their current programmes and be accommodated via rotation planning as they would now. HEE-funded training posts, and the resource allocation attached to the post, will only move when a post becomes available in the donor area.

Expansion Programme

1. What is the Expansion Programme, and will it have an impact on this programme?

The NHS Long-Term Plan set out the five-year ambition for service delivery from 2019, but COVID-19 placed unprecedented, unpredicted demands on the NHS workforce.

The most recent Spending Review supported an initial boost to medical specialty training posts by 1000 posts over the course of the three-year spending review, to support three priority areas:

- Elective recovery
- Acute and urgent care
- the response to the Ockenden report.

This is in addition to the previous commitments to increase the medical workforce in Cancer and Diagnostics, Mental Health, and General Practice, all highlighted as Long-Term Plan priorities.

How much the expansion plans impact on the distribution workstream will vary depending on the specialty.

For instance, there will be an additional 40 training posts in total across Obstetrics and Gynaecology this year nationally and they are being distributed using the same methodology, as the MSD Programme. Within London, Obstetrics and Gynaecology will lose seven permanent, HEE-funded training

posts this year and will gain seven posts (fixed term appointments for junior doctors), via the Expansion Programme resulting in the same number of trainees for this year.

The received posts are time limited to the length of the programme, after which time funding is expected to be reviewed. We anticipate that there will be further expansion next year and the year after, but this requires sign off from the Department of Health and Social Care (DHSC).

2. Are the expansion posts time limited in funding?

Yes, currently the expansion posts are temporary. Posts will be time-limited for the duration of specialty training and this will vary depending on the length of each programme.

3. What happens after the additional 1,500 foundation doctors complete their programmes in 2025?

We are only three years away from having 1,500 additional doctors ready to enter specialty training. NHSE is aware that they need to plan how they are going to be accommodated. This work needs to be completed jointly with the DHSC and will evolve in the coming years.

4. What is the expectation of trusts receiving expansion posts?

Expansion posts are decided at a national level and will be linked to demand and service delivery in line with the NHS Long Term Plan. Further expansion is expected for 2024 and likely beyond. However, exact figures for regions have not yet been confirmed.

Training experience / commitment to training quality

1. How will NHSE ensure the standard of training is appropriate in new locations?

HEE will not be moving training posts unless the local Postgraduate Dean is able to assure all key stakeholders / the wider healthcare system that there is local capacity to train and deliver the full curriculum, taking into account specific training elements.

In addition to local assurance, there are two Task and Finish groups within the programme tasked with enabling and supporting gaining locations. These are the:

- Remote, rural, coastal, and small training locations group, including a delivery network incentivising and preparing locations

- Creating Educational Capacity group tasked with piloting alternative supervision models whilst in a period of growth and supporting gaining locations.

2. The loss of training posts potentially impacts on the remaining trainees' experiences. How will that be mitigated?

We are very aware that the impact on training, the training programme, the reduction in numbers, fewer trainees having to do more work and trainers having to do more clinical work are very present risks, which are all on the programme's risk register.

To mitigate against these risks, NHSE is looking at various different potential methods of delivering the workforce in the future. This includes expanding the multi-professional workforce as well developing Certificate Equivalence Specialist Registration (CESR) training programmes, Staff and Specialty (SAS) doctors and locally employed doctors. London will also have opportunities to offer international doctors experience.

3. Could a consequence of this be that trusts decide to set up their own training programmes through the CESR route and are there any plans to mitigate against this?

The decision to run CESR is a trust decision. NHSE will monitor any impact on quality of training and aim to support good training opportunities.

4. If we cannot fill rotas with other types of trainees, we will need to run reduced rotas or the increased stress will have a detrimental effect on trainees.

Each trust will need to ensure safe rotas are maintained. NHSE can help you, through workforce transformation planning, to ensure the resulting workloads are maintained to appropriate levels to ensure quality patient care.

5. How do we appropriately train the future workforce in specialist areas beyond the curriculum?

Where this is a curricular requirement, programmes will need to ensure that this is available. Where this is beyond the requirements of the curricular, the training opportunities exist as Out of Programme Experience (OOPE) or post CCT.

Trainee movement

1. What does the MSD Programme mean for those trainees wanting to apply for inter-deanery transfers (IDTs) into London?
   As London programmes reduce posts, there are unlikely to be the same number of posts available to be offered up for IDTs.

2. Has anybody considered that the desire to choose London as a base starts before people become trainees / get to registrar level? People put down roots in London to stay in London.
   The new medical schools being established across the country (in England) have been placed in areas with the intention that the people who go to medical school there will hopefully stay and settle there, so an attempt has already been made to try and address this long-standing training imbalance.

3. How would we promote local trust level solutions to attract good international candidates?
   The Medical Training Initiative (MTI) is a national scheme designed to allow a small number of doctors to enter the UK from overseas for a maximum of 24 months, so that they can benefit from training and development in NHS services before returning to their home countries. More information on the MTI process can be found on the relevant college websites.

4. We are training more medical students than ever since the new medical schools / places opened and they need specialty training posts to go to, so we need more NTNs (National Training Numbers), rather than shuffling around a too-small number.
   The modelling is currently aligned to the NHS Long Term Plan and will be updated in line with the new Workforce Plan once available.

Service delivery / quality and patient safety

1. What work has HEE done to mitigate the threat to services that the removal of these posts will pose?
   NHSE London has delayed the number of posts being distributed in 2022 in recognition of the tight timeframes needing to be met. Longer term services will need a broad response plan that takes account of service demands, Covid recovery and education.

NHSE will need to work jointly with trusts to better understand the impact of removal of posts on service provision. NHSE is developing workforce planning tools to develop solutions around this and wants to work with affected stakeholders / trusts and Integrated Care Boards (ICBs).

2. How will smaller trusts with limited registrar numbers be supported?

The programme is looking to ensure that the training posts are fairly distributed across the whole of London. Once the modelling is done, there will be an opportunity to risk assess the impact and support focused solutions.

An intra-regional distribution tool is currently being developed which will show at a granular level the fairest distribution of training posts within each region.

3. We already have difficulties balancing the competing demands of higher specialty training in medical specialties with those of maintaining the acute medical take. Can you ensure that this problem is not exacerbated by the loss of medical training posts?

Across the programme, we are ensuring we consider the balance of all group 1 medical specialty training programmes and how they are impacted individually and collectively by the distribution programme. As well as modelling being done across all group 1 specialties to understand the overall impact, issues such as the potential challenges for the medical take rota will form part of specialty discussions.

We are also engaging with service providers and ICBs to ensure conversations are joined up. There is an acknowledgement that London is not 'over-doctored' and a reduction in trainees may have an adverse impact on remaining trainees. Work is being done to understand this impact and to look at what can be done to alleviate additional pressures.

Pace

1. Why is this programme being rolled out now when the service is challenged?

There has been a long-standing desire to address the health inequalities across England and to 'level up' the national situation, from those within the wider healthcare system and from the Government.

The programme will be rolled out in three phases, all of which will be five years or more in duration.

There will never be a good time for this piece of work to be undertaken and steps are being taken to agree realistic training post numbers as much as

possible and to offset these numbers through specialised commissioning and other means. This aligns with the DHSC policy around addressing health inequalities.

2. This change is happening at the same time as problems with staffing of midwives and other Allied Health Professions in London. Would it exaggerate the gaps in quality which has already been highlighted in the Ockenden review of trusts?

We appreciate that there are ongoing clinical staffing challenges across London and due to the continuous developments within healthcare, finding an ideal time to start this distribution work is challenging. There will always be challenges within the workforce and other factors that need to be taken into consideration when carrying out workforce planning. To ensure clinical teams can continue to function safely throughout distribution, clinical leads and TPDs will be leading much of this work and providing clinical expertise to ensure any post movement does not have an unforeseen detrimental effect as we go through this process.

Where there is an identified shortfall within the workforce, specialties will work with their regional NHSE Workforce Transformation Team to review and assess the available workforce options to ensure that high quality services can be maintained. Work has already started on a National Workforce Transformation Toolkit that will be rolled out when ready. The workforce transformation team in London are also supporting the task and finish group process and are on hand for specialties to liaise with for additional support or consultation.

NHSE colleagues are supporting the implementation of the Ockenden recommendations, as well as the ongoing Maternity Transformation work.

Impact of HEE and NHSE integration

1. What will this programme look like when HEE and NHSE merge? And how will Integrated Care Boards deal with this?

This programme has been led jointly by NHSE and HEE with both Executive Teams signing off this programme. The integration of both these two organisations will take some time. The role of the ICB will become increasingly important in service delivery and their workforce requirements, of which this is a major part.

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