



Medical and Dental Workforce Development



East Midlands Strategic
Health Authority
Octavia House
Interchange Business Park
Bostock's Lane
Sandiacre
Nottingham
NG10 5QG
T: 0115 968 4444
F: 0115 968 4400
www.eastmidlands.nhs.uk



Background

It has been recognised for many years that planning for the future medical and dental workforce is extremely complex. This is because of the ever increasing rate of change in service delivery resulting from the use of new technology, drugs and developments in patient care, the long lead times for medical and dental education and the international nature of the medical and dental labour market (in particular, the extent to which the number of countries that are net importers are increasing). The situation is exacerbated by the changing demographics of the population; ageing populations experience more ill health and disease and thus require more healthcare interventions. In addition, the population as a whole is less active, significantly more obese and advances in healthcare mean that an increasing proportion of the population live with disease and/or disability which in previous generations would have rapidly caused death. This not only increases the need for medical intervention but also requires adjustments in the balance of doctors working in primary and secondary care and the balance between specialities.

It is also worth noting that there are 67 nationally approved specialty training programmes (including GP) and in excess of 20 sub-specialties. All this makes matching medical and dental workforce supply and demand a very difficult activity.

In the past the majority of the planning has been undertaken at a national level, with variable results, although in general the processes have served the NHS well. Nonetheless, the pace of change and the extent of regional variation has increased and this requires adjustments to these processes. One of the recently identified regional factors is the extent to which the medical workforce has become relatively immobile, in comparison to historical norms. In recent years the evidence has been collected and collated by the Workforce Review Team. Whilst this national process has merit, especially for the smaller specialities, it generally lacks regional sensitivity in assessing future demand and as a direct consequence reduces regional and local ownership of the challenges and decisions.

Since the inception of NHS East Midlands we have been considering this process and have undertaken some small scale work in this field in conjunction with the Local Health Community Workforce Teams. It is clear that the implementation of *A High Quality Workforce*, with the emphasis on improved workforce planning, has raised the level of debate on how processes can be improved for medical and dental workforce planning for 2009/10. Beyond this there is the need to embed this within mainstream healthcare workforce planning so that interconnections with other staff groups are made and understood. This section outlines what has already been done and what needs to be done to achieve the best outcomes for the future.

It is important to note that medical and dental student numbers remain centrally controlled but it would be anticipated that such commissioning of student numbers would be adjusted in due course in response to more sophisticated planning of training and trained doctor numbers at a local or regional level.

National Context

There are some major national issues that have and will continue to influence how NHS East Midlands takes this forward and it is worth stating these as the back drop.

- The implementation of Modernising Medical Careers with changes in the balance between education and service for junior doctors and the introduction of explicit training and nationally approved curricula for all specialities
- The demographic changes in the medical and dental workforce (currently approx 60% of medical students and 70% of dental students are female)
- The recognition that there is an insufficient supply of GPs (to meet changes due to retirement and in addition to address any enhancement in GP activity)

- The possibility of a move from 3 to 5 year training for GPs
- The suggestion that there may well be oversupply in some specialities
- The introduction of the Working Time Regulations (WTR) for doctors in training
- The recognition that there is a significant uneven distribution of both career grade and junior doctor posts across the regions; due to historical factors
- The continuing inability of some patients to gain access to NHS dentists
- Changes to the educational curriculum in a number of specialties at national level

East Midlands: Initial Work 2008/2009

• Medical Workforce Baseline

A project was undertaken to establish a full picture of the existing medical workforce and the likely increase needed due to population based demographic change. This was set against the likely output from education over the next 5 years if no changes were made to the number or speciality of new trainees. This gave some basic indicators of the likely over or under supply. This did give a good picture of the existing workforce but the lack of granulation in the detail meant it was only helpful in providing a broad picture of the balance between demand/supply.

• Modelling GP Demand/Supply

In response to the national indications of a required increase in GP workforce i.e. an increase in whole time equivalent (WTE) a project was undertaken in the East Midlands to model the future number of new GP trainees that would be needed. This was dependent on agreeing the level of practising GPs that would be needed in the future workforce. This whole system model is now complete and is a useful tool to prompt discussion and debate. It will also be useful to model the changes if there is a move to five year training.

• Emergency Department Medical Staffing

There was an increasing concern about the sustained achievement of targets in Emergency departments. Often problems with medical staffing were quoted as one of the main reasons behind this. A project was commenced to examine the evidence and to pinpoint the major issues. The hypothesis was that the change arose from changes in working patterns and service provision due to WTR and adjustments to the education and training curriculum and assessment framework. This was being compounded by the inability to find locum cover or a reliable source of SAS or Trust grade employed doctors (a situation that applies across the UK).

• Dental Workforce

Work has been undertaken with NHS Yorkshire and the Humber to understand the workforce planning and education commissioning system for the dental workforce. All but Northamptonshire has been served by the Dental Deanery in Sheffield while Northamptonshire is served by Oxford. All East Midlands counties will be served by Sheffield from 2010.

• Working Planning round 2008/2009

It was recognised that in the 2008/09 planning round by the Local Health Communities and the SHA medical and dental staffing was only featured where there was an interconnection with other staff groups. The workforce plan was the poorer as a result.

Introduction of a High Quality Workforce and Working Time Regulations

• Workforce Planning round 2009/10

The introduction of *A High Quality Workforce* has meant that all workforce planning will come under greater scrutiny and this will be both at regional level (Regional Advisory Mechanisms) and national level (MEE, other professionals boards and the DH via the newly established Centre for Workforce Intelligence).

It is therefore essential that we have a much greater and clearer focus on our understanding of the medical and dental workforce now and for the future. To this end the local health communities have paid greater attention to the medical workforce in their current planning round. Two half day workshops were held to look separately at the secondary and primary care medical workforce to provide the opportunity for a wider audience to look at the evidence produced. This included, for example, the GP supply model in order to highlight any specific capacity or capability issues. It also provided the opportunity to debate the challenges for the future. A meeting has already taken place with the regional Dental Dean in Sheffield to understand the capacity and capability issues of the dental workforce. The output from these events will be reflected in the workforce plan for 2010 to 2015.

The medical and dental workforce plan was scrutinised by the Regional Advisory Mechanism workshop on November 6th 2009.

• Working Time Regulations for doctors in training

The introduction of these regulations has without doubt focused a great deal of attention on how we utilise our trainee doctor workforce and how we find sustainable service solutions which are not detrimental to their education and training. The interaction between the process and outcomes of training are poorly understood and yet are critical as over 50% of doctors in specialty training in the East Midlands will practice here as consultants, and in General Practice the figure exceeds 70%. The learning will be fed into the two workforce planning workshops and the resulting workforce plan.

For the Future

• Estimating Demand

Two projects will be undertaken to begin to get a more effective way of estimating the future demand for the medical workforce.

1. A Whole Trust Approach

Sherwood Forest Hospital NHS Foundation Trust, under the sponsorship of the Chief Executive, has indicated that it would be willing to examine its overall medical staffing planning in some detail, looking at likely future demand, the probable supply and innovative solutions for creating a balance.

2. Obstetrics Project

As part of the Next Stage Review the maternity and neonatal work stream has been undergoing some workforce modelling to develop understanding of the workforce implications of the implementation of the changes heralded in *From Evidence to Excellence*. This project has now been separated into three – Maternity workforce, Neonatal workforce and Obstetrics workforce. An initial meeting of the group of Obstetrics and Gynaecology Clinical Directors led to agreement to commence a project which would examine how to estimate of the demand for the career grade workforce for the future. This project will commence in November 2009.

- **Workforce planning round 2010/2011**

The workforce planning round for 2010/2011 commences with the strategic plans of the PCTs as part of World Class Commissioning. This is just commencing and it is hoped that there will be a much greater awareness by the commissioners of their responsibilities for workforce planning, including medical and dental workforce planning both in hospitals and in the community. It is anticipated that this will feed through to the Local Operating Plans.

As the Local Health Community Workforce Teams commence their workforce planning phase they will be asked to consider some specific issues eg obstetrics and gynaecology in the medical and dental workforce. These will feed through to the regional planning process where it is hoped the new Commissioner/Provider separation for education will make it more feasible to influence both the number and speciality of future trainees.

The scrutiny of these plans will be strengthened as the Regional Advisory Mechanisms and national Boards such as the Centre of Workforce Intelligence, MEE and other advisory boards are developed and matured.

Medical Training Numbers

Introduction

The English Joint Working Group of the Medical Programme Board (MPB) and the Workforce Availability Policy and Programme Implementation Group (WAPPIG) have recommended that GP training numbers be increased and that specialty training places be decommissioned by at least 5% overall for 2010 with a 10% minimum reduction in specified specialties, and for SHAs to contribute more reductions than this average of 7% where they were able. The Joint Working Group has endorsed the direction of travel toward a 50:50 split in the numbers of specialist training places relative to GP training places. The Joint Working Group has noted that if specialty training places were not decommissioned, the strategic intent to increase GP numbers could not be realised and there would be significant and unaffordable oversupply in certain specialties. These include certain surgical and medical specialties, anaesthesia, paediatrics and obstetrics and gynaecology.

Detailed planning proposal

In July 2009, both WAPPIG and the Medical Programme Board (MPB) discussed a paper on medical training numbers. The key elements of the paper were to:

- Make the case for returning to lower levels of specialty training from 2010. Outline the impact of the Modernising Medical Careers (MMC) changes to medical education since 2007, but more particularly the implementation of the WTR and continuing reliance of Trusts on the service contribution of doctors in training which have led to exceptional and unprecedented investment in hospital posts for specialty training at Specialty Training (ST2) or core training (CT1/2) levels and above. It put forward the argument for the proposed change on the basis of a predicted, significant oversupply of Certificate of Completion of Training (CCT) holders in most specialties.
- Confirm the proposed GP training expansion to meet the expectations of *A High Quality Workforce* and the anticipated retirement bulge (2010-2014). This would increase GP training intakes from 2,700 in 2009 to 3,000 in 2010 and ultimately 3,300 in 2011.

- Outline the implications of the latest workforce planning assumptions which suggests the future NHS requires an overall investment of around 6,500 training programmes after foundation training to meet future long-term medical demand. This level of specialty training is consistent with the current and planned output from UK medical schools and from Foundation Programme training, plus a small inflow of 5-10% from the EU and internationally.
- Draw out the implications for specialty training of realigning GP and consultant training investment, consistent with the overall envelope of around 6,500 intake level outlined above. This intake coupled with the plan to expand GP training to roughly 50% of ST1 training suggests other ST1 specialty training investment of around 3,250 posts.

Decommissioning posts will always be challenging. However, given the need to increase GP training posts, it is essential that the recent exceptional investment in specialist training posts is curtailed and brought back into a better balance with longer-term workforce planning assumptions. It is viewed as imperative that momentum is built up, in making these challenging changes, by making some progress in 2010.

Proposed Approach to Specialty Training Commissions in 2010

1. The appropriate balance of the overall investment in ST1 training posts across specialties needs to be determined. In the longer term, specialty specific workforce planning by clinical pathways will be supported by robust assessments from the newly established Centre for Workforce Intelligence. As the Centre becomes fully operational some advances in specialty specific intelligence could be delivered for 2011 commissioning decisions, with further gains beyond. The 2010 commissioning decisions must be made on current information.
2. Current specialty specific workforce planning assessments are not of sufficient reliability to aid in decision making, particularly on the demand side. There are potential inconsistencies in the methodologies used across Colleges, Faculties and Specialty Societies in their demand assessments; a lack of challenge from a service perspective; and a lack of clarity on how they reflect constraints in the system, particularly affordability. A key element of the Centre's work will be to align medical workforce demand aspirations with affordability and the new models of clinical care emerging from the SHA clinical visions. This is now particularly relevant given the future fiscal climate.
3. With the need for reductions in line with longer-term workforce planning identified and the implications of the fiscal context considered, WAPPIG proposes an interim basis for commissioning decisions in 2010 that will be developed with support from the Centre next year. This proposal adopts a two-pronged approach:
 - **Apply prudent reductions to most ST1 intakes**
The need to decommission specialist ST1 intakes to be consistent with longer term workforce planning has been accepted. This is further reinforced by the emerging financial climate. The mix and level of ST1 intakes will eventually be informed by the work of the Centre for Workforce Intelligence, but in the meantime it is prudent to apply modest reductions to most intakes. For most cases, this is likely to be consistent with the direction of travel that will subsequently be identified by the Centre. Where this is not the case, recovery from one year's reduction should be possible.

- **Apply further reductions in ST1 intakes for targeted specialties**

In some cases, the case for decommissioning training posts is clearly justified by projected oversupply even before the Centre for Workforce Intelligence can further inform specialty specific planning. These cases should be targeted for further reductions to supplement the prudent reductions applied to other specialties.

After analysis of plans submitted by SHAs (for 30th October) WAPPIG and MPB planned to issue final recommendations to the SHAs to inform their initial commissioning decisions in October. It was anticipated that these plans would be driven by their local clinical visions and workforce plans. The importance of local decision making within the national context is not underestimated. Local decision making was seen as key when reflecting:

- Which local geographies have the most scope for post reductions
- Which specialties have the most scope for reductions in training intake
- The quality of training posts
- The local method of service delivery
- The achievable pace of change

NHS East Midlands response

Each SHA has been asked to report its planned training numbers in the light of these overall recommendations, their own start point and their own clinical visions.

As a result of these considerations the East Midlands has responded to the proposals as outlined as follows:

NHS East Midlands (in consultation with the East Midlands Healthcare Workforce Deanery) acknowledges and recognises the need to address the documented potential oversupply of CCT holders in certain specialties and undersupply of CCT holders in General Practice across the UK. It further recognises that this situation will worsen if steps are not taken across England to adjust the training numbers and active training programmes in the affected specialties and GP.

The attached spreadsheet (table 3) and adjusted forecast for recruitment (table 4) to medical training posts, the East Midlands in 2010 is aiming to ensure that at least 50% of recruited posts are in General Practice. This measure will help to address the problems of GP undersupply which is a longstanding, recognised problem for the East Midlands. However, this year's recruitment experience (2009) has not been encouraging as 20 of the advertised GP programmes remain unfilled. This has caused major service difficulties for our local Trusts, particularly as it coincided with the full implementation of Working Time Regulations (WTR).

East Midlands has already instituted plans to reduce core surgical training placements and will continue to look at steps that will more closely match medical workforce supply and demand at an East Midlands level. These plans will be instituted over the next 2 to 3 years.

We would also like to point out that collecting figures for just 2009 and 2010 is likely to lead to misleading conclusions.

For examples, see below for CST recruitment:

Core Surgical Training (CST)
2008: 57 2009: 45 2010: 47

Thus whilst 2010 shows an indicative recruitment of 47 (an increase of 2 on 2009 figures) this would be seen against the 2008 recruitment – overall a fall of 10.

Similarly for Core Medical Training (CMT) recruitment:
2002: 89 2008: 75 2009: 73 2010: 78

The figures demonstrate a fall over time, and the 2010 figure currently takes no account of the likely Annual Record of Competence Progression (ARCP) failures which force 2010 recruitment down, further, quite probably below 2009 levels.

In addition, the East Midlands SHA wishes to emphasise that the picture as outlined in the WAPPIG reports is England-wide (or even UK-wide) and the extent to which it applies specifically to different NHS regions will vary significantly by both geography and specialty. There is a danger in adopting a reductionist approach that is predicated on seeking local reductions to meet an overall national target without due consideration of local medical workforce demand and supply calculations. This is ever more significant as CCT holders become more likely to remain in their training locality as either GPs or specialists. The previous national 'market' in trained medical supply is declining in most specialties, and there seems little prospect of this trend reversing. In addition, the significant training excess in London has seldom benefited either consultant or GP recruitment in any part of the East Midlands despite some claims made nationally to the contrary. Neither do we see junior trainees (ST1 and 2) moving out of area for more senior training in significant numbers.

The overall problem of potential specialist oversupply and GP undersupply has been identified for several years but there has been no agreed national policy on how this might be effectively addressed through a process of medical educational decommissioning and transfer of the released resources to new commissions at an SHA level. Indeed for the last 2 years this issue has been acknowledged but no specific actions proposed. Even this year's attempts at CMT/CST recruitment reductions will have absolutely no impact on future CCT output.

The situation is complicated by the historically determined inequitable distribution of MPET funded medical and dental training programmes and posts across England. East Midlands remains approximately 13.5% below national capitation equity for medical trainee posts at all levels. As a consequence, it has in the past been and still remains, unclear as to whether educational decommissioning should be conducted on a pro rata basis from this position of historical inequity or via a process that seeks to rebalance the distribution of trainees and training programmes to a position closer to capitation equity or a similar calculation. It is likely that the latter approach would more closely match supply and demand at a regional level, which as indicated previously is an increasingly important consideration for effective medical workforce planning and consequent service planning. After all, service planning must include consideration of professional skill mix; and in the absence of a reliable supply of trained doctors different service delivery models will need to be developed.

The East Midlands is developing a comprehensive healthcare workforce strategy but at present the information on future demand for medical workforce is limited in comparison to their professional groups, though improving. Extensive work is ongoing (including meetings with local health communities and others in October and November 2009) but it will not produce an effective overall plan for implementation for the 2010 August intake of trainee doctors.

East Midlands views this ongoing local work as critical, and these results need to be reviewed before we can commit to further specific East Midlands contributions to the outcomes outlined in the WAPPiG papers. To do otherwise has the potential to de-stabilise local service provision in the short term and undermine service planning in the longer term. Furthermore, the Learning and Development agreement* negotiations in the East Midlands have a substantially greater lead in period than the few months remaining in the 2009/10 financial year and thus cannot be completed in time for 2010 recruitment. This is particularly the case in this present year because of continued significant uncertainty over the impact of both the present MPET allocation and the results of the planned implementation of the MPET review.

As previously implied it is clear that if we try to reduce hospital specialty posts for this year (i.e. August 2010 entry) there will be considerable problems in maintaining safe, high quality services and in meeting the WTR. East Midlands proposes to work with Trusts to plan changes over the next 3 years as we acquire more local intelligence about future demand and when the situation, for example, regarding 3 year core training in medicine and surgery and the proposed GP training extension will be clearer.

*Note – Learning and Developments agreements are the service level agreements between the SHA and local Trusts over the placements of doctors in training. They also include other provisions relating to non-medical education and training issues.

Table 3: Number of Posts in 2009 – ACTUAL POSTS RECRUITED TO IN 2009 LEVEL ONE (CT/ST) POSTS – THIS DOES NOT INCLUDE ANY FTSTA POSTS

	EM	EE	KSS	LON	MER	NW	NOR	OX	PEN	SEV	WES	WM	YH	All
Acute Care Common Stem	33 26	24	22	49	15	31	16	8	7	14	11 8	43	24	287
Anaesthesia	14 20	6	38	128	38	30	34	22	34	20	21 24	43	33	470
Chemical Pathology	0	0	0	0	0	2	0	0	0	0	0	0	0	2
Clinical Radiology	10	12	0	44	13	13	11	4	12	7	8	15	24	173
Histopathology	6 0	0	0	68	0	0	5	0	0	0	3	0	0	73
Medical Microbiology & Virology	3 4	2	0	12	0	3	7	0	0	0	1 2	3	2	35
Medicine in General	68	108	54	298	66	109	73	36	41	55	61 64	112	166	1,250
Neurosurgery	1 0	0	0	0	0	5	1	0	0	0	1	0	32	39
Obstetrics & Gynaecology	12 15	30	0	89	13	19	15	9	8	10	10 11	22	23	264
Ophthalmology	5 7	3	0	23	2	1	17	2	2	3	2 11	7	8	86
Oral & Maxillo-facial Surgery	0	0	0	6	0	1	2	0	0	0	2	3	3	17
Paediatrics	27	33	21	109	21	33	23	14	8	15	16 22	44	44	414
Psychiatry in General	26 31	44	17	90	24	52	20	24	19	11	22 29	46	58	465
Public Health	5 7	8	0	21	0	6	6	2	6	0	1 2	9	6	73
Surgery in General	45 50	80	35	104	38	66	42	33	35	37	30 42	75	70	707
Total number of ST posts	255 265	350	187	1,041	230	371	272	154	172	172	189 226	422	493	4,355
General practice	206 226	241	278	405	141	242	156	99	88	128	126 139	299	276	2,718
ST + GP posts	461 491	591	465	1,446	371	613	428	253	260	300	315 365	721	769	7,073

**Table 4: Deaneries' Intended Number of Posts for 2010 – FORECAST OF 2010
LEVEL ONE (CT/ST) POSTS – THIS DOES NOT INCLUDE ANY FTSTA POSTS**

	EM	EE	KSS	LON	MER	NW	NOR	OX	PEN	SEV	WES	WM	YH	All
Acute Care Common Stem	28	28	22	82	4	29	24	12	16	25	17	36	28	351
Anaesthesia	14	24	41	88	27	40	29	16	22	6	24	40	21	392
Chemical Pathology	0	0	0	4	0	0	0	0	0	0	3	0	3	10
Clinical Radiology	10	18	1	41	12	14	10	6	12	8	8	16	18	174
Histopathology	4	2	0	20	3	6	4	4	0	0	5	4	9	61
Medical Microbiology & Virology	1	0	0	10	3	0	6	0	0	0	1	2	2	25
Medicine in General	83	113	63	320	60	87	47	35	35	37	54	92	70	1,096
Neurosurgery	1	0	0	5	0	2	1	1	0	0	1	2	1	14
Obstetrics & Gynaecology	7	21	0	67	11	18	14	7	5	9	7	18	22	206
Ophthalmology	3	2	0	22	1	3	4	3	2	1	0	5	6	52
Oral & Maxillo-facial Surgery	0	0	0	5	1	2	2	0	1	0	2	0	1	14
Paediatrics	20	34	21	112	19	24	18	10	8	14	15	38	32	365
Psychiatry in General	27	30	18	86	20	40	28	16	13	20	22	53	46	419
Public Health	7	8	0	20	6	0	3	4	0	2	3	9	5	67
Surgery in General	47	89	40	101	30	63	32	23	33	16	25	70	55	619
Total number of ST posts	252	369	206	983	197	328	222	137	147	138	187	385	319	3,865
General practice	252	237	280	315	144	242	156	100	88	126	140	323	387	2,761
ST + GP posts	504	606	486	1,298	341	570	378	237	235	264	327	708	706	6,626

Dental Training

Dental training for the NHS East Midlands is overseen by the Dental Deanery which is based in Sheffield.

Undergraduate training

The number of Dental graduates is increasing. In England there has been an increase of 170. On graduation they have a choice between entering vocational or specialist training. There is an increasing risk of unemployed new graduates.

Vocational training

Dental graduates wishing to be Dentists need to complete one year vocational training. There are 5 vocational training schemes in the East Midlands based in Chesterfield, Leicester, Lincolnshire, Derby and Nottingham. Northamptonshire will join this year. There is external vocational training competency assessment. The new dental contract between the PCT's and dental practices has made it harder to become a dental trainer. There are set up costs and inspection but following that a training grant of £8,000. There are discussions about a more to two years training and the suggestion of the introduction of an exam.

Dental Learning Networks

These are available for all members of the dental care team and are organised at PCT level.

Return to Practice

Return to practice courses for Dental Care Practitioners have just started.

Secondary Care

There are ten different specialities in the East Midlands. There are 62 SHO's and 44 Specialists Registrars.

Specific Issues:

- Possible tariff for Dentistry
- Suggestion of combined quality assurance visits with the Healthcare Workforce Deanery
- Inclusion in the Learning and Development Agreement
- The national Workforce Review Team still controls the numbers in the localities
- There are lead Dean arrangements

Specific Issue for specialities:

- Restorative Dentistry require additional trainees.
- Dental Radiology / Dental Microbiology require trainees.
- Dental Public Health - There are insufficient Dental Public Health Consultants in the East Midlands. This is unacceptable. It also presents a challenge to our ability to train the next generation of professionals
- Community Dental Services - The training and funding for Community Dental services needs to be reviewed

Continuing Professional Development

There are over 400 courses signposted from the Dental Deanery website.