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

Distribution of Medical Specialty Training Programme (formerly known as Medical Specialty Distribution Programme)

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 MSD 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 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 has a budget which we are required to fairly allocate across the country.

   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. **Is the driver for this programme to distribute HEE training monies equitably across England?**
   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 funding and service demand. The result with be an evidenced-based distribution to deprived rural, remote, and coastal areas.

3. **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.**
   HEE and NHSE/I acknowledge 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.

In under-served areas, we are increasing overall training post numbers, and we do this by allocating any additional funding or posts to areas in the country considered to be in greatest need. In turn, this reduces the effect of these changes on areas that are currently deemed better medically served. However, the historical imbalance in the distribution of HEE-funded training posts is such that it would not be affordable to achieve a fair distribution of medical training simply by increasing training posts in underserved areas.

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 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 HEE, NHSE/I, and the educator network. In addition, each specialty will be drawing up a proposed implementation plan for approval by the oversight group.

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 currently being developed which will show, at a granular level, the fairest distribution of training posts within each region.

   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.

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. **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. HEE and NHSE/I are 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.

Training experience/ commitment to training quality

1. **How will HEE 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, HEE and NHSE/I are 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. **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.

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?**
   HEE 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.

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

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.

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.

Impact of HEE and NHSE/I integration

1. **What will this programme look like when HEE doesn't exist? And how will Integrated Care Systems deal with this?**
   This programme is being led jointly by NHSE/I and HEE with both Executive Teams signing off this programme. The integration of both these two organisations will take a period of time. The role of the ICS will become increasingly important in service delivery and their workforce requirements, of which this is a major part.

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