Postgraduate Medical Education and Training  
NHS Scotland Chief Executives Meeting – 15th January 2014

1. **UK Shape of Training Review**

1.1 *Securing the future of excellent patient care: Final Report of the independent Shape of Training review led by Professor David Greenaway* was published on 29 October 2013.

1.2 The full report¹, together with detailed annexes, is now available on the Shape website². The final report offers an approach which will ensure doctors are trained to the highest standards and prepared to meet changing patient needs. It also offers an approach which will be fit for purpose for many years to come and a framework for delivering change and for doing so with minimum disruption to service. The final report contained a number of key messages, and made 19 recommendations. The key recommendations are set out below, the recommendations are listed in Annex 1.

1.3 **Shape of Training : Key Messages**

a. Patients and the public need more **doctors who are capable of providing general care in broad specialties across a range of different settings**. This is being driven by a growing number of people with multiple co-morbidities, an ageing population, health inequalities and increasing patient expectations.

b. We will continue to need doctors who are trained in **more specialised areas** to meet local patient and workforce needs.

c. Postgraduate training needs to adapt to prepare medical graduates to deliver safe and effective **general care in broad specialties**.

d. Medicine has to be a **sustainable career with opportunities for doctors to change roles** and specialties throughout their careers.

e. Local workforce and **patient needs should drive opportunities to train** in new specialties or to credential in specific areas.

f. Doctors in **academic training pathways need a training structure that is flexible** enough to allow them to move in and out of clinical training while meeting the competencies and standards of that training.

g. **Full registration should move to the point of graduation** from medical school, provided there are measures in place to demonstrate graduates are fit to practise at the end of medical school. Patients’ interests must be considered first and foremost as part of this change.

h. **Implementation of the recommendations must be carefully planned on a UK-wide basis** and phased in. This transition period will allow the stability of the overall system to be maintained while reforms are being made.

i. A **UK-wide Delivery Group** should be formed immediately to oversee the implementation of the recommendations.

1.4 **Shape of Training : Proposed Structure**

The proposed revised training structure is set out diagrammatically below, and described in detail in Annex 2. Briefly, undergraduate education is unchanged, but with full GMC registration at the point of graduation This would be followed by a foundation programme largely

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² [http://www.shapeoftraining.co.uk/home.asp](http://www.shapeoftraining.co.uk/home.asp)
unchanged from the current model, but with a requirement for community placements. Following the foundation programme, doctors would enter broad based specialty training for 4 – 6 years, leading to a certificate of specialty training, following which doctors would be required to engage in structured CPD, and have the opportunity to undertake further credentialed training.

1.5 Next Steps: 4 Nation Co-ordination Group

It is proposed that there should be established a 4 Nation Co-ordination Group to provide oversight, co-ordination and direction to post-Greenaway implementation activities, with the following remit and accountability:

a. provide policy oversight, co-ordination and direction for implementation activities arising from the Shape of Training report;

b. commission specific activities, and individual workstreams where required, that will inform and contribute to implementation of the Shape of Training recommendations, and to receive progress reports and recommendations from commissioned activities;

c. report to respective Ministers on progress, and on issues requiring Ministerial approval.

2. GMC Recognition and Approval of Trainers

2.1 The GMC has determined that it wishes to move to a position whereby all trainers in secondary care, whether of undergraduate medical students, or postgraduate doctors in training, are formally ‘recognised’ and in due course ‘approved’. This reflects the current position in primary care.

care, whereby all GP trainers are subject to statutory approval. The GMC is currently working to secure legislative change so that the process of ‘recognition’ becomes a statutory approval process for secondary care trainers in due course.

2.2 The GMC have therefore established a phased process for implementing arrangements for recognising trainers. All trainers in four specific roles will be fully recognised by 31 July 2016. The details are set out in their ‘Recognising and Approving Trainers – the Implementation Plan⁴, which supports and promotes the publication of guidance on training developed by the Academy of Medical Educators and by NACT UK, both commissioned by Health Education England

2.3 In Scotland, NES Medical Directorate have been working with the undergraduate Scottish Deans Medical Education Group (which represents all five Scottish Medical Schools) towards developing a single approach to implementation of the GMC regulatory changes for trainers in both undergraduate and postgraduate roles across Scotland.

2.4 **Scope.** The arrangements relate to:

a. named educational supervisors in postgraduate training  
b. named clinical supervisors in postgraduate training  
c. lead coordinators of undergraduate training at each local education provider  
d. doctors responsible for overseeing students’ educational progress for each medical school.

Recognition will not be necessary for other doctors whose practice contributes to the teaching, training or supervision of students or trainee doctors. But recognition will be available to trainers not currently in the four specific roles.

2.5 **Standards.** The GMC have adopted the Academy of Medical Educators’ *Framework for Supervisors⁶* as the competency framework against which all trainers (defined clinical teachers and supervisors) will be expected to provide evidence of their current and ongoing development. The Framework covers seven broad aspects of the trainer role known as “areas”:

1. Ensuring safe and effective patient care through training  
2. Establishing an effective learning environment  
3. Teaching and facilitating learning  
4. Enhancing learning though assessment  
5. Supporting and monitoring progress  
6. Guiding personal and professional development  
7. Continuing professional development as an educator

2.6 **Responsibilities.** The NES Medical Directorate and the Medical Schools in Scotland are responsible for ensuring with Local Education Providers (LEPs - ie Territorial Health Boards), that there is an accurate database of trainers, and also that we establish a system of accreditation, based on defined criteria, as the basis for recommending recognition to the GMC.

⁶ [http://www.medicaleducators.org/index.cfm/linkservid/C575BBE4-F39B-4267-31A42C8B64F0D3DE/](http://www.medicaleducators.org/index.cfm/linkservid/C575BBE4-F39B-4267-31A42C8B64F0D3DE/)
The GMC implementation document indicates that LEPs are responsible for identifying trainers currently in the roles requiring recognition and choosing recognised trainers to perform the four roles, ensuring sufficient trainers are in post and available to train, supporting trainers through job planning and annual appraisal and revalidation processes.

The responsibilities of EOs are to take the lead in recognising trainers, including establishing criteria and processes consistent with the GMC’s standards and requirements, reaching agreement with LEPs on respective roles and responsibilities, quality managing training arrangements, and reporting to the GMC on the adequacy of job planning at each LEP.

2.7 **Milestones.** The next milestone is to confirm that full information has been entered for all medical trainers and that the trainers have been categorised as provisionally or fully recognised by 31 July 2014. The final milestone is to confirm that all medical trainers are fully recognised (without use of interim conditions) by 31 July 2016. Scotland reports to the GMC against these milestones through existing Deanery Reports and Medical School Annual Reports but to a single agreed script and common reference documents. The GMC will subsequently quality assure the accreditation systems developed.

2.8 **Scottish criteria for trainer recognition.** The process for the formal recognition of trainers will consist of 2 parts, each of which must be completed in order that an EO can make a recommendation to the GMC:

- Trainers must be formally identified by the LEP.
- Trainers must meet the accreditation requirements (criteria) set out by the EO.

To achieve recognition it is proposed that all trainers in Scotland must meet the following criteria which have been shared with the GMC as part of the ongoing monitoring process for implementation:

1. Comply with all legal, ethical and professional obligations including completion of mandatory training requirements.
2. Comply with all aspects of GMC’s Good Medical Practice.
3. Be currently practising within their field. For undergraduate trainers this may include academic practice or health professionals in disciplines other than medicine.
4. Have appropriate time allocated for their role.
5. Demonstrate awareness of their role and how that role fits with other educational and clinical roles.
6. Know how to get support if needed and know about the relevant EOs’ quality management procedures.
7. Demonstrate awareness of the curriculum and level of students/trainees.
8. Demonstrate an appropriate level of teaching competence.

2.9 **Scottish arrangements for meeting these criteria.** It is proposed that criteria 1-4 will be signed off at annual appraisal through existing processes for doctors and using the Scottish Online Appraisal Resource (SOAR) system. NES will host a single maintained database of all Scottish trainers (undergraduate & postgraduate) on our Training Management (Pinnacle) system. Trainers will self-declare compliance with these criteria to be signed off as part of the annual appraisal process. Criteria 5-7 will be achieved by completing an induction to the role provided by or under the direction of the relevant EO. Criterion 8 can be achieved by (a) Completion of a recognised qualification in teaching/medical education or an approved basic training programme or (b) having full membership of a recognised Teaching / Medical Education organisation, or (c) trainers with more than 3 years experience in a recognised role may submit an online portfolio of evidence using an approved tool.
2.10 **The Scottish Trainer Framework** is a tool that has been developed to support anyone involved in teaching medical students or training trainees in Scotland. Its purpose is to enable trainer role development and allow existing trainers to self-assess their development against contemporary standards.

3. **GMC Review of Quality Assurance**

3.1 The GMC is currently engaged in a root-and-branch review of its approach to the quality assurance of medical education and training. This review is expected to report in the early part of 2014, and to address the following themes:

   a. Approval against standards: Consistency and divergence in the GMC’s quality framework
   b. The case for approving the educational environment
   c. Reporting the outcomes of quality assurance activities
   d. Quality measures: measuring systems and measuring outcomes
   e. The QIF
   f. The use of evidence to support decisions on quality
   g. The purpose and nature of ‘visits’
   h. Responding to concerns
   i. The role of the medical Royal Colleges
   j. Legislative reform

3.2 In particular, the review is expected to result in a revised set of Standards to replace those currently set out in The Trainee Doctor. It is also anticipated that the GMC will publish new standards and descriptors for the educational environments expected in local education providers. These are likely to cover:

   a. Management of education and training: board level engagement or equivalent
   b. Safe supervision
   c. Team working
   d. Educational infrastructure
   e. Time for trainers to train
   f. Time for trainees (support for learning and reflection)
   g. Individual review meetings
   h. Selection, Appointment and Review of Trainers
   i. Local mechanisms for learning through audit including Significant Event Audit and quality improvement projects
   j. Educational governance including audit and trainee feedback on their training experience
   k. Supporting learners in difficulty

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7 Scottish Trainer Framework (version 211113CM). NES, University of Aberdeen, University of Dundee, University of Edinburgh, University of Glasgow, and University of St Andrews.

8 [http://www.gmc-uk.org/education/10932.asp](http://www.gmc-uk.org/education/10932.asp)

4. GMC National Training Survey

4.1 The GMC National Training Survey (NTS) was publically released on 12 June 2013\(^\text{10}\). This year the GMC produced an overview analysis of the key findings with a separate report for each of the devolved administrations. Scotland fared very favourably with scores higher than the UK average in almost every analysed category. The overall satisfaction score has increased slightly this year (81.3) compared to the 2012 results (81.1).

4.2 The report shows a number of positive indicators in Scotland, for example relating to overall training experience and quality of supervision. Trainees also reported that they gained appropriate practical experience and were confident that they were acquiring the competencies appropriate for their stage of training. Areas that scored slightly lower in general (in Scotland and throughout the UK) related to areas such as feedback to trainees on performance, some aspects of induction and the impact of workload and work intensity.

4.3 In addition to the core indicators contained in this report (and now available through the public online reporting tool), the 2013 survey also included questions about patient safety, and in addition collected anonymous free text comments about the clinical environment, and undermining. These responses have been managed separately to the core survey dataset, according to a process set out by the regulator\(^\text{11}\). Briefly, the GMC reviewed all concerns on receipt, and those regarded as ‘immediate’ were passed directly to Deans for attention. Other concerns were collated and passed as a ‘package’ to Deans following closure of the survey in May.

4.4 These concerns were reviewed by NES regional teams working with NHS Board Directors of Medical Education, and action plans developed where required, and returned to GMC for review in late July. The attached table summarises the volume of comments received broken down by category and region. The areas highlighted by respondents included: Clinical Supervision, Staff Capability, Working Practices, Workload/Staffing, Capacity/Facilities and Staff Interaction.

<table>
<thead>
<tr>
<th>Region</th>
<th>Survey Responses</th>
<th>Patient safety</th>
<th>%</th>
<th>High Risk</th>
<th>%</th>
<th>Clinical Environment</th>
<th>%</th>
<th>Undermining</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>WoS</td>
<td>2502</td>
<td>130</td>
<td>5.20%</td>
<td>24</td>
<td>0.96%</td>
<td>80</td>
<td>3.20%</td>
<td>104</td>
<td>4.16%</td>
</tr>
<tr>
<td>SES</td>
<td>1199</td>
<td>44</td>
<td>3.67%</td>
<td>6</td>
<td>0.50%</td>
<td>31</td>
<td>2.59%</td>
<td>50</td>
<td>4.17%</td>
</tr>
<tr>
<td>EoS</td>
<td>499</td>
<td>34</td>
<td>6.81%</td>
<td>3</td>
<td>0.60%</td>
<td>13</td>
<td>2.61%</td>
<td>31</td>
<td>6.21%</td>
</tr>
<tr>
<td>NoS</td>
<td>713</td>
<td>26</td>
<td>3.65%</td>
<td>4</td>
<td>0.56%</td>
<td>16</td>
<td>2.24%</td>
<td>37</td>
<td>5.19%</td>
</tr>
<tr>
<td>All</td>
<td>4913</td>
<td>234</td>
<td>4.76%</td>
<td>37</td>
<td>0.75%</td>
<td>140</td>
<td>2.85%</td>
<td>222</td>
<td>4.52%</td>
</tr>
</tbody>
</table>

\(^\text{10}\) [http://www.gmc-uk.org/education/surveys.asp](http://www.gmc-uk.org/education/surveys.asp)

5. **Strategy for Attracting and Retaining Trainees (StART)**

*Why Scotland Needs Start*

5.1 In the each of the last 3 years, on average 190 training posts (including Locum Appointment for Training (LAT) posts) in Scotland have been unfilled after national recruitment rounds; in 2013 this represents ~11% of the ST posts that are available for recruitment each year and ~4% of our entire compliment of 5700 training posts. The distribution of these unfilled posts among our WoS, SEoS, NoS & EoS Regions is 56%, 13%, 20% & 10% respectively. Unfilled posts impact on a range of specialties including Medicine, Anaesthetics, Emergency Medicine and Psychiatry.

**Recruitment 2013**

<table>
<thead>
<tr>
<th>Post Group</th>
<th>Establishment</th>
<th>Vacancies</th>
<th>Filled</th>
<th>Unfilled</th>
<th>Fill Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foundation</td>
<td>1608</td>
<td>804</td>
<td>804</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Core</td>
<td>588</td>
<td>289</td>
<td>288</td>
<td>1</td>
<td>99.6%</td>
</tr>
<tr>
<td>Run Through</td>
<td>1792</td>
<td>411</td>
<td>372</td>
<td>39</td>
<td>90.5%</td>
</tr>
<tr>
<td>HST</td>
<td>1741</td>
<td>345</td>
<td>236</td>
<td>109</td>
<td>68.4%</td>
</tr>
<tr>
<td>LAT</td>
<td>139</td>
<td>70</td>
<td>69</td>
<td></td>
<td>50.0%</td>
</tr>
<tr>
<td>Total</td>
<td>5729</td>
<td>1988</td>
<td>1770</td>
<td>218</td>
<td>89.0%</td>
</tr>
</tbody>
</table>

5.2 Gaps in training programmes that arise from failure to fill posts at recruitment add to gaps that result from other reasons, such as out-of-programme training (OOPT), career breaks (including maternity leave), resignation following CCT and less than full-time training (LTFT). While these vacancies may present opportunities to recruit to LAT posts, currently the demand for these is low, and consequently they are even harder to recruit to.¹²

5.3 Specialties such as Paediatrics and Obstetrics & Gynaecology tend to achieve high levels of recruitment and yet carry high rates of gaps for these other reasons. Separate initiatives seek to mitigate the impact of gaps in programmes that arise from reasons other than failure to recruit.

*Who is involved in StART*

5.4 StART has been led by a Core Group from the Medical Directorate within NES comprising Professor Alastair McLellan, Professor Rowan Parks, Dr Ronald MacVicar, & Ms Anne Dickson. To ensure integration and coordination of the efforts of StART, directed at doctors in training, with initiatives targeting trained doctors, the latter are now represented through engagement of Dr John Colvin, the Scottish Government Advisor on attractiveness of Scotland as a member of the StART Core Group.

5.6 While StART is led by NES, key to delivery of our aims is the collaboration of stakeholder organizations through the StART Alliance; our Alliance comprises representatives from Scottish Government, territorial Health Boards, Specialty Training Boards, Royal Colleges (including the Scottish Academy of Royal Colleges), Scottish Medical Schools, BMA & NES and includes postgraduate trainee representatives.

¹² The fill rate of vacant core and specialty training posts in 2013 was 86%, and for LAT posts 50%.
**Informing**

5.7 To inform our strategy NES has commissioned a) market research of FY1 & CT1 trainees undertaken by Bright Signals, an external marketing agency and b) novel research undertaken by Prof Jen Cleland and her team at the University of Aberdeen into the ‘push-pull’ factors that determine choice in medical careers decision making.

5.8 The StART core group has been working with Bright Signals to develop strategic goals, headline messages, and to consider how we might a) work with trainees to promote the strengths of our training, b) work through social media and c) maximise our impact through participation in careers fairs. StART’s key marketing message is: ‘Scotland: home of medical excellence’; the aim is to develop the themes of Scotland as home, as well as Scotland for training, in the context of its history of medical excellence.

5.9 A vital component of the START initiative is to progress our understanding of the factors that determine location of training, in particular at the key career transitions (undergraduate to Foundation, Foundation to Core or GP, Core to ST3/4 training and from ST6/7+ to Consultant). This body of work entitled ‘Understanding push-pull factors in medical careers decision-making’ has recently been submitted to the StART core group to inform our next phase of activities.

5.10 Among the key messages from this work are:

- The greatest influence on medical students’ decision making is lifestyle, including location – with proximity to friends and family, and familiarity with the local and work environments impacting mostly on decision making.
- Career decision making among doctors in training is more complex, but overall the greatest influencers are cited to be work-related factors, specifically good working conditions, desirable location, good reputation for quality training and availability of linked training positions (linked with their partners’ appointment).
- While some factors that have been identified are personal and are not amenable to intervention – improving the quality of the working and training experience may increase the attractiveness of posts and locations.
- Early positive experiences are very important to careers decision making.
- Overseas doctors are more tolerant of less desirable options including poorer working conditions and departments with lesser reputation.

**Connecting**

5.11 The StART group have embarked upon a number of interventions, designed to improve our communication with current and aspiring trainees. These initiatives have included:

a. ScotMT Website redesign
b. Careers Fairs
c. Trainees - the T in StART – Trainee Ambassador Programme
d. Keeping in Touch
e. StART Social Media - @scotmedtraining
f. Trainers – make me want to train in Scotland
6. **UK Medical Selection and Recruitment**

6.1 Since the introduction of MMC in 2007, there have been significant developments and improvements to medical selection and recruitment. This has led to more transparent, robust, consistent, fairer and efficient methodology and processes which have evolved year on year.

6.2 GP and Foundation recruitment have been organised on a UK-wide basis for several years and more recently, there has been a sustained move towards national co-ordination of selection and recruitment to specialty training.

6.3 The move towards the national co-ordination of recruitment and selection has resulted in a reduction in the numbers of applications from 127,000 in 2007 to 19,000 in 2011 (UK data). This has brought very significant efficiency savings in terms of time and resource for deaneries, employers, consultants and trainees involved in the selection and recruitment process, as well as producing improved fill rates. The streamlined application and offer co-ordination process is highly valued by trainees. The approach is also favoured by the regulator as it ensures greater equity and equivalence.

6.4 In 2012, Scotland took a policy decision to move towards UK-wide national recruitment on a pilot basis for the 2013 intake. As this was the first year for many specialties participating in this process, a national Scottish evaluation process was undertaken by the Medical Directorate of NES. A survey was sent to 11 Health Board teams and via 7 STB chairs to consultants involved in recruitment.

6.5 Overall, the results of the survey were positive towards national recruitment. Seven of the 9 Health Board teams wished to continue to participate in national recruitment, 1 team was reluctant due to the need for a more user friendly recruitment system and 1 did not answer. All teams acknowledged that the process for conducting interviews was clear and 8 teams stated that there was good communication from the lead recruitment College/Deanery. Issues highlighted were that there was limited input to timelines and deadlines, training on use of the recruitment system could be improved, and Scotland was not always well profiled on recruitment websites.

6.6 Feedback from consultants involved highlighted that >75% would be keen to continue with national recruitment, 94% stated that there was a clear process for interviews and 80% received regular communication regarding the process. Benefits included transparency, fairness, reliable standardized processes, wider pool of candidates, efficient method to ensure the best candidates got the jobs, avoidance of multiple interviews for candidates and less service time disruption for both applicants and interviewers. Some negative views were also expressed including the challenge of interviews being held outside Scotland in some specialties, less influence on how or who we recruit into our training programmes, loss of ownership of the process, less personal approach and difficulties in reviewing progress of offers and fill rates.

6.7 A major project of the Medical and Dental Recruitment and Selection (MDRS) programme has been to tender for a UK-wide IT system to support national recruitment. Historically numerous IT systems were employed. Deloitte MCS Ltd was awarded this contract and brought together two existing system (Konetic and Hicom) as sub-contractors. The new IT system (called Oriel) will be developed, tested and implemented in phases over a number of years. An initial pilot in February 2014 will involve 22 specialties, including various medical specialties, anaesthesia and ENT.
6.8 With the introduction of Oriel, applicants will be able to register for specialty training, view vacancies, apply, book and manage interviews, all within the one location. The aim is to create a single applicant journey and ensure a consistent experience throughout the specialty recruitment process by ensuring all relevant specialty training information can be sourced, and applications can be managed, within the one location.

7. Move to a Single Postgraduate Deanery

7.1 NES and its Medical Directorate will face many challenges over the next few years. These include delivering the ever more demanding requirements of the General Medical Council (new training standards, a revised approach to quality assurance, revalidation for all doctors in training in Scotland, the recognition and approval of trainers; ensuring high quality recruitment to training grade posts in medicine; contributing to the workforce planning process; managing changes in specialty training numbers; implementing the recommendations of the UK Shape of Training Review and promoting excellence in educational delivery.

7.2 This demanding agenda and the ongoing contribution of the Directorate to further the development of NES as an organisation and to the support of multi-professional, team based education will have to be delivered in the context of reductions in core funding as a consequence of the public sector fiscal position. For the Medical Directorate to ensure quality, strive to improve and achieve savings, it is essential that the Directorate Executive Team work as a closely coordinated and integrated team within NES to a common vision and purpose and have mature and effective interactions with external partner organisations in Scotland and the UK – the latter being particularly important in the light of the significant changes now taking place in England as the NHS is re-organised and Health Education England (HEE) becomes established.

7.3 The directorate therefore engaged in a development process to build a vision and way of working designed to achieve the twin requirements of excellence and efficiency. This process included engagement and consultation with representatives from key external stakeholders in Scotland (Health Board Medical Directors, Medical Schools, Healthcare Improvement Scotland as well as Specialty Training Boards Chairs, GP Directors and Associate Postgraduate Deans).

7.4 The vision for the future of the Medical Directorate was developed over a period of time by MDET, approved by the NES Business Group in October 2011 and the Board in November 2011. In addition to developing a statement of vision, values and objectives - mapped to the NES corporate objectives - work undertaken through the LEAN and ABC programmes had highlighted the need to address significant organisational and financial anomalies that existed as a legacy from previous structures.

7.5 Briefly, the regional Postgraduate Deaneries had, over time, evolved local approaches to a broad range of key tasks and processes, which were significantly different. This was giving rise to a range of challenges, was resulting in significant inefficiencies as a consequence of the duplication of activity, and our cost base demonstrated significant regional differences. We therefore determined to begin by aligning processes across the 4 Deaneries. Because many of our processes are underpinned by the core NES trainee database – Pinnacle - this work led to a project to develop and implement a new and updated version of Pinnacle (version 3 – Pv3) underpinned by work to analyse and align processes, and so to align and change the job descriptions of associated staff.
7.6 At the start of 2012 our new structure was determined as being composed of:

- Directorate Executive Team (MDET) – composed of the medical director, an executive manager, professional leads and general managers
- General management support – with our business processes aligned into 4 coherent national cross-cutting workstreams
- Regional linkages – a leadership and interface role for professional leads, aligned to territorial boards and Universities
- Specialty Training Boards – to advise MDET

7.7 Our vision for change across the medical directorate has always recognised that it is essential that the Directorate Executive Team work as a closely coordinated and integrated team, that as the landscape of medical training continues to change, we also must change to remain fit for purpose and to demonstrate value for money, and was predicated on the value of developing a Directorate-wide rather than Deanery based approach.

7.8 As we have developed our thinking around the implementation of our vision, the world around us has not stood still – elsewhere in the UK Health Education England (HEE) has emerged, and English Deaneries have been absorbed into the regional committee structure of HEE - Local Education and Training Boards – LETBs. We will shortly be seeing the publication of the UK review of the Shape of Training, which is likely to bring significant change to many of our programmes. And the General Medical Council (GMC) is currently completing a major review of their approach to the quality assurance of medical education and training.

7.9 We have therefore been thoughtful about how best to give life to the vision of a coherent single system approach to the work of the medical directorate of NES, while maintaining our key regional linkages, and putting ourselves in the best position to deal with the challenges that lie ahead. MDET have formed the clear view that a move to a single Scottish deanery, across the existing regional offices represents the best way to deliver our vision. This will allow us to secure the advantages of national workstream working to deliver some services on a national basis where that is more efficient and effective, while also maintaining the local Board and University facing functions in the regions.

7.10 This would mean that each regional office would be working within a sustainable single large Deanery, and would give us much more freedom to review the allocation of trainees, and how national and regional training programmes work. However, it is vital that we retain a regional presence and a ‘single Deanery’ would not mean a closure or reduction in regional offices, or a reduction in the importance of providing a regional and board facing presence to support trainees, trainers, TPDs, and LEPs.

7.11 The key benefit from moving to a single Deanery approach will be to recognise and give life to the reality of our position as a single directorate within the Scottish education and training Board.

- It will enable us to ensure that we drive consistent business processes across the organisation, with improved consistency of decision making.
- It will enable us to maximise our ability to manage processes ‘once for Scotland’ rather than replicating these in quadruplicate – while recognising that there are some processes that require to be managed close to the place of training. For example, it will enable us to manage one relationship with the regulator, as opposed to four.
• It will enable us to leverage the unique position of NES as a special board with a coherent view of the quality (and quality management / control) of education and training across all Boards. We already know that the next GMC QA review of PGMET in Scotland will be a ‘regional visit’ to the whole of Scotland in 2017.

• It will place us in the best position to respond to the key challenges which we already know lie ahead – the implementation of the UK review of the Shape of training, and the changes being developed by GMC as a result of their review of QA and Standards.

8. Health Education England

8.1 HEE was established as a Special Health Authority in June 2012 and became fully operational in April 2013. It took over Strategic Health Authorities’ responsibilities for education and training. HEE has been established as a non-departmental public body operating on a statutory basis at arm’s length from the Department of Health.

8.2 The role of HEE will be to provide national leadership for education, training and workforce development. The new organisation will be accountable for a budget of around £5 billion in education and training across England. The primary focus of HEE will be professionally qualified healthcare and public health staff. It will support a network of Local Education and Training Boards (LETBs) which will plan education and training of the workforce to meet local and national needs.

8.3 A framework agreement exists between the DH and HEE which articulates the relationship between DH and HEE, and identifies how HEE will be held to account in the new health and social care system. HEE in partnership with the DH, NHS Commissioning Board, and Public Health England will agree strategic education outcomes and priorities. The policy document ‘Liberating the NHS: Developing the Healthcare Workforce – From Design to Delivery’ (January 2012\textsuperscript{13}) describes strategic direction for 2013/14 and this is affirmed in the mandate to HEE from the DH, ‘Developing high quality, effective, compassionate care: Developing the right people with the right skills and the right values’ (May 2013\textsuperscript{14}).

8.4 The DH mandate covers strategic objectives for workforce planning, health education, and training and development from April 2013 to March 2015. The framework aligns with and reflects the priorities set out in the mandate for NHS England, the NHS and public health outcomes frameworks, and the government’s response to the Francis Report.

8.5 The primary focus of HEE will include the following:
• providing national leadership on planning and developing the healthcare and public workforce
• authorising and supporting the development of Local Education and Training Boards (LETBs)
• promoting high quality education and training, including responsibility for medical trainee recruitment

• allocating and accounting for NHS education and training resources and the outcomes achieved
• ensuring the security of supply of the professionally qualified workforce
• supporting the development of the healthcare workforce across a multi-professional and UK-wide context
• supporting innovation across the NHS in order to improve the quality of care
• delivering against the Education Outcomes Framework to ensure the allocation of education and training resources is linked to quantifiable improvements

8.6 Organisational Structure. The Board is led by Sir Keith Pearson, Non-Executive Chair and the position of Chief Executive is held by Professor Ian Cumming. The directorates comprise:
• Strategy & Planning - To lead the development of HEE’s strategic framework to reflect the long term strategy needs of the health and public health service.
• Performance & Development - To provide national leadership for the development and performance management of Local Education Training Boards (LETBs).
• People & Communications - To lead and direct the people, communications, and corporate development strategies for the organisation to ensure that it develops a workforce which meets the needs of the service.
• Finance - To develop and deliver a national finance strategy for Health Education England
• Education and Quality - To provide clinical leadership for HEE and ensure high quality education and training for the health care workforce in England. To ensure that education and training reflects the needs of patients and communities.

8.7 Key relationships. HEE will work in partnership with the NHS Commissioning Board (NHS CB) and Public Health England (PHE) with the aim of ensuring that future developments in health and healthcare are reflected in plans for workforce development. The HEE Strategic Education Operating Framework is informed by service commission priorities from the National Commissioning Board and public health priorities from Public Health England.

8.8 Local Education and Training Boards (LETBs) have been set up and will be accountable to HEE for their investment in education and training and delivery against the Education Outcomes Framework and national priorities set out in the strategic Education Operating Framework. There are a total of 13 LETBs across England. LETBs comprise representatives from local providers of NHS services (deaneries are part of LETBs). As part of their commission responsibilities, LETBs will be required to establish workforce needs and educational priorities for their local area across the full range of disciplines and services. They will be expected to consult on skills and development strategies so that patients, local communities, staff and service commissioners and education providers are able to input their views about how LETBs plan to develop the local healthcare and public health workforce. Details of the HEE LETBS, trainee numbers and budget are set out in Annex 4.

8.9 Workforce Planning. HEE, as an autonomous national body is responsible for providing system wide leadership and oversight of workforce planning, education and training, and to ensure that healthcare staff are recruited in the right numbers with the right values and behaviours to support the delivery of excellent healthcare and drive improvement. HEE published their first workforce plan in December 2013.

Annex 1

UK Shape of Training: Recommendations

1. Appropriate organisations must make sure postgraduate medical education and training enhances its response to changing demographic and patient needs.

2. Appropriate organisations should identify more ways of involving patients in educating and training doctors.

3. Appropriate organisations must provide clear advice to potential and current medical students about what they should expect from a medical career.

4. Medical schools, along with other appropriate organisations, must make sure medical graduates at the point of registration can work safely in a clinical role suitable to their competence level, and have experience of and insight into patient needs.

5. Full registration should move to the point of graduation from medical school, subject to the necessary legislation being approved by Parliament and educational, legal and regulatory measures are in place to assure patients and employers that doctors are fit to practise.

6. Appropriate organisations must introduce a generic capabilities framework for curricula for postgraduate training based on Good medical practice that covers, for example, communication, leadership, quality improvement and safety.

7. Appropriate organisations must introduce processes, including assessments, that allow doctors to progress at an appropriate pace through training within the overall timeframe of the training programme.

8. Appropriate organisations, including employers must introduce longer placements for doctors in training to work in teams and with supervisors including putting in place apprenticeship based arrangements.

9. Training should be limited to places that provide high quality training and supervision, and that are approved and quality assured by the GMC.

10. Postgraduate training must be structured within broad specialty areas based on patient care themes and defined by common clinical objectives.

11. Appropriate organisations, working with employers, must review the content of postgraduate curricula, how doctors are assessed and how they progress through training to make sure the postgraduate training structure is fit to deliver broader specialty training that includes generic capabilities, transferable competencies and more patient and employer involvement.

12. All doctors must be able to manage acutely ill patients with multiple co-morbidities within their broad specialty areas, and most doctors will continue to maintain these skills in their future careers.

13. Appropriate organisations, including employers, must consider how training arrangements will be coordinated to meet local needs while maintaining UK-wide standards.

14. Appropriate organisations, including postgraduate research and funding bodies, must support a flexible approach to clinical academic training.

15. Appropriate organisations, including employers, must structure CPD within a professional framework to meet patient and service needs, including mechanisms for all doctors to have access, opportunity and time to carry out the CPD agreed through job planning and appraisal.
16. Appropriate organisations, including employers, should develop credentialed programmes for some specialty and all subspecialty training, which will be approved, regulated and quality assured by the GMC.

17. Appropriate organisations should review barriers faced by doctors outside of training who want to enter a formal training programme or access credentialed programmes.

18. Appropriate organisations should put in place broad based specialty training (described in the model).

19. There should be immediate consideration to set up a UK-wide Delivery Group to take forward the recommendations in this report and to identify which organisations should lead on specific actions.
Annex 2

UK Shape of Training: Revised Training Model

1. Doctors will complete medical school after four to six years and enter the Foundation Programme.

2. Full registration will happen at the point of graduation. Rigorous and consistent measures will need to be put in place to make sure graduates are fit to work as fully registered doctors. They will also be restricted to working in approved training environments.

3. Doctors will complete the two-year Foundation Programme. The Foundation Programme will continue to give a wide range of training opportunities in different specialty areas. Doctors must have placements in both hospital and community settings. Each placement should aim to be between four to six months long. Doctors must have opportunities to support and follow patients through their entire care pathway during medical school and the Foundation Programme.

4. After the Foundation Programme, doctors will enter broad based specialty training. Specialties or areas of practice will be grouped together. These groupings will be characterised by patient care themes – such as women’s health, child health and mental health – and be defined by the dynamic and interconnected relationships between the specialties. They will have common clinical objectives, within those specialty curricula. There should be consideration about how these themes bridge the boundary between hospital and community care.

5. Across all specialty training, doctors will develop generic capabilities that will make sure professionalism is embedded into their medical practice. With more personalised evaluation and assessment linked to progression, training will be less driven by the need to meet lists of competencies, described as ‘box-ticking exercises’.

6. Broad based specialty training will last between four to six years, after the Foundation Programme, depending on specialty requirements (and individual’s progress through curricula). For example, GPs will probably need at least four years of training to meet their outcomes and enter professional practice. Other general specialties (like anaesthesia) and craft specialties may need longer to develop the necessary technical knowledge, skills and experiences (within the timeframe of between four and six years). The specific duration of training for different specialties will have to be developed by the UK-wide Delivery Group.

7. During postgraduate training of between four and six years, doctors should be given opportunities to spend up to a year working in a related specialty or undertaking education or management work (similar to specialty fellowships). This year, which can be taken at any time during training, will allow them to gain wider experiences that will help them become more rounded professionals. Doctors will be able to train across the breadth of a broad based specialty. But they will be able to theme their training within patient groups at any point in the training. During training, doctors will provide general care in their broad specialty in both hospitals and in the community.

8. When doctors want to change specialties either in or between specialty groups, they will be able to transfer relevant competencies they have acquired in one specialty to their new area of practice without having to repeat the same learning in the new specialty. This will include learning gained during the optional year and generic capabilities. By recognising previous learning and experiences, retraining in new areas should be shorter.

9. Nationally funded clinical academic training will be a flexible training pathway. Doctors on this pathway will be able to focus their academic training in their academic or research area while also undertaking broad based training. Where possible, they will also deliver general care. Time
spent in academic experiences will still be counted within training, but some of these doctors may occasionally take longer to reach the exit point of postgraduate training, particularly those training in craft specialties. The optional year could also be dedicated to research. In addition, most doctors on the academic pathway are likely to need further time to complete doctoral research (PhD) studies. In exceptional circumstances, clinical academic doctors may be able to restrict their clinical practice to a narrow specialty, special interest or subspecialty areas. To make sure doctors are able to work more flexibly in this pathway, and to encourage more doctors to think about building academic and research into their careers, they will have opportunities to move in and out of academic training at any point during their training.

10. The exit point of postgraduate training will be the Certificate of Specialty Training. It marks the point when doctors are able to practise within their identified scope of practice with no clinical supervision while working in multiprofessional teams. This means they must be able to make safe clinical and professional judgements.

11. Most doctors will work in the general area of their broad specialty based on patient and workforce needs throughout their careers. They will be expected to maintain and develop their scope of practice and generic capabilities through CPD, and meet the requirements of revalidation. Learning and reflecting on their practice and patient outcomes will help to give doctors the depth of knowledge and skills necessary to master their specialty area. Doctors will also have options at any point in their careers to develop their education, management and leadership roles.

12. Doctors may want to enhance their career by gaining expertise in areas equivalent to some special interest areas in a specialty, and subspecialty training through formal and quality assured training programmes leading to a credential in that area (credentialing). These programmes would be driven by patient and workforce needs, and may be commissioned by employers as well as current postgraduate education organisers. These areas would need to be approved and quality assured by the GMC to ensure appropriate standards and portability.
### Annex 3: NES Regions and NHS Scotland Boards

<table>
<thead>
<tr>
<th>Board</th>
<th>Population</th>
<th>Activity</th>
<th>NRAC</th>
<th>Trainees</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Grampian</td>
<td>566,891</td>
<td>716,276</td>
<td>9.68</td>
<td>607</td>
</tr>
<tr>
<td>NHS Highland</td>
<td>315,286</td>
<td>380,243</td>
<td>6.36</td>
<td>171</td>
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<tr>
<td>NHS Orkney</td>
<td>20,437</td>
<td>20,169</td>
<td>0.43</td>
<td>4</td>
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<tr>
<td>NHS Shetland</td>
<td>22,703</td>
<td>29,672</td>
<td>0.46</td>
<td>10</td>
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<tr>
<td>NHS Western Isles</td>
<td>26,062</td>
<td>36,218</td>
<td>0.62</td>
<td>11</td>
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<tr>
<td><strong>NES North</strong></td>
<td><strong>951,379</strong></td>
<td><strong>1,182,578</strong></td>
<td><strong>17.55</strong></td>
<td><strong>803</strong></td>
</tr>
<tr>
<td>(17.89%)</td>
<td>(14.87%)</td>
<td>(17.55%)</td>
<td>(15.17%)</td>
<td></td>
</tr>
<tr>
<td>NHS Tayside</td>
<td>411,677</td>
<td>718,435</td>
<td>7.84</td>
<td>571</td>
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<tr>
<td><strong>NES East</strong></td>
<td><strong>411,677</strong></td>
<td><strong>718,435</strong></td>
<td><strong>7.84</strong></td>
<td><strong>571</strong></td>
</tr>
<tr>
<td>(7.74%)</td>
<td>(9.03%)</td>
<td>(7.84%)</td>
<td>(10.79%)</td>
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<tr>
<td>NHS Lothian</td>
<td>868,352</td>
<td>1,195,155</td>
<td>14.86</td>
<td>1014</td>
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<tr>
<td>NHS Borders</td>
<td>114,511</td>
<td>176,010</td>
<td>2.10</td>
<td>76</td>
</tr>
<tr>
<td>NHS Fife</td>
<td>371,498</td>
<td>459,182</td>
<td>6.90</td>
<td>202</td>
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<tr>
<td><strong>NES South East</strong></td>
<td><strong>1,354,361</strong></td>
<td><strong>1,830,347</strong></td>
<td><strong>23.86</strong></td>
<td><strong>1292</strong></td>
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<td>(25.47%)</td>
<td>(23.01%)</td>
<td>(23.86%)</td>
<td>(24.40%)</td>
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<tr>
<td>NHS Ayrshire and Arran</td>
<td>367,207</td>
<td>545,068</td>
<td>7.36</td>
<td>255</td>
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<tr>
<td>NHS Dumfries &amp; Galloway</td>
<td>148,129</td>
<td>214,007</td>
<td>3.00</td>
<td>96</td>
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<td>NHS Forth Valley</td>
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<td>336,940</td>
<td>5.51</td>
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<tr>
<td>NHS GG &amp; C</td>
<td>1,217,227</td>
<td>2,308,542</td>
<td>24.01</td>
<td>383</td>
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<tr>
<td>NHS Lanarkshire</td>
<td>566,274</td>
<td>773,477</td>
<td>10.88</td>
<td>1719</td>
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<td><strong>NES West</strong></td>
<td><strong>2,598,023</strong></td>
<td><strong>4,178,034</strong></td>
<td><strong>50.75</strong></td>
<td><strong>2628</strong></td>
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<tr>
<td>(48.90%)</td>
<td>(52.52%)</td>
<td>(50.75%)</td>
<td>(49.64%)</td>
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</table>

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16 Data from ISD

17 Data from ISD: Outpatient + Inpatient + Daycase + A&E Episodes

18 Data from ISD: NRAC 2013-14 excess cost adjusted % Share

19 Data from NES Pinnacle August 2013 - Excludes GPST trainees in practice – NES employed
### Annex 4: HEE LETBs

<table>
<thead>
<tr>
<th>LTB</th>
<th>Budget (2013/14) (£m)</th>
<th>PGM Trainees</th>
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<tbody>
<tr>
<td>East Midlands</td>
<td>361.7</td>
<td>3,172</td>
</tr>
<tr>
<td>East of England</td>
<td>383.7</td>
<td>3,187</td>
</tr>
<tr>
<td>Yorkshire and the Humber</td>
<td>496.5</td>
<td>4,807</td>
</tr>
<tr>
<td>Wessex</td>
<td>195.0</td>
<td>2,081</td>
</tr>
<tr>
<td>Thames Valley</td>
<td>162.0</td>
<td>1,836</td>
</tr>
<tr>
<td>North West London</td>
<td>261.6</td>
<td></td>
</tr>
<tr>
<td>South London</td>
<td>413.0</td>
<td>9,799</td>
</tr>
<tr>
<td>North Central and East London</td>
<td>447.6</td>
<td></td>
</tr>
<tr>
<td>Kent, Surrey and Sussex</td>
<td>277.3</td>
<td>3,316</td>
</tr>
<tr>
<td>North East</td>
<td>263.1</td>
<td>2,656</td>
</tr>
<tr>
<td>North West</td>
<td>711.4</td>
<td>6,017</td>
</tr>
<tr>
<td>West Midlands</td>
<td>497.9</td>
<td>4,509</td>
</tr>
<tr>
<td>South West</td>
<td>329.2</td>
<td>3,433</td>
</tr>
<tr>
<td><strong>SubTotal : LETBs</strong></td>
<td><strong>4,800.0</strong></td>
<td><strong>44,840</strong></td>
</tr>
<tr>
<td>HEE Central Running</td>
<td>12.0</td>
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<tr>
<td>HEE Central Programmes</td>
<td>71.3</td>
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<tr>
<td><strong>Subtotal HEE Central</strong></td>
<td><strong>83.3</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Total HEE</strong></td>
<td><strong>4,883.4</strong></td>
<td></td>
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<tr>
<td>Scotland (NES)</td>
<td>430.4</td>
<td>5,046</td>
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<tr>
<td>Wales (Deanery)</td>
<td>92.0</td>
<td>2,287</td>
</tr>
<tr>
<td>Northern Ireland (NIMDTA)</td>
<td>53.0</td>
<td>1,676</td>
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<tr>
<td><strong>UK</strong></td>
<td></td>
<td><strong>53,932</strong></td>
</tr>
</tbody>
</table>

20 Finance Report to HEE Board, July 2013

21 Based upon GMC NTS Published Survey Data

NHS CEOs 15 Jan Briefing v2