Department of Health

Expansion of Undergraduate Medical Education

A consultation on how to maximise the benefits from the increases in medical student numbers

March 2017

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Foreword

When the National Health Service came into operation in July 1948, it was the first time anywhere in the world that completely free healthcare was made available on the basis of citizenship rather than the payment of fees. It has continued to deliver universal healthcare for almost 70 years and is the envy of the world.

Since 2010, the NHS has seen 2.4 million more A&E attendances, 5.9 million more diagnostic tests and 820,000 more GP referrals seen by a specialist for suspected cancer.

Our job as politicians is to ensure the NHS can continue to adapt to a changing world so it can continue to deliver safe, compassionate and effective care for all our citizens.

With increasing populations and the World Health Organisation projection of a global shortage of 2.3 million doctors by 2030[i], we need to be looking ahead to ensure our NHS is able to meet the challenges ahead.

That is why we have taken the decision to increase our supply of home grown doctors by up to 1,500 places each year, in addition to the 6,000 places currently available in England. This 25 per cent increase is the biggest such increase in the history of the NHS. It will ensure that the NHS is equipped to care for a growing and ageing population with far more complex conditions.

By widening participation and providing more opportunities for people from all backgrounds to study medicine, intelligent and motivated people will no longer be turned away by medical schools and forced to do other degrees, while the NHS ends up short of home grown doctors.

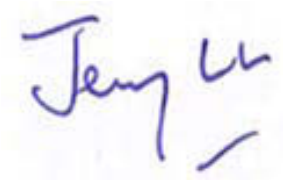
Over time, it will mean that we are taking fewer doctors from countries overseas where the domestic need is arguably greater than ours. This is a longstanding moral issue in our NHS given the number of well qualified home-grown applicants we turn away.

Increasing the number of doctors being trained will also help reduce reliance on expensive medical agency staff, and ensure the money is better spent on treating more patients.

We believe the additional numbers we are investing in are right for the NHS, right for the long term self-sufficiency of this country and right for the public.

However, in order to make sure we get this right we want to hear from as many individuals and organisations involved in medical education as possible. This consultation has been written with that open request in mind so that everyone has the ability to be heard.

I sincerely encourage as many as wish to contribute constructively to take part in the consultation exercise so that we can realise the full potential of this historic expansion and deliver our medical workforce education and training in the best way it can be.



Jeremy Hunt, Secretary of State for Health

1. Introduction

1.1. The world is changing. We as a country are changing. The NHS needs to change and improve in order to continue to provide the best possible care to the nation.

1.2. People are living longer, with increasingly complex care needs that require more support from health and social care services. There are a growing number of older people across the UK, many with multiple conditions including dementia. Even though they make up a relatively small group compared with the population as a whole, many older people require more medical interventions.

1.3. The NHS itself is moving towards a 7 day service and integration across organisational and sectoral boundaries. Evolving models of delivering care mean that it needs to be more person-centred and coordinated, especially for people with more than one long-term condition, and a greater focus on community services is required to avoid people in hospital beds who do not need to be there.

1.4. The current medical workforce has a reliance on expensive locum doctors and also on doctors from overseas. Overseas doctors make an important contribution to the NHS and will continue to do so, but as a country and a National Health Service, we need to be more self-sufficient with a medical workforce that can better respond to the demands placed upon the service.

1.5. To meet the challenges of the future in a cost efficient way we plan to increase the number of doctors that we train. In order to allow medical schools to expand in a managed way, and subject to Higher Education Funding Council for England (HEFCE) board approval, our intention is that in the academic year 2018/19 the number of medical school places available at established providers increase by approximately 500. The Higher Education Funding Council for England (HEFCE) will provide further information on the 2018/19 allocations in due course.

1.6. And to reach 1,500 additional places, we intend to increase the number of medical school places by a further approximately 1,000 per year from the academic year 2019/20. This consultation seeks your views on the criteria for determining where the increases should occur to achieve the most impact.

2. The case for medical education expansion

The current system for medical education

2.1. The Government makes a significant investment in medical education in England. As with all other students at English universities, medical students are required to pay tuition fees, although they are eligible for a bursary to cover these fees from the fifth year of study, or from the second year of the graduate entry programme. These fees do not cover the full cost of providing medical education, so HEFCE provides teaching grants to universities in recognition of the additional costs, such as specialist staff, equipment and facilities.

2.2. Medical students spend a significant amount of time undertaking clinical placements with healthcare providers. Health Education England (HEE) provides a placement fee (tariff) to providers who deliver placements.

2.3. In addition to the funding provided to universities and placement providers, medical students are also able to apply for funding to contribute towards their living costs whilst studying. This is provided both as repayable loans in the first four years and as a non-repayable bursary in the fifth (and sixth) year(s) of their course.

2.4. Because of this investment and the need to plan the future medical workforce for the NHS, the Government has historically chosen to retain control over the number of medical students accepted to English medical schools each year. The Department of Health, on advice from HEE, decides how many student places are needed in order to meet workforce requirements. This number is agreed with DfE and HEFCE, with HEFCE responsible for applying this intake target. The number is kept under review. The most recent review, in 2012, saw the overall number of places reduced by 2%.

2.5. HEFCE is responsible for determining how to distribute the agreed number of places between universities, which is achieved through the use of set intake targets for each medical school. HEFCE makes informed decisions which take into account the advice of HEE, both on future geographic or service need, as well as the availability of clinical placements.

2.6. HEFCE can increase or decrease the intake target for any given medical school to take account of specific circumstances or to respond to changes in the overall number of required places. When the number of medical school places was increased in the early 2000s, HEFCE ran a competitive allocation process with the sector which resulted in new medical schools being established as well as existing medical schools receiving increases to their intake targets.

2.7. Medical schools are also able to fill up to 7.5% of their places with overseas students from outside of the European Union (EU). These students do not attract the HEFCE teaching grant; they pay the full cost of their tuition and living costs at medical school. However, their clinical placement costs are met by the Government, the same as UK and EU students.

2.8. HEFCE controls the recruitment at medical schools through the intake targets to ensure that universities keep to their allocated number of students. If a university exceeds its intake target, then HEFCE will apply an adjustment to their grant allocation in order to ensure that the institution does not receive any advantage from over-recruitment. The current target intake figures for each medical school in 2016 can be found in the Annex.

2.9. In addition to the medical school places that are funded through government investment, some medical schools offer places to students who are able to self-fund all of the costs of their education, including their clinical placements. If the medical school is designated for student support under the Education (Student Support) Regulations 2011, these students may be able to claim student loans (living cost loans and tuition fee loans of up to £6,000) to support them through their studies (if eligible home/EU students). Such self-funding students are outside of the HEFCE intake controls.

What opportunities are being missed with the current system?

2.10. The NHS is experiencing increasing demand for care due to demographic changes and evolution of services to be more person-centred. Services will continue to transform to put the NHS on a long term sustainable footing. In the coming decades this means we will be facing an increased demand for services and healthcare workers.

2.11. Because of the significant investment that the Government makes in medical education – with it costing around £230,000[ii] to put a UK or EU national through medical school – controls have to be placed on the number of students at medical schools which limits the number of graduates available to take up employment in the NHS.

2.12. At present, of the 7,400 training places available in specialty training, around 700 of these currently go unfilled[iii]. The vacancies within some training programmes, and the knock-on impact on the ability to fill consultant and GP posts, may have contributed to a reliance on locum doctors which is a costly solution to the workforce challenges the NHS faces. In the financial year 2015/16 the NHS in England spent £3.6 billion[iv] on agency staff overall.

2.13. In addition, around 25% of doctors in the NHS are non-UK nationals[v]. Whilst we absolutely value the contribution these doctors make to the NHS, we need to expand the number of medical school places to be more self-sufficient with a medical workforce that can better respond to the demands placed upon the Service.

2.14. Not only does the current limit on medical school numbers present challenges for the NHS, it is also anomalous within the higher education sector. Since 2015 there have been no limits on the number of university students studying non-healthcare courses (apart from initial teacher training) at HEFCE funded providers in England. From 2017, the limits on overall university nursing, midwifery and allied health professional courses have also been removed. Whilst we are not proposing to remove the limit on medical school numbers, increasing the limit will allow the medical education sector to capitalise

on some of the benefits that have been seen with the removal of the limits in the rest of the higher education sector.

2.15. Entry into medical school has always been extremely competitive. In 2017 almost 20,000 applicants have applied for the just under 8,000[vi] places available at medical schools in the UK. Although the number of applicants seeking a place has reduced slightly, medicine continues to be highly competitive and there is no evidence that this is likely to change. Every year, medical schools have to turn down applications from talented applicants. Increasing the number of places will allow more of these students to achieve their ambition of becoming doctors.

2.16. We need to do more to attract graduates to work in areas that are struggling to recruit sufficient doctors in order to deliver high quality and sustainable services. The NHS fully intends to capitalise on having more medical students by offering a greater number of high quality placements in these areas to encourage students to think seriously about continuing their medical careers there. Having more students undertaking placements will also give general practice, and other specialties that need to increase the number of doctors in training, the opportunity to showcase their specialties to a greater number of students.

2.17. We need to do more to achieve greater diversity in the students we attract into medicine. By providing more opportunities for people from all backgrounds, intelligent and motivated people will no longer be turned away by medical schools and forced to do other degrees. This is discussed in greater detail at paragraph 3.21.

2.18. We also need to ensure that students are taught to embrace technological advances in service delivery to be better prepared to meet future challenges, able to adapt to constantly evolving techniques, and indeed, lead the development of innovative future practice across medicine, leadership and management. We therefore propose to use this process to stimulate the development of courses that not only focus upon theory and clinical skills, but also encourage students to think outside of current protocols and positively embrace innovation , change as well as leadership and management.

2.19. Medical schools in the UK provide some of the most respected medical education in the world. This government investment in medical education will allow universities to increase the quality even further, innovate the way they deliver education, adapt to the requirements of the new models of care being developed by the NHS and go further with their programmes to widen access to medical education and increase social mobility. The additional numbers also present an opportunity for new providers to enter medical education.

What are the benefits of expanding the number of places?

2.20. It takes between 4 and 6 years for a student to graduate from medical school so the benefit of increasing the number of students will take some time to be achieved, but this is about laying the foundations for the future and taking the long term decisions now. However, once the number of medical graduates increases we expect to see the following benefits:

- a move towards self-sufficiency which should reduce spend on locum/agency staff, and the reliance on overseas doctors
- improved recruitment to general practice and shortage specialties as students have more exposure to placements in these specialties
- improved recruitment to posts in areas that traditionally struggle to recruit as more placements are offered in these areas and there is a greater supply of graduates
- greater diversity of medical graduates as universities take further measures to widening participation and increasing social mobility through outreach and other initiatives and offering the brightest and the best the opportunity to become a doctor regardless of their background or where they studied

3. How we will make this happen

Summary

3.1. The changes to the current system will mean:

- universities will no longer be limited on the number of international medical students they can recruit
- from the academic year 2018/19, the intention is that new international students will need to fund their own clinical placements, in addition to the tuition and living costs they pay currently
- allocating approximately 500 additional places to HEFCE fundable medical schools currently providing education for take up in the academic year 2018/19
- running a competitive bidding process for the allocation of the remaining approximately 1,000 places for take up by the academic year 2019/20 or earlier

3.2. This consultation seeks views on:

- the criteria for the competitive bidding process for the allocation of the remaining approximately 1,000 places
- the options for a return of service agreement
- the implications of the proposed changes on the point of registration
- any potential impact on equalities

3.3. Financial impact and equalities assessments will be published with the Government's response to this consultation.

Changes to funding

3.4. We need to review the system for medical education to enable us to increase the number of medical school places by up to 1,500 per year. Controls on the number of students will remain in place to ensure affordability and sustainability but the additional numbers are likely to be distributed differently between medical schools, with the opportunity for new universities to bid for places. HEFCE, working in partnership with HEE, the Department for Education and the Department of Health, will lead that competitive process and monitor the subsequent recruitment. Subject to legislation, HEFCE responsibilities in this area will transfer to the Office for Students from 2018/19.

3.5. We currently invest around £1.3bn in medical education with approximately £600m coming from higher education budgets and £700m from NHS budgets. It costs around £230,000 to educate a UK or EU national through medical school. The funding broadly falls into three categories – provided to the student (to contribute to their living costs and

tuition), to cover the additional costs incurred by universities because of the specialist nature of the courses, and to contribute to the costs incurred by the NHS of providing clinical placements to students. Table 1 sets out the current funding arrangements for UK and EU students.

Table 1: Funding arrangements for UK students

Item	Current Arrangements
Student support[1]	Loans for tuition fees and living costs available in first 4 years of undergraduate course. From year 5 students can apply for an NHS bursary to contribute to living costs and pay for tuition fees.
Teaching grant	Universities receive a scaled allocation of £1,500 per student for the non-clinical years and £10,000 per student during the clinical years to recognise the higher cost of delivering medical education.
Placement tariff	Healthcare providers receive an average tariff of around £36,000 to provide a year's worth of placements to students.

[1] The student support outlined is for students on the undergraduate course. The funding for students on the graduate entry programme is different with NHS bursary funding commencing in year 2 of study.

Determining Student Eligibility

3.6. Department for Education (DfE) is responsible for determining whether students are eligible for the majority of student support and all students' eligibility for placement funding, the NHS Bursary and the teaching grant will be aligned to their student support eligibility.

3.7. Future arrangements for student support after the UK leaves the European Union (EU) will need to be considered as part of wider discussions about the UK's relationship with the EU. However, the Government has confirmed that EU students starting their courses in 2017/18 or before will continue to be eligible for student loans and home fee status for the duration of their course. Applications for 2018/19 open in September 2017, and we will ensure that students applying have information in advance of this date.

3.8. UK nationals studying at medical schools outside of the HEFCE funding regime currently fund their own clinical placement costs but, subject to the status of their education provider, can apply for loans to contribute towards their living and tuition costs.

International Students

3.9. Although international medical students[vii] currently pay the full cost of their tuition and living costs at medical schools, their training is subsidised with their clinical placement costs being met by the Government. This is a substantial cost, currently at over £110,000 per student.

3.10. This subsidy for international students is taking funds away from the training of the domestic medical workforce. In order to expand the domestic medical workforce supply, therefore, we propose to make changes to the arrangements for international students.

3.11. It is our intention that from 2018/19 new international students studying at English universities will be expected to fund their own placements, and there will be no limit on the number of international medical students that English universities can recruit. International students currently pay the full cost of their tuition and living costs at medical schools and will continue to do so.

3.12. Steps are and will continue to be taken to monitor recruitment at English institutions to ensure that there is no unintended destabilising effect on medical provision as a result of the expansion and any potential changes to overseas numbers.

Increasing the number of places in 2018/19

3.13. To move quickly with the expansion of medical school places, we plan to make an initial increase of approximately 500 places in 2018/19 to be allocated to HEFCE fundable medical schools currently providing education to students as at 1st March 2017 that are either on the General Medical Council (GMC) list of awarding bodies entitled to award a primary medical qualification or have had a decision taken by the GMC to commit resources to their school for a rolling programme of quality assurance to become an awarding body. This will enable new graduates to enter the NHS as quickly as possible through existing providers and allow medical schools to expand in a planned way.

3.14. HEFCE will release further information on the 2018/19 allocation process in due course, though it is likely that the allocation will take account of capacity, sustainability and placement quality to ensure a fair distribution that keeps central the student interest and the needs of the NHS, for example priority specialties such as general practice and psychiatry.

Increasing the number of places in 2019/20

3.15. The Secretary of State for Health announced in October 2016 that we would increase the number of medical school places by 1,500. We therefore plan to add approximately 1,000 additional places from 2019/20, on top of the extra approximately 500 places introduced in 2018/19.

3.16. As part of this expansion we want to offer new high quality providers a direct route of entry to the medical education and training market. It is important therefore that education providers are aware of the Government's longer term plans in this area.

3.17. We need to ensure that the allocation criteria enables all providers to compete on a level playing field for the extra places, enables innovation and creates a sustainable and modern medical education system for the future.

Distribution of places across the next few years

3.18. Our plan is to introduce all remaining additional places as soon as possible via a competitive bidding process. The expectation is that these places will be available by 2019/20 or earlier, depending on institutional capability.

Question 1

How would you advise we approach the introduction of additional places in order to deliver this expansion in the best way?

Distribution of places across medical schools

3.19. HEFCE (or subject to legislation, from 2018/19 OfS) will be responsible for allocating the additional places to universities. In doing so they will ensure that successful universities are able to demonstrate that they have the capacity to teach additional students in a high quality environment and have strong agreements in place with healthcare providers to deliver effective clinical placements to all of their students.

3.20. In addition, it is important that the criteria used by HEFCE for allocating the places achieve the benefits envisaged for the increased investment, including boosting numbers into GP training and other shortage specialities such as psychiatry. We have set out a number of areas we believe should be reflected in the criteria that will be developed by HEFCE and welcome your views on these.

Question 2

What factors should be considered in the distribution of additional places across medical schools in England?

Answer options: (please choose as many as appropriate)

University staffing capacity

University estates/infrastructure capacity

University capital funding capacity

NHS/GP clinical placement capacity

Mobilisation / timing capability

New medical schools

Others: (please specify)

Incentivise social mobility

3.21. In 2012 the Social Mobility and Child Poverty Commission[viii] reported that, in terms of widening access and thus improving social mobility, 'medicine lags behind other professions both in the focus and in the priority it accords to these issues. It has a long way to go when it comes to making access fairer, diversifying its workforce and raising social mobility.'

3.22. The Medical Schools Council sought to address this and other issues relating to the diversity of medical school selection procedures through the Selecting for Excellence project which published its final report in December 2014[ix], making a number of recommendations that could improve social mobility within the medical profession and build on the substantial amount of activity already undertaken. The report recognised that it was the start of an ongoing mission for medical schools and a progress report was published in 2016[x].

3.23. We believe universities should be incentivised to continue to improve widening access and social mobility if they wish to benefit from the extra medical student places.

Question 3

Do you agree that widening access and increasing social mobility should be included in the criteria used to determine which universities can recruit additional medical students?

Answer options: *Yes / No*

Question 4

Do you think that increased opportunities for part-time training would help widen participation?

Answer options: *Yes / No*

Question 5

If you have any additional information/experiences around widening access and increasing social mobility that would be helpful in developing the allocation criteria, please provide it here.

Ensuring sufficient doctor supply in all areas

3.24. We know that some parts of the country have historically experienced problems recruiting and retaining doctors, resulting in challenges to the delivery of services and increased spend on expensive locums. Table 2 shows the average percentage of posts filled at the first level of specialty training in each HEE local team area over the three years 2014 to 2016. The data illustrates the significant difference in the ability of areas such as the North East and London and the South East to attract trainees.

Table 2: Fill rates for specialty training posts

Area	Average percentage of CT1/ST1 posts filled 2014-2016 (%)	Average proportion of CT/ST1 trainees with non-UK primary medical qualification (%)
London	100	4
Kent, Surrey and Sussex	99	19
Thames Valley	99	11
Wessex	96	12
South West	96	7
East of England	95	29
West Midlands	91	21
North West	89	20
East Midlands	88	24
Yorkshire and Humber	86	21
North East	83	21

Source: Health Education England

3.25. We believe that graduates are more likely to consider a career in these areas if they go to university there and have an enjoyable and rewarding student experience. Research by Goldacre et al, 2013[xi] found that 48% of UK trained doctors undertook specialty training in the same region as their medical school. It further found that 34% of respondents who had reached GP or consultant level had settled in the same region as their home before entering medical school.

3.26. Table 3 shows how the proportion of medical student intake in each HEE local team area compared to the proportion of the population resident in those areas in 2014.

Table 3: Proportion of medical school intake compared to UK population

Area	Proportion of English medical school intake in the area (%)	Proportion of UK population in the area (%)
North East	5.7	4.8
North West	11.9	13.2
Yorkshire and Humber	10.5	10.0
West Midlands	11.2	10.5
East Midlands	9.3	8.2
East of England	7.4	11.0
London	26.8	16.3
Kent, Surrey and Sussex	2.3	8.2
Thames Valley	3.0	4.4
Wessex	4.1	5.0
South West	7.8	8.5

Source: Health Education England

3.27. The 2016 progress report of the Selecting for Excellence project provided an analysis of the outreach activity undertaken by medical schools and identified 'cold spots' within England where medical schools in some areas were not engaging with their local secondary schools. This provides valuable information for medical schools to use in order to encourage applications from certain parts of the country that may also be struggling to attract doctors.

3.28. The NHS also needs to play its part by engaging pro-actively with local schools in their area and, for example, offering support with applications and offering relevant work placements. This approach will also ensure the NHS workforce will be more reflective of the communities it serves and become a central and visible part of local schools, which will have wide ranging benefits across all workforce groups.

3.29. Increasing the number of medical students in areas that experience recruitment difficulties will provide more opportunities for students, through their clinical placements, to experience the reality of working in the NHS in these areas and enable them to consider making their careers there. We therefore propose that the allocation criteria should incentivise universities, working with HEE and placement providers, to deliver education and placements in geographical areas that experience recruitment difficulties and to attract students who reside in these areas prior to applying to medical school.

Question 6

Do you agree that where the NHS needs its workforce to be located should be included in the criteria used to determine which universities can recruit additional medical students?

Answer options: *Yes / No*

Question 7

If you have any additional information/experiences about attracting doctors to areas facing recruitment challenges that would be helpful in developing the allocation criteria, please provide it here.

Support recruitment into general practice and shortage specialties

3.30. We know that it can be harder to fill specialty training posts in certain specialties. Table 4 illustrates the difference in the percentage of speciality training posts filled at core and higher level in some of the larger specialties in the last two years.

Table 4: Recruitment to Core Training and Specialty Training posts in England

Specialty	2016		2015	
	Posts	Fill Rate	Posts	Fill Rate
Core /Specialty Training 1				
Cardiothoracic surgery	5	100.0%	6	100.0%
Clinical Radiology	212	100.0%	212	100.0%
Community Sexual and Reproductive Health	5	100.0%	2	100.0%
Neurosurgery	23	100.0%	28	100.0%
Ophthalmology	61	100.0%	74	100.0%
Oral and Maxillo-facial Surgery	3	100.0%	5	100.0%
Public Health Medicine	57	100.0%	78	100.0%
Core Surgical Training	507	99.8%	508	98.0%
ACCS Anaesthetics/Core Anaesthetics	487	99.2%	519	100.0%
Obstetrics and Gynaecology	230	99.1%	205	100.0%
Acute Care Common Stem - Emergency Medicine	321	98.8%	327	99.4%
Histopathology	79	98.7%	74	102.7%
ACCS Acute Medicine/Core Medical Training	1,375	95.2%	1,368	97.9%
Paediatrics	379	92.9%	373	96.3%
General Practice	3,250	92.9%	3,117	88.8%
Core Psychiatry Training	506	80.0%	463	78.4%

Specialty	2016		2015	
	Posts	Fill Rate	Posts	Fill Rate
Specialty Training 3 & 4				
Cardiology	122	100.0%	122	98.4%
Cardio-thoracic surgery	7	100.0%	11	100.0%
Dermatology	40	100.0%	51	100.0%
Diagnostic neuropathology	2	100.0%	2	50.0%
Medical Ophthalmology	1	100.0%	4	100.0%
Nuclear Medicine	7	100.0%	8	37.5%
Otolaryngology	52	100.0%	63	100.0%
Paediatric Surgery	11	100.0%	12	100.0%
Plastic Surgery	41	100.0%	78	97.4%
Trauma and Orthopaedic Surgery	124	100.0%	193	100.0%
Urology	56	100.0%	63	100.0%
Medical Psychotherapy	1	100.0%	2	100.0%
Paediatric Cardiology	7	100.0%	16	100.0%
Gastroenterology	99	99.0%	151	85.4%
Rheumatology	43	95.3%	74	77.0%
Neurology	42	95.2%	56	82.1%
Palliative Medicine	38	94.7%	49	91.8%
General Surgery	164	94.5%	200	95.5%
Anaesthetics	411	93.4%	447	97.5%
Intensive Care Medicine	140	90.0%	125	86.4%
Sport and Exercise Medicine	9	88.9%	14	64.3%
Clinical Neurophysiology	7	85.7%	13	69.2%
Medical Oncology	45	84.4%	39	74.4%
Occupational Medicine	6	83.3%	13	84.6%
Geriatric Medicine	127	82.7%	151	87.4%
Respiratory Medicine	116	79.3%	157	74.5%
Clinical Oncology	59	78.0%	82	72.0%
Combined Infection Training	68	77.9%	72	63.9%
Paediatric and perinatal pathology	9	77.8%	6	33.3%
Endocrinology and Diabetes Mellitus	85	77.6%	98	69.4%
Renal Medicine	76	72.4%	81	49.4%
Clinical Genetics	14	71.4%	20	70.0%
Immunology	7	71.4%	9	77.8%

Specialty	2016		2015	
	Posts	Fill Rate	Posts	Fill Rate
Haematology	107	70.1%	80	85.0%
Acute Internal Medicine	111	69.4%	113	54.0%
General Psychiatry and Old Age Psychiatry	64	68.8%	60	61.7%
General Psychiatry and Medical Psychotherapy	12	66.7%	10	70.0%
Genito-urinary Medicine	36	61.1%	49	32.7%
Rehabilitation Medicine	17	58.8%	23	47.8%
General Psychiatry	215	58.1%	136	80.1%
Child and Adolescent Psychiatry	85	54.1%	55	67.3%
Psychiatry of Learning Disability	46	52.2%	36	50.0%
Audio vestibular Medicine	2	50.0%	1	100.0%
Forensic Psychiatry	45	44.4%	27	70.4%
Oral and Maxillo-facial Surgery	29	41.4%	28	64.3%
Old Age Psychiatry	74	27.0%	40	65.0%
Emergency Medicine	97	25.8%	121	18.2%
Metabolic Medicine	23	13.0%	22	22.7%

Source: Health Education England

3.31. HEE and the Medical Schools Council have recently published 'By choice - not by chance: Supporting medical students towards future careers in general practice'[xii]. This sets out a number of recommendations on how medical education can support general practice to attract doctors but we need to go further to support general practice and other specialties to fill their training posts.

3.32. We believe that giving students additional exposure to high quality placements in general practice and specialties that experience recruitment difficulties will improve recruitment into these specialties. We therefore propose that the allocation criteria should incentivise universities, working with HEE and placement providers, to support general practice and shortage specialties to attract doctors.

Question 8

Do you agree that supporting general practice and shortage specialties to attract new graduates should be included in the criteria used to determine which universities can recruit additional medical students?

Answer options: *Yes / No*

Question 9

If you have any additional information/experiences about attracting doctors to general practice and shortage specialties that would be helpful in developing the allocation criteria, please provide it here.

Ensure education equips students to maximise the use of technology in practice

3.33. Better use of data and technology has the power to radically improve health, transform quality and increase efficiency in the delivery of health and care services. From the application of artificial intelligence in decision support to genomic medicine in diagnosis and treatment, we are already seeing an accelerating role for emerging science and technology. These innovations are also key to enhancing training and learning across the health and social care workforce. HEE is working with partners to deliver the vision set out in 'Personalised Health and Care 2020: A framework for action'[xiii] to support care professionals to make the best use of data and technology.

Ensure quality of training and placement experience is maintained

3.34. In increasing the number of medical students it is important that the quality of training and the placement experience is not diminished. In fact, we believe that increasing the number of students should provide an opportunity for universities and placement providers to invest more in the student experience and quality of supervision and support. We therefore propose that the allocation criteria should incentivise universities that can demonstrate the additional investment in extra students will have a positive impact on the quality of training and placements.

Question 10

Do you agree that the quality of training and placements should be included in the criteria used to determine which universities can recruit additional medical students?

Answer options: *Yes / No*

Question 11

If you have any additional information/experiences about how to improve the quality of training and placements that would be helpful in developing the allocation criteria, please provide it here.

Encourage education innovation and market liberalisation

3.35. Increasing the number of medical student places provides opportunities for the range of universities; those with existing medical schools, either large or small, new or old; and those seeking to establish medical schools.

3.36. The Government is already taking forward a set of reforms to higher education that will support this ambition. These are set out in the White Paper 'Success as a Knowledge Economy: Teaching Excellence, Social Mobility, and Student Choice', and supported by the Higher Education and Research Bill currently before Parliament. The planned reforms will make it simpler and quicker for new high quality providers to set-up and enter the higher education sector, but only if they offer high quality provision. They aim to level the playing field for providers and stop treating institutions differently based on incumbency and corporate form, and instead create a single route to entry and a risk-based approach to regulation.

3.37. Under the current regime, new and innovative providers have to wait before operating as degree awarding bodies in their own right, no matter how good their offer is or how much academic expertise they have. We need to address this and offer a direct route of entry to the market for new high quality providers. It is important that quality is checked, and that students interests are well served, but at the moment we have a situation where new providers who are in a position to deliver high quality provision are being held back.

3.38. We need to ensure that the allocation criteria enables all providers to compete on a level playing field for the extra places, enables innovation and creates a sustainable, plural medical education system for the future. To increase choice, competition and quality in the undergraduate medical education market, universities will need to offer creative solutions to compete successfully for medical school places.

Question 12

Do you agree that all providers should be offered the opportunity to bid for the additional medical school places?

Answer options: *Yes / No*

Question 13

Do you agree that innovation and sustainability should be included in the criteria used to determine which universities can recruit additional medical students?

Answer options: *Yes / No*

Question 14

If you have any additional information/experiences about how to encourage innovation and sustainability that would be helpful in developing the allocation criteria, please provide it here.

Question 15

We would be interested in hearing views on how meeting the needs of the NHS aligns with the role universities wish to have in the future distribution of places in an expanded market - please provide your views here.

4. Return of service agreement

Introduction

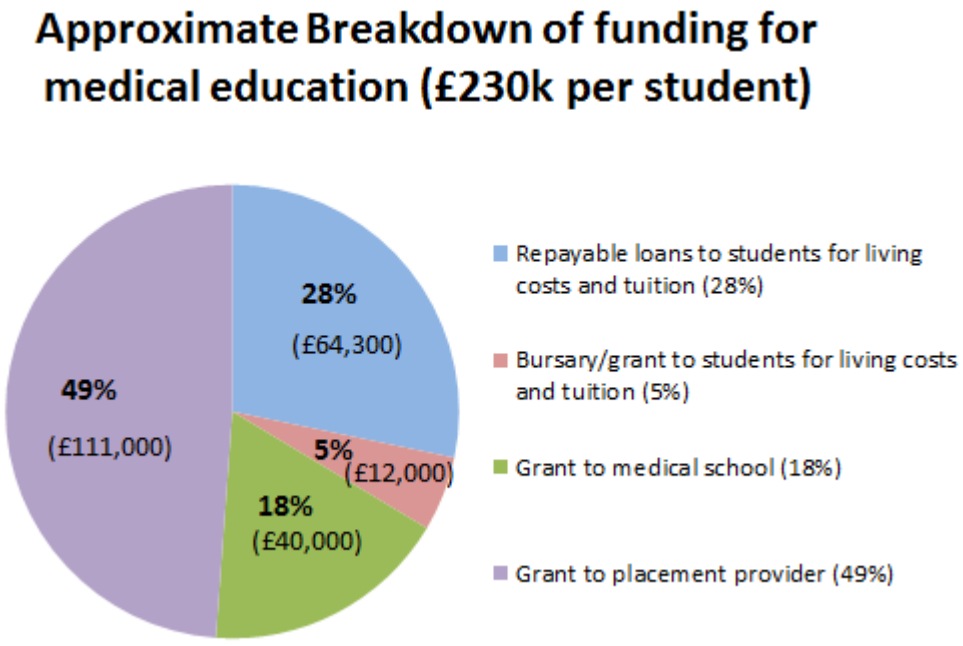
4.1. To meet future staffing needs Health Education England (HEE) is responsible for planning and commissioning postgraduate medical training in England. That is the stage of training between completion of undergraduate education and eligibility to apply for consultant and GP posts, where trainees work as junior doctors and pursue their chosen specialty training programme.

4.2. HEE is responsible for determining the appropriate numbers along with their specialty and geographical distribution in order to comply with its remit to support the delivery of excellent healthcare and health improvement to the patients and public of England by ensuring that the workforce of today and tomorrow has the right numbers, skills, values and behaviours, at the right time and in the right place.

A Return on Investment

4.3. Each year the Government spends around £1.3bn on undergraduate medical education. It costs around £230,000 to put a UK or EU national through medical school. A proportion of the funding (around £65,000) is paid to students as loans which they are required to repay once they reach a certain level of earnings (currently £21,000). The remainder of the funding is provided to the student to support them through university (to contribute to their living costs and tuition), to cover the costs of providing their clinical placement and to cover the additional costs of tuition. Figure 1 shows the breakdown of the funding:

Figure 1: Breakdown of Funding



4.4. Given the amount of taxpayer investment in training a doctor, we would like feedback on the principle of ensuring a return on investment for the tax payer.

4.5. One proposal may be that medical graduates are required to work in the NHS in England for a continuous period of time. And doctors who choose not to do so could be required to repay the recoverable elements of funding invested in their education.

4.6. This would be similar to the system operated by the armed forces whereby medical students receive funding to support them to complete their degree in return for agreeing to serve for a given period.

4.7. If a medical graduate chooses not to complete the required amount of time in the NHS then they could be required to repay a sum of money in addition to their loan repayments.

4.8. Of course, there are a range of circumstances, for example those covered under statutory provisions including maternity leave, which may mean that doctors do not gain employment immediately after graduating. There will need to be agreed criteria by which to assess to whom a return of service agreement might apply.

4.9. The responses we receive from this consultation will inform our decision on whether to undertake further work to develop detailed policy proposals.

Principle

Question 16

Do you agree with the principle that the tax payer should expect to see a return on the investment it has made?

Answer options: *Yes / No*

Mechanism

Question 17

Do you agree in principle, that a minimum number of years of service is a fair mechanism for the tax payer to get a return on the investment it has made?

Answer options: *Yes / No*

Question 18

Do you have any views on how many years of service would be a fair return for the tax payer investment?

Answer options: *2 / 3 / 4 / 5 / more than 5*

Question 19

Do you agree with the principle that graduates should be required to repay some of the funding invested in their education if they do not work for the NHS for a minimum number of years?

Answer options: *Yes / No*

Impact

Question 20

Can you think of any potential impacts of requiring graduates to repay some of the funding if they do not work in the NHS for a minimum number of years?

Further Work

Question 21

Is this a policy you wish to see explored and developed in further detail?

Answer options: *Yes / No*

5. Longer Term Considerations

Point of Registration

5.1. At the end of their degree programme, medical graduates are only entitled to provisional registration with the General Medical Council (GMC), and need to successfully complete one year of paid training (the first year of the foundation programme) to be granted full registration with a licence to practice which enables them to practice as a doctor in the UK and elsewhere.

5.2. There has been a significant amount of discussion in recent years at what point doctors should be granted registration and this was covered in the 'Shape of Training' report. As such, we recognise that some stakeholders may consider that expanding undergraduate medical training places may mean there should be changes to the point at which doctors receive registration.

5.3. This is in the context of the Medical Licensing Assessment consultation that the GMC is currently running, and will be impacted by the conclusions GMC draw from the responses, and the decisions they make.

5.4. This is a UK-wide issue that impacts the countries of the devolved administrations.

5.5. The purpose of this consultation is not to consult on whether there are changes to the point of registration. However, the Government acknowledges that there may be a number of advantages to moving the point of registration and therefore this consultation provides an early vehicle for some of these benefits to be submitted to Government, ahead of considering options in the longer term.

5.6. The Government recognises that a number of stakeholders may wish to make specific mention of their views on the implications of the policy and that may include views around the point of registration.

5.7. As part of evidence gathering and longer-term planning, we would welcome views on this directly to undergradmedicalexpansion@dh.gsi.gov.uk. Any changes to the point of registration would be subject to a full public consultation.

6. Equalities

Public Sector Equality Duty and the Family Test

6.1. In considering this matter Ministers must comply with the Public Sector Equality Duty under the Equality Act 2010. Section 149 of the Equality Act 2010 requires public authorities to have due regard to the need to:

- eliminate discrimination, harassment, victimisation and any other conduct prohibited by the Act
- advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it
- foster good relations between people who share a relevant protected characteristic and people who do not share it.

6.2. These three aims all apply to the following relevant protected characteristics: age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation. Marriage and civil partnership is also a protected characteristic in relation to the first aim of having due regard to the need to eliminate discrimination, harassment, victimisation and any other conduct prohibited by the Act.

6.3. The proposals are aimed at ensuring the NHS can continue to deliver safe, compassionate and effective care for all citizens in the long term. It is considered that the proposals would generally have a positive impact on equalities. This includes advancement of equality of opportunity and fostering of good relations between persons who share a relevant protected characteristic and others.

6.4. Department of Health will continue to consider carefully the data with a view to the on-going discharge of the Public Sector Equality Duty. The Department of Health will assess available data on medical students and is asking the following questions to build upon its on-going analysis of the potential impact of the proposals:

Question 22

Do you have any comments about the impact any of the proposals may have on people sharing relevant protected characteristics as listed in the Equality Act 2010?

Question 23

Is there anything more we can do to advance equality of opportunity and to foster good relations between such people and others or to eliminate discrimination, harassment or victimisation?

Question 24

We are interested to hear views about the impact the proposals may have on families and relationships. For example, do you consider training more doctors will have a positive impact on flexible working because of additional system capacity?

Annex

2016 Intake Figures Medical Schools in England

Institutions	Total Intake Target	Anticipated home	Anticipated overseas
University of Birmingham	374	346	28
Universities of Brighton and Sussex	138	128	10
University of Bristol	251	232	19
University of Cambridge	292	270	22
University of East Anglia	167	154	13
Universities of Hull and York	141	130	11
Imperial College	322	298	24
Keele University	129	119	10
King's College London	403	373	30
Lancaster University	54	50	4
University of Leeds	258	239	19
University of Leicester	241	223	18
University of Liverpool	307	284	23
University of Manchester	371	343	28
University of Newcastle	343	317	26
University of Nottingham	327	302	25
University of Oxford	184	170	14
University of Plymouth	86	80	6
University of Exeter	130	120	10
Queen Mary, University of London	316	292	24
St George's Hospital Medical School	259	240	19
University of Sheffield	237	219	18
University of Southampton	242	224	18
University College London	322	298	24
University of Warwick	177	164	13
TOTAL	6071	5615	456

Source: HEFCE

References

[i] Global strategy on human resources for health: Workforce 2030 – World Health Organisation, 2016.
[ii] The cost of putting a student through medical school, for the purpose of this policy, has been calculated from data obtained from HEE, HEFCE, DfE and the NHS BSA. It may differ from data published elsewhere.
[iii] Health Education England, Specialty Recruitment Acceptance and Fill Rate, August 2016.
[iv] NHS Trusts end of year accounts for the financial year 2015/16.
[v] NHS Digital, NHS Workforce Statistics for Trusts & CCGs, September 2016.
[vi] UCAS data for the October 2017 deadline, for courses starting in the academic year 2017/18.
[vii] International students in this document refer to those students not considered as Home Fee paying and eligible for student loans from the Student Loans Company.
[viii] Fair Access to Professional Careers: A progress report by the Independent Reviewer on Social Mobility and Child Poverty, May 2012.
[ix] Medical Schools Council, Selecting for Excellence: Final Report, December 2014.
[x] Medical Schools Council, Implementing Selecting for Excellence: A progress update, May 2016.
[xi] Goldacre M, Davison J, Maisonneuve J and Lambert T (2013): 'Geographical movement of doctors from education to training and eventual career post: UK cohort studies' J R Soc Med, 106(3), 96-104.
[xii] Health Education England and Medical Schools Council, By choice – not by chance: Supporting medical students towards future careers in general practice, November 2016.
[xiii] National Information Board, Personalised Health and Care 2020: Using Data and Technology to Transform Outcomes for Patients and Citizens. A Framework for Action.