



Department
of Health

Expansion of Undergraduate Medical Education

Government Response to Consultation

August 2017

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Ministerial Foreword



In 2016, the Secretary of State for Health announced the Government's commitment to expanding undergraduate medical training places by 1,500, with students due to take up initial additional places from September 2018. This expansion of home-grown doctors will not only increase our supply of doctors but will also provide more opportunities for students with the talent, drive and ambition to train as a doctor.

Medical education is important because it is integral to the future of all our citizens and our country. The Government makes a significant investment on behalf of the taxpayer in the training of our doctors and we need to think carefully when making changes to the medical education system. This is why we consulted on our proposals, so that collectively we can ensure our medical education system is the best it can be.

We launched the public consultation by saying 'we want to hear from as many individuals and organisations involved in medical education as possible'. We have had a fantastic response to the consultation, with over 3,500 responses. We thank all of those who responded to the consultation, as it is through this engagement that we can create policy that truly serves all our citizens.

The Government remains dedicated to the diversity of the future NHS workforce; we know how important it is that our health service reflects the people it serves and that people from all backgrounds feel that studying medicine is accessible.

The Government has listened to the views and experiences provided by individuals and organisations. Based on the feedback we received, the Government response confirms our manifesto commitment to an expansion of 1,500 places from September 2018 and outlines the Government's priorities for inclusion in the bidding criteria that the Higher Education Funding Council for England and Health Education England will develop.

Reflecting on responses to the consultation and engagement across Government, the Government will pause changes to charges for international students for their NHS funded clinical placements which were planned for 2018-19. This will allow for further consideration and work on maximising the return on taxpayer investment in medical education.

A handwritten signature in black ink, appearing to read 'Philip Dunne', written in a cursive style.

Philip Dunne MP

Minister of State for Health

1. Introduction

- 1.1. In the consultation we launched on 14 March 2017, we set out the case for increasing the number of domestic students entering medical schools in England, why it was necessary and how we would achieve an increase of 1,500 places quickly. This comprised:
 - an immediate increase of approximately 500 places for allocation across existing medical schools, details of which have since been set out by the Higher Education Council for England (HEFCE)
 - and
 - an increase of a further approximately 1,000 places via an open competitive bidding process, the criteria for which was the focus of the consultation
- 1.2. Alongside this we also:
 - announced plans for changes to the arrangements for international¹ students
 - asked high level questions of principle on how best to maximise a return on taxpayer investment in medical education
 - sought views on changes to the point of registration
- 1.3. This response document sets out the Government's proposed way forward on:
 - the allocation of the 1,000 additional places
 - arrangements for international students starting in 2018-19 and thereafter
 - maximising taxpayer investment in medical education
 - point of registration
 - analysis of the consultation responses and evidence
- 1.4. Alongside this, we are also publishing equalities and financial impact assessments.

2. Key points of Government response

- 2.1. We thank all those who took the time to respond to the consultation. The responses have been mixed and wide ranging.
- 2.2. In formulating its response, the Government has been guided by our responsibility to ensure the provision of safe and high quality healthcare to all of our citizens, in every part of England, as well as the views expressed through the consultation.
- 2.3. The Government response provides an overview of all the responses received through the consultation. The consultation and the Government response to it will ensure that Health Education England (HEE) and HEFCE are able to proceed with a competitive bidding process for allocation of the remaining places.
- 2.4. We have set out below next steps on implementing the expansion. We will share anonymised analysis of consultation responses with HEE and HEFCE to ensure that feedback is considered and the concerns raised are addressed as far as possible in implementing the expansion, whilst also taking account of the need to provide effective public services and make best use of public funds.

Overall expansion numbers

- 2.5. The Government is committed to expanding government-funded undergraduate medical places by 1,500, as announced by the Secretary Of State in October 2016. However, the Government recognises there will be in the future a need to anticipate demand for medical students, and we will continue to monitor the NHS future workforce needs.
- 2.6. As set out in the consultation, our intention is that in the academic year 2018-19 the number of medical school places available at established providers will increase by approximately 500. The remaining 1,000 places will be allocated through a competitive process with the expectation for delivery in 2019-20. There will be some flexibility to consider phased starts in 2018-19 or 2020-21 where bids that are best able to meet the Government's policy objectives provide strong evidence of the need to provide places to a different timescale.

Competitive bidding process for the additional 1,000 places

- 2.7. HEFCE and HEE will set out later in 2017 details of the competitive bidding process for the allocation of the further 1,000 places.
- 2.8. The bidding criteria will be determined jointly by HEFCE and HEE, and will be prioritised to address the following:
 - widening participation and improving access so that the medical workforce is more representative of the population it serves
 - aligning expansion to local NHS workforce need with an emphasis on priority geographical areas, including rural and coastal areas
 - supporting general practice and other shortage specialties so that the NHS can deliver services required to meet patient need

Key points of Government response

- ensuring sufficient provision of high quality training and clinical placements (with funding provided to HEFCE for the additional teaching costs and funding to HEE to support additional high quality placements)
- encouraging innovation and market liberalisation

International students

- 2.9. The consultation outlined the Government's intention to increase domestic supply and charge international students the full costs of their course from 2018-19.
- 2.10. Following feedback provided through the consultation, these changes will commence in 2019-20 and not in 2018-19 as indicated in the consultation. This means the Government will continue to fund clinical placements for international students commencing study at English universities in 2018-19 while it undertakes further cross-government work on implementing the change in 2019-20.

Return of service agreement

- 2.11. There was some agreement, particularly from organisations that responded, on the principle of ensuring that the significant taxpayer investment in medical education is maximised, but no general consensus on the mechanism by which to achieve this.
- 2.12. The Government will ask Health Education England to consider this in the context of changes to medical education curricula in the wake of the Greenaway recommendations on the *Shape of Training*ⁱⁱ report, and report back by Spring 2018.
- 2.13. In doing so, we will ensure HEE considers all consultation responses on the minimum number of years of service and its impact on those with protected characteristics.

Longer term considerations – point of registration

- 2.14. There was a range of responses on the point of registration. The Government is committed to making reforms in this area in the context of wider reforms to medical education. We will consult before changing the point of registration.

Widening participation

- 2.15. This policy provides an opportunity to widen participation and incentivise social mobility in the medical profession.
- 2.16. Medical schools already offer a variety of outreach schemes with some offering summer school for secondary students that assist with medical school applications and gaining work experience, while others outreach to primary schools to inspire children at a young age to consider medicine. However, we recognise more needs to be done in this area.
- 2.17. In expanding the number of medical school places in England by 1,500 the Government set out its clear intention that widening participation and increasing social mobility would be central to this historic expansion. Funding an additional 1,500 medical school places in England will provide more opportunities for people to study for a career in medicine,

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regardless of their social and economic background or the school at which they studied. This approach means greater opportunities for all and fewer intelligent and motivated people are turned away by medical schools and forced to do other degrees.

- 2.18. By keeping central the need to widen participation and ensuring fair selection decisions, we allow access to education and employment regardless of age, race, disability and social status.
- 2.19. A large number of respondents to the consultation discussed funding arrangements and participation.
- 2.20. The Government is committed to ensuring that anyone with the talent and potential should have an opportunity to go into higher education - this principle is central to the expansion of medical school places. The student funding system is fair and progressive. It removes financial barriers for anyone hoping to study and is backed by the taxpayer, with outstanding debt written off after 30 years.
- 2.21. UCAS dataⁱⁱⁱ show that in England in 2016 the entry rate for young students from disadvantaged backgrounds was at an all-time high. The application rate for entry in 2017^{iv} for disadvantaged English 18 year olds is at a record high. This shows that in England we have made real progress in widening access to higher education, with this expansion intended to support progress in widening access to medical education.

POLAR – Participation of Local Areas

- 2.22. The participation of local areas (POLAR) classification is based on the proportion of the young population across the UK that participates in higher education (HE) and shows how this varies by area.
- 2.23. Table 1 shows the percentage of students in each quintile who study medicine in England, compared with those in the wider student population shown in Table 2.

Table 1

<i>MEDICAL UNDERGRADUATE^v</i>	POLAR					
	Quintile 1 (lowest participation areas)	Quintile 2	Quintile 3	Quintile 4	Quintile 5 (highest participation areas)	Not known
2012	4.2%	8.6%	14.9%	23.6%	48.2%	0.5%
2013	4.3%	8.6%	14.9%	23.4%	48.2%	0.5%
2014	4.4%	8.7%	14.8%	23.5%	48.1%	0.4%
2015	4.4%	9.1%	14.7%	23.5%	47.7%	0.5%

Table 2

<i>ALL SUBJECTS UNDERGRADUATE</i>	POLAR					
	Quintile 1 (lowest participation areas)	Quintile 2	Quintile 3	Quintile 4	Quintile 5 (highest participation areas)	Not known
2012	9.7%	14.5%	19.2%	23.5%	32.5%	0.5%
2013	9.9%	14.7%	19.3%	23.5%	32.1%	0.5%
2014	10.3%	14.9%	19.5%	23.3%	31.5%	0.5%
2015	10.4%	15.1%	19.6%	23.2%	31.2%	0.5%

Source: HEFCE

- 2.24. This shows that over the past few years, the proportion of students from the lower participation areas studying medicine at undergraduate level in England has been around half that of those studying across all subjects.
- 2.25. The proportion of students studying medicine from the top two quintiles is over 70%, whereas it is only around 55% for those studying across all subjects.
- 2.26. While there have been slight increases in the proportion of students from the lower participation areas studying across all subjects in the years 2012 to 2015, the proportion of those studying medicine has remained fairly static.
- 2.27. It is the Government's ambition to change this trend, and increase the proportion of students from the lower quintiles who access undergraduate medical education.

3. Data sources

- Office for National Statistics (ONS)

<http://www.ons.gov.uk/ons/index.html>

Source of data relating to the UK Population. Where possible, this report has used population estimates for mid-2014, as these are the closest available to the most recent equality monitoring data collection for NHS Bursary recipients. Where this is not possible, 2011 census data has been used.

- NHS Business Services Authority (BSA)

<http://www.nhsbsa.nhs.uk/>

Publishes annual reports containing Equality and Diversity data for current and past recipients of the NHS Bursary covering the following protected characteristics: Sex, Age, Sexual Orientation, Disability, Ethnicity and Religion/Belief.

- Higher Education Statistics Agency (HESA)

<https://hesa.ac.uk/>

HESA publish data on the population of students as a whole, allowing comparison between NHS Bursary recipients and the full student population.

- Higher Education Funding Council for England (HEFCE)

<http://www.hefce.ac.uk/>

HEFCE funds and regulates universities and colleges in England, and invests on behalf of students and the public to promote excellence and innovation in research, teaching and knowledge exchange.

- National Union of Students – No Place for Hate

<http://www.nusconnect.org.uk/resources/no-place-for-hate-religion-and-belief-report-may-2012>

Home Office-funded research exploring the extent and nature of hate crime and incidents on campus related to religion and belief – includes survey of the religious affiliation of around 10,000 students.

Data sources

- Universities and Colleges Admissions Service (UCAS)

<https://www.ucas.com/corporate/data-and-analysis>

Publishes data covering applications and admissions to full-time higher education in the UK.

4. Responses

- 4.1. The public consultation was launched on 14 March 2017 on the gov.uk website and lasted 12 weeks until 02 June. A total of 3,630 responses were received via Citizenspace, email and hard copy.
- 4.2. Please note that throughout this document where quotes from responses are given they are not necessarily given in full due to limited space, although we have sought to reflect balanced input from respondents.
- 4.3. A list of organisations that responded to the consultation or provided evidence is set out at Annex A.
- 4.4. For the sake of completeness, all responses, including a few received in the days after the closing date, have been considered as part of the consultation evidence.

Analysis

- 4.5. The respondents can be categorised into two distinct groups:
 - Individuals, setting out their own personal views
 - Organisations, setting out the views of their members
- 4.6. In our analysis, we have presented the responses received from these two groups alongside each other.

Analysis of Responses

- 4.7. Some consultation questions asked for yes/no answers, with room for further comment, whereas others asked open questions designed to garner a wide range of opinions.
- 4.8. Set out below are the rate of responses for each question, as well as headlines and dominant themes from each of the qualitative questions posed. Percentages may not always total to 100 due to rounding.

Q 1 How would you advise we approach the introduction of additional places in order to deliver this expansion in the best way?

Individuals

Answered: 65%

No response: 35%

Organisations

Answered: 97%

No response: 3%

This question asked for opinions about the phasing of the additional places over time – is it appropriate for the additional 1,000 places to be brought on stream in 2019-20 or whether they could be brought in to different timescales?

Some respondents did not address this directly in question 1 but rather in responses to other questions through the consultation document.

Responses

Individuals:

- A small number of individuals directly addressed the issue of phasing of places – most discussed more general issues around the allocation of places.
- A small number of respondents believed that places should be brought on stream as soon as possible, in order to increase the number of doctors in the shortest possible time.
- Respondents discussed potential issues with placement and HEI capacity the sooner places are made available to students.

Organisations:

- Respondents were generally supportive of the competitive bidding process for places to be introduced in 2019 and beyond.
- The overriding aims of the process would be to deliver high quality training. Capacity, at both the HEI and placement providers, would be crucial to success and would, to some extent, dictate the pace of expansion.
- There were mixed views on bringing additional places into 2018-19; some acknowledged that additional places for 2018-19 had already been allocated; some aspirant universities supported a swift expansion of medical places – including in 2018-19.
- Some respondents, particularly from the education sector, discussed potential challenges with getting all places on-line in 2019-20. For example new medical schools securing clearance with the GMC or the time it would take to develop new, innovative, curricula.
- Respondents agreed that the timeline for expansion in 2019-20 was ambitious and that information was required soon on the bidding process and criteria.
- Some noted that it can take up to 3 years for a new medical school to secure GMC approval – this may need to be taken into account if new medical schools are to be included.
- There was widespread agreement that institutions would need to provide evidence of placement capacity and how they were engaging the local healthcare community.

Q 2 What factors should be considered in the distribution of additional places across medical schools in England?

Factors	Individuals	Organisations
University staffing capacity	76%	72%
University estates/infrastructure capacity	60%	69%
University capital funding capacity	35%	60%
NHS/GP clinical placement capacity	89%	84%
Mobilisation / timing capability	25%	58%
New medical schools	25%	52%

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Q 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?

Individuals		Organisations	
Yes:	75%	Yes:	93%
No:	23%	No:	2%
No response:	2%	No response:	6%

Q 4 Do you think that increased opportunities for part-time training would help widen participation?

Individuals		Organisations	
Yes:	64%	Yes:	66%
No:	34%	No:	22%
No response:	2%	No response:	11%

Q 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.

Individuals		Organisations	
Answered:	32%	Answered:	86%
No response:	68%	No response:	14%

This question sought additional information about social mobility programmes that may exist at different universities or examples of things that may increase diversity.

Individuals:

- Individuals supported the idea of widening participation on the assumption that it would not impact the quality of education or the standard of medics produced.
- A large number of respondents discussed funding arrangements in the system with many feeling that student loans and debt act as a disincentive to widening participation.
- Many respondents talked about their experiences with the application system and how it may benefit certain groups who are able to get access to enhanced support for applications. Some felt that there was an “unconscious bias” within the current application system.
- Many talked about outreach programmes and the importance of early intervention. A large body of evidence is required to apply for medical school and so students need to be “caught” early.

Responses

- There was some support for conversion courses for those from other healthcare professions or 'Access' courses such as seen at Kings or Leeds.
- There was limited support to reduce grade requirements as a means of widening participation; it was noted that these students may require additional support while at medical school.
- There was support for graduate entry medicine as an example of attracting a different group of students who may be attracted to roles like that of a GP.
- There was no consensus on part time training. Some thought it could be a motivating factor for groups that have not typically attended higher education and help in widening participation, but it would take them a long time to train.

Organisations:

- There was resounding support for widening participation as an allocation criteria and support for making medicine more reflective of the community.
- Many respondents discussed the importance of outreach activities. Different respondents highlighted individual programmes but recognised that a "one-size approach" will not work.
- During the competitive bidding processes universities should be required to show what they are doing to improve widening participation and provide evidence to show previous experience.
- There was only limited support for part time training; it was noted that these students would take a long time to complete their training. There were also concerns raised about how these students would get 5,500 placement hours in line with GMC regulations.
- There was some support for new ways of delivering training, for example 'access' courses leading to a medicine course (e.g. the Extended Medical Degree Programme at King's) or conversion courses for those from other healthcare disciplines.
- While outside of the scope of this consultation, there was support for graduate entry medicine.
- It was widely agreed that strategic buy-in was required by the university to make a success of widening participation.

Q 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?

Individuals

Yes: 44%

No: 54%

No response: 2%

Organisations

Yes: 74%

No: 17%

No response: 8%

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Q 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

Individuals

Answered: 44%

No response: 56%

Organisations

Answered: 87%

No response: 13%

This question sought additional information about experience with recruiting to areas of the country that face recruitment challenges.

Individuals:

- The most dominant theme was related to the attractiveness of locations; options around pay supplements and other incentives were widely supported.
- Others felt that working conditions need to be made more attractive to bring people to these areas with some feeling that the current system is not treating them fairly.
- Some respondents discussed practical issues with having placements in these areas; there tends to be greater physical distance between placements which impacts on family and personal life and in turn makes these placements less attractive.
- Several raised the quality of training; it was perceived that the quality of training is not as good in these areas, perhaps without the access to specialist centres, and so fewer people apply.
- There were mixed views on the issue of new medical schools. Some felt that it would be a useful tool in attracting people to new areas whereas others believed that the nature of the foundation programme as a national recruitment exercise meant that doctors are more mobile than other professions.
- A small number of respondents provided examples of areas which had dealt with recruitment challenges (e.g. Emergency Medicine in Bangor).
- Some highlighted the challenges of recruiting in rural and coastal areas; the greater the distance from an urban centre the more difficult it becomes to recruit.
- Some believed that these issues could be addressed by increasing the number of specialty training places in these areas.

Organisations:

- As shown in the responses to the “yes/no” question there was a difference of opinion for this question.
- Some respondents felt that there was a clear link, based on data in the consultation, between medical school and eventual career destination. Therefore more places should be given to those areas which face recruitment challenges. One respondent cited a study which showed a link between the choice of foundation programme post and positive placement experiences at undergraduate level.

Responses

- Some respondents pointed to the difference between the proportion of population in an area and the proportion of medical school places as something which could be balanced.
- Others were less convinced about the link between school and career destination. Some noted that the foundation programme is a national scheme and only 42% of students indicate a preference to complete the foundation programme in the local area.
- Some respondents felt that there was a stronger link between where a student undertakes specialty training and final career destinations.
- The quality of the training experience was widely cited as a driver for students; some mentioned scope for better integration between schools and placement providers.
- Some respondents advocated new medical schools in areas facing challenges, for example in rural areas which have traditionally faced recruitment challenges.
- Some recognised the importance of working conditions and thought that incentives for working in these areas might be appropriate (at the moment training is London-centric).
- Some organisations, mainly from London, discussed the pull factors of London as a place to work and how vacancies in places like Kent are often filled by London students.
- Some respondents gave more radical options such as mandating that all hospitals provide training or restrict the choice at foundation programme level to those places with recruitment challenges.

Q 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?

Individuals		Organisations	
Yes:	44%	Yes:	74%
No:	54%	No:	15%
No response:	2%	No response:	10%

Q 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.

Individuals		Organisations	
Answered:	41%	Answered:	85%
No response:	59%	No response:	15%

This question sought additional information about experience with recruiting to specialties with lower fill rates; at present this covers general practices and psychiatry training.

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Individuals:

- A large number felt that the attractiveness of roles was a key factor; they talked about making roles more attractive by offering additional incentives such as pay or help with accommodation.
- Some talked about the perception of different specialities (which ties into the Health Education England and Medical Schools Council report, By choice – not by chance: Supporting medical students towards future careers in general practice). Some specialities, such as general practice, don't have the same reputation as being good specialities to choose which can impact student choice. In addition these specialities may not have access to the same mentors or role models which can influence decisions.

Organisations:

- The dominant theme was around placements in the shortage specialties.
- Many respondents talked about ensuring that students are given more exposure to placements in these specialties, perhaps at an earlier stage in the degree. The quality of the placement was also thought to be very important; a poor placement experience can put students off.
- A small number of respondents discussed how shortage specialties may change over time and therefore the system would need to be kept under review.
- Some respondents discussed curriculum design to ensure that these specialties are given the appropriate weight.
- Some respondents highlighted that medical education must remain balanced and produce well rounded medics.
- In line with recommendations from "By Choice not Chance" some people talked about the need to change the culture around these specialties and ensure that leadership involves experts from these specialties.

Q 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?

Individuals

Yes: 93%

No: 5%

No response: 2%

Organisations

Yes: 91%

No: 2%

No response: 7%

Q 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.

Individuals

Answered: 19%

No response: 81%

Organisations

Answered: 83%

No response: 17%

Responses

This question sought additional information about experience with recruiting to specialties that have struggled to recruit – at present this covers general practice and psychiatry training.

Individuals:

- Individuals agreed that the quality of placements was paramount to training.
- The most dominant theme was the ratio of students to teaching staff and the risk of oversaturation of placements. It was felt that a direct link exists between the number of students and placement quality. By extension placement capacity will be critical to the success of expansion.
- The next common theme was around ensuring protected time for those providing teaching, for example to ensure that training is effective and objectives are met.
- Respondents discussed the amount of exposure to different specialties, in particular greater exposure to general practice and other shortage specialties.
- A small number of respondents raised the issue of placement funding, in particular the introduction of a general practice tariff.
- Some respondents called for longer clinical placements and a change in the curriculum in light of a more integrated system.
- Many respondents asked for more work on leadership and mentors, for example named mentors for students.
- Some respondents wondered if new medical schools would be able to prove placement quality.

Organisations:

- Respondents agreed that the quality of placements should be a key criterion in allocation.
- Many organisations highlighted the importance of close working relationships between placement providers and universities in delivering good placements.
- Several recommended students be exposed to a wide range of placement settings including general practice and community care.
- The need for a robust quality assurance and feedback system for students and providers was widely mentioned.
- There were differing views on the use of the National Student Survey.
- Some respondents felt that smaller placement groups led to better placements and that capacity was a key feature of expansion.
- Some believed that quality metrics could act as a barrier to new medical schools that may not have evidence of existing relationships.
- Some respondents called for reform to placement funding, in particular a tariff for placements in general practice to improve incentives for these placements.

Q 12 Do you agree that all providers should be offered the opportunity to bid for the additional medical school places?

Individuals

Yes: 64%

No: 34%

No response: 3%

Organisations

Yes: 69%

No: 19%

No response: 11%

Q 13 Do you agree that innovation and sustainability should be included in the criteria used to determine which universities can recruit additional medical students?

Individuals		Organisations	
Yes:	68%	Yes:	78%
No:	29%	No:	9%

Q 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.

Individuals		Organisations	
Answered:	12%	Answered:	80%
No response:	88%	No response:	20%

Individuals:

- Respondents agreed that the medical schools would have to show sustainability in order to be given additional places.
- Some believed that schools would require a minimum number of places, over the long term, in order to become sustainable (places should not be removed once awarded).
- There was less agreement on innovation. Respondents felt that innovation should only be pursued if it would be of certain benefit to students. Others discussed previous innovation (e.g. Problem-Based Learning) and how that perhaps hadn't been successful.
- Respondents provided some ideas of the kinds of things they might want to see in terms of innovation, for example the ability of the curriculum to adapt to changes in medicine, more team based approaches or increased flexibility.
- Some respondents discussed the placement experience and how that could be innovated, for example beginning placements sooner and making more use of community and general practice settings.

Organisations:

- There was widespread agreement that sustainability was an important factor. Some felt that there was a minimum number of students below which it would not be able to offer courses. Equally, courses with too many students may not be sustainable in the long term.
- Innovation was widely thought to be valuable but that innovation for the sake of innovation should be avoided; only those changes which could demonstrably improve experiences for students should be pursued. It was also seen to be a secondary criterion after things like placements quality and geographic requirements.
- Several respondents discussed innovation in the context of the expansion timeline; more innovative courses may not be ready for 2019-20.

Responses

- Respondents provide examples of innovations they had developed including team based learning, greater use of technology, different ways of structuring placements or modules focussed on leadership skills.
- One respondent mentioned the GMC Medical Licensing Assessment (MLA) and the impact it could have on innovation; the MLA implies a more standard curriculum which could reduce innovation.
- Programmes where there is greater integration with placement providers, including NHS Sustainability and Transformation Plan footprints, could be good examples of innovation.
- A number of respondents mentioned the power of students in being able to drive innovation at university level.

Q 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.

Individuals

Answered: 18%

No response: 82%

Organisations

Answered: 84%

No response: 16%

Individuals:

- Respondents recognised the link between education and the NHS and the importance of producing high quality doctors capable of working in the NHS.
- Many respondents used this question to oppose privatisation of the NHS or medical schools.
- Some discussed the importance of clinical placements and the need for collaboration between providers and educators.
- A small number discussed workforce planning.

Organisations:

- It was generally agreed that the core aim of medical schools was to produce high quality medics for the NHS.
- The core theme was one of collaboration; it was recognised that there is a need for closer working between universities and providers to ensure:
 - Students are given access to high quality placements
 - Medical education equips students with the skills required to work in the 21st century NHS (e.g. more community provision)
 - Some believed that there is currently a tension between medical schools and providers
- Some believed that different approaches would be required in different parts of the country to support local communities.
- It was again recognised that it takes a long time to train a doctor and so these relationships need to be dynamic; for example the list of shortage specialties may be different in the future.

Expansion of Undergraduate Medical Education

- Some believed that more work was required to increase collaboration between medical schools and GPs as well as ensuring the provision of other staff including researchers and academics.
- A small number talked about the need to improve workforce planning.

Q 16 Do you agree with the principle that the taxpayer should expect to see a return on the investment it has made?

Individuals		Organisations	
Yes:	27%	Yes:	74%
No:	71%	No:	7%
No response:	1%	No response:	20%

Q 17 Do you agree in principle, that a minimum number of years of service is a fair mechanism for the taxpayer to get a return on the investment it has made?

Individuals		Organisations	
Yes:	8%	Yes:	44%
No:	91%	No:	36%
No response:	0%	No response:	21%

Q 18 Do you have any views on how many years of service would be a fair return for the taxpayer investment?

Individuals		Organisations	
2 years:	16%	2 years:	15%
3 years:	2%	3 years:	8%
4 years:	1%	4 years:	3%
5 years:	2%	5 years:	15%
+5 years:	1%	+5 years:	2%
No response:	78%	No response:	57%

Responses

Q 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?

Individuals		Organisations	
Yes:	8%	Yes:	40%
No:	92%	No:	32%
No response:	1%	No response:	28%

Q 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?

Individuals		Organisations	
Answered:	85%	Answered:	86%
No response:	15%	No response:	14%

Individuals:

- Individuals were largely opposed to the concept of a minimum service contribution.
- Respondents noted that the vast majority of graduates already work in the NHS so it isn't a problem that needs addressing.
- Respondents believed that medical students already have a large amount of student debt and make a positive contribution to society already.
- Comparisons with the army bonding scheme were criticised on the basis that those students are fully funded.
- Individuals felt that a bonding scheme could reduce the number of applications to medicine and could have negative impacts on the widening participation agenda.
- A number of practical concerns were raised about how the criteria would be applied and how it would deal with exceptional circumstances, for example illness, people who decide medicine is not the correct option or those entering research.
- There were concerns about equality groups under a minimum service contribution, for example they felt it would have a disproportionate effect on women or those with caring responsibilities.
- Some believed that it might lead to changes in the demographics of people who apply for medicine, for example those from debt-averse communities may be put off from applying.
- Some believed that if such a policy was pursued for medics there should be reciprocity for other professions.

Expansion of Undergraduate Medical Education

Organisations:

- Organisations were generally more receptive to the idea of a return on investment but were less convinced that a minimum service commitment was the best mechanism.
- Some organisations were opposed to a minimum service contribution; they noted that most graduates already continue to work in the NHS and make a contribution.
- Respondents discussed the practical issues with the policy, for example how to deal with exceptional circumstances or ensure that people would continue to pursue research opportunities.
- Several organisations raised concerns about the impact that a service commitment could have on medical morale and industrial relations. There were also some concerns about the impact this could have on the goodwill of medical students and junior doctors.

Q 21 Is this a policy you wish to see explored and developed in further detail?

Individuals		Organisations	
Yes:	10%	Yes:	46%
No:	90%	No:	35%
No response:	1%	No response:	19%

Q 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?

Individuals		Organisations	
Answered:	19%	Answered:	63%
No response:	81%	No response:	37%

Individuals:

- Respondents raised a number of concerns about the impact a minimum service contribution would have for those with protected characteristics.
- Many respondents discussed the impacts for women including those who have caring or childcare responsibilities or those who need to work part time.
- Several raised the issue of those with disabilities; these individuals may not be able to commit to a minimum service contribution. Some extended this to include those with mental health issues and the stresses of being a medical professional.
- Some thought that a bonding scheme would be in breach of the family test, especially women and those with caring responsibilities.
- Some discussed pregnancy and maternity; these respondents believed there would be a disproportionate impact for these groups if they are not able to meet service commitments. They pointed out that it also relates to the issue of age, where those of child-bearing age may be adversely impacted.

Responses

Organisations:

- Organisations raised concerns about a minimum service contribution for certain equality groups, for example the impact for women or those with disabilities.
- Those with disabilities may have health reasons why they cannot complete a service commitment and women may be adversely affected by anything that limits part time employment or caring responsibilities.
- Some believed that part time training could be a way to make medical careers available to those from certain equality groups.
- It was noted that any change to conditions of employment would require an Equalities Impact Assessment.

Q 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?

Individuals

Answered: 20%

No response:80%

Organisations

Answered: 54%

No response:46%

Individuals:

- Some supported the idea that increasing the number of medics could be used as a catalyst to increase numbers from some, for example disadvantaged, groups.
- Many talked about how a minimum service contribution could have a negative impact on morale and working conditions.
- Some mentioned funding for medical degrees and were opposed to tuition fees for medical courses.
- There was some support for more flexibility within training programmes both at undergraduate and postgraduate levels as a way of opening up medical careers.
- Some believed that changes should be made to whistleblowing processes including the use of anonymous reporting.
- A small number discussed changes to the application system which might be weighted toward those from certain societal groups.

Organisations:

- Some respondents talked about changes to the application system to improve equity, for example anonymised applications or more support for interviews.
- Respondents were generally in support of the widening participation agenda and the opportunities it could deliver.
- Some raised the issue of “differential attainment” with some groups performing worse than others.
- Some believed there were links between this question and more general treatment of bullying and harassment in the workforce.

Q 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?

Individuals

Answered: 47%

No response:53%

Organisations

Answered: 79%

No response:21%

Individuals:

- There were mixed opinions about the impact training additional medics would have on family life.
- Some respondents believed that it would add additional capacity to the market which would enable the development of more flexible career paths and improve the widening participation agenda.
- Other respondents believed that it would have a minimal impact; it takes a long time to train a medic and demand is likely to increase further in the future. Some believed that further expansion would be required to alleviate current issues.
- Some expressed concerns about the impact a minimum service contribution would have on families and relationships, for example those with childcare responsibilities.
- Some noted that more changes would be required to support flexible working, for example greater use of less than full time training and more acceptance in the Service of part time training. A small number talked about the potential benefits of portfolio careers.
- Some respondents highlighted issues with clinical placements, for example needing to travel long distances between posts. They believed this could have a negative impact on family life.

Organisations:

- Respondents were generally receptive to the idea that it would be possible to increase flexibility if there was an increased supply of doctors, for example by accommodating part time employment and training.
- Several respondents noted that Brexit would have a much larger impact on workforce supply and thus flexible working.
- It was noted that it would take a long period of time for any increase in medical students to feed into the health system.
- Some noted that any change in flexibility would require not only an increase in student numbers but also a change in mind set at the top of organisations.
- It was noted that the majority of student doctors are female; changes may be required to training to accommodate more use of less than full time training and flexible careers.

ANNEX

Academy of Medical Royal Colleges
Anglia Ruskin University
Association for the Study of Medical Education
Association of Anaesthetists of Great Britain & Ireland
Association of UK University Hospitals
Aston University
Barts & The London School of Medicine & Dentistry, Queen Mary University of London
Barts NHS Foundation Trust
British Medical Association
British Pharmacological Society
British Society for Rheumatology
Brunel University London
Cancer Research UK
Central Manchester University Hospitals NHS Foundation Trust
Devon Partnership NHS Trust
Doncaster and Bassetlaw Teaching Hospitals
East Kent Community educator provider network
East Lancashire Hospitals NHS Trust
Edge Hill University
Faculty of Sexual and Reproductive Healthcare
Gateshead Health NHS Foundation Trust
Guys and St Thomas NHS Foundation Trust
Hospital Consultants & Specialists Association
Hull Clinical Commissioning Group
Hull York Medical School (University of Hull & University of York)
Humber NHS Foundation Trust
Imperial College London
Keele University School of Medicine
Kent Community Health NHS Foundation Trust
Kent Surrey and Sussex Academic Health Science Network
Kings College - Medical Student Association
King's College London

Expansion of Undergraduate Medical Education

King's College London Students Union (KCLSU)and GKT Medical Students Association
Lancaster University
Lincolnshire County Council
London Medicine & Healthcare (London Higher)
London-wide Local Medical Committees Maidstone Borough Council
Manchester Metropolitan University
Medic Footprints
Medical Career Support
Medical Schools Council
Medical Women's Federation
Medway Community Healthcare
Newcastle University
NHS Business Services Authority
NHS Clinical Commissioners
NHS Employers
NHS Improvement
NHS Surrey Heath Clinical Commissioning Group
North Tees and Hartlepool NHS Foundation Trust
Northumbria University
Norwich Medical School (University of East Anglia)
Oxford University
Portsmouth Hospitals NHS Trust
Rouleaux Club
Royal Berkshire NHS Foundation Trust
Royal College of Anaesthetists
Royal College of General Practitioners
Royal College of Pathologists
Royal College of Physicians
Royal College of Physicians of Edinburgh
Royal College of Psychiatrists
Royal College of Physicians and Surgeons of Glasgow
Royal College of Radiologists
Russell Group
Salisbury House Surgery
School of Psychiatry, HEESW, Peninsula
Sheffield Children's NHS Foundation Trust

Responses

Sheffield Hallam University
Sheffield Health and Social Care NHS Foundation Trust
Shelford Group
Specialist Urological Registrars' Group
St George's, University of London
Surrey and Borders Partnership NHS Foundation Trust
Surrey and Sussex Healthcare NHS Trust
Surrey County Council
Swansea University
Tees, Esk and Wear Valleys NHS Foundation Trust
Thames Gateway Kent Partnership
The Association of Surgeons in Training
The British Association of Dermatologists
The General Medical Council
The Royal College of Surgeons of Edinburgh
The Royal Free, University College and Middlesex Medical Students Association
The University of the West of England, Bristol
University College London
United Hospitals MedGroup
Universities and College Union
Universities UK
University of Birmingham
University of Bradford
University of Brighton
University of Cambridge
University of Chester
University of East Anglia
University of Exeter
University of Leeds
University of Leicester
University of Lincoln
University of Liverpool
University of Nottingham
University of Plymouth
University of Portsmouth
University of Reading

Expansion of Undergraduate Medical Education

University of Salford

University of Sheffield

University of Southampton

University of Sunderland

University of Surrey

University of Warwick

University of Worcester

Warrington and Halton Hospitals NHS Foundation Trust

ⁱ 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

ⁱⁱ www.shapeoftraining.co.uk/static/documents/content/Shape_of_training_FINAL_Report.pdf_53977887.pdf

ⁱⁱⁱ UCAS 2016 End of Cycle Report: www.ucas.com/corporate/data-and-analysis/ucas-undergraduate-releases/ucas-undergraduate-analysis-reports/ucas-undergraduate-end-cycle-reports

^{iv} UCAS UK application rates by the January 2017 deadline: www.ucas.com/corporate/data-and-analysis/ucas-undergraduate-releases/ucas-undergraduate-analysis-reports

^v Full-time students in all years of study who were 2018-19 years old and UK domiciled on entry