

## They Don't Call It Social Mission in the United Kingdom

### I. Abstract

In the true spirit of the International Medical Workforce Collaborative, I have written the United Kingdom's paper on social mission as an American on a one year secondment with the National Health Service (NHS) Workforce Review Team. My position created the unique opportunity to explore differences and similarities in the concept of social mission in the two countries. This paper summarizes my foray into what turned out to be somewhat uncharted territory and highlights the lessons I learned from the experience.

The United Kingdom rapidly expanded medical school enrolment over the last decade from an intake of 4,499 students in 2000 to 8,111 students in 2009. Literature searches combining the terms "social mission" or "social accountability" and medical education yield abundant research from Australia, Canada and the United States but very few studies from the UK. But, a review of published documents from the Department of Health (DH), the professional colleges, and other organizations clearly demonstrate that decisions about how and where to expand undergraduate medical training explicitly included social mission criteria. Thus, this paper was a challenging journey to make explicit a concept that is deeply ingrained in the UK health care system but not labelled or conceptualized in the same way as in other countries.

Social mission concepts are embedded in the current policy agenda to have NHS services reflect the needs of local communities; in the way that funding streams and the NHS organizational infrastructure are designed to promote accountability for, and responsiveness to, population health in a region; and in the British culture more generally. As well, the four new medical schools were placed in areas of lower doctor supply and medical schools' applications for new slots were evaluated by the degree to which they widened access to the profession from groups traditionally under-represented in medicine.

Training of junior doctors is skewed toward London, and the South East Coast has far fewer trainees than would be expected. Substantial variations exist between regions in the balance of consultants (i.e. specialty doctors) and General Practitioners (GPs) used to deliver health care services. These differences have not gone unnoticed and discussions are currently underway about whether to shift funding of medical education to a mechanism that reduces variation. Compared to the United States, there seems to be greater awareness in the UK that social accountability goals should not just be focused on undergraduate education, but should be integrated across the medical training spectrum to include foundation programme, postgraduate specialty training and continuing professional development.

One notable aspect of medical education and training in the UK is the degree to which decisions are led by the Department of Health (DH) —as evidenced by DH's current effort to have 50% of medical school graduates enter general practice. The planned shift toward general practice has been slowed by numerous factors including the attractiveness of general practice relative to other specialties and the difficulty in convincing postgraduate deaneries and the service to remove specialty training posts in favour of general practice ones.

## II. Introduction

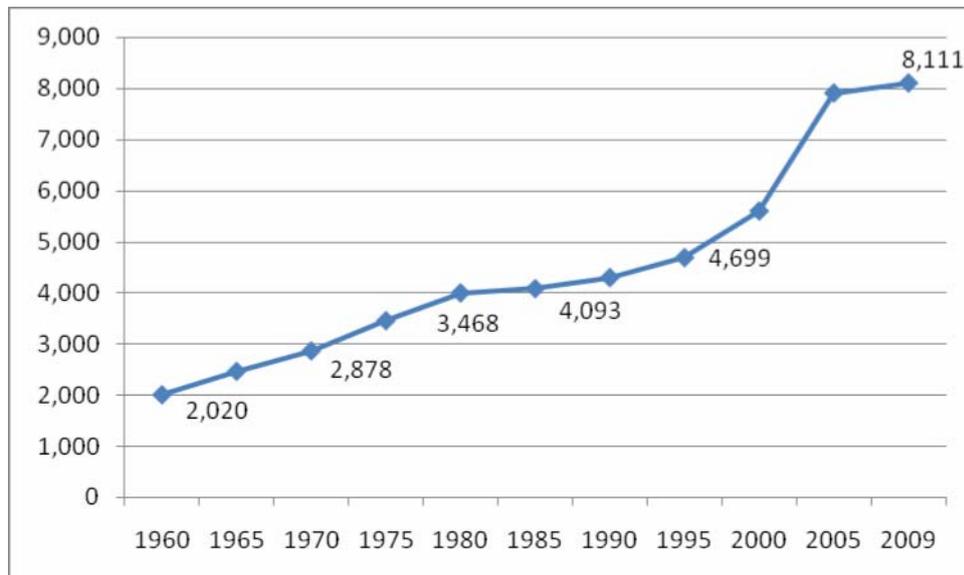
In the true spirit of the International Medical Workforce Collaborative, I am writing the United Kingdom's paper on social mission as an American on a one year secondment with the National Health Service (NHS) Workforce Review Team. My position created the unique opportunity to explore differences and similarities in the concept of social mission from the two countries. But, it posed a significant challenge to learn how medical education works in the UK and then ascertain how my American concept of social mission translated in the context of a publicly funded health care system. Because of the steep learning curve and because I am based in England, this will be more of an English paper, but where relevant I have tried to take a UK-wide perspective.

This paper summarizes my foray into what turned out to be somewhat uncharted territory and highlights the lessons I learned from the experience. My hope is that these lessons learned are not only relevant to my colleagues in the United States and United Kingdom but to delegates from Australia and Canada as well. But before I delve into outlining my American views on British social mission, I should clarify that the spelling in this paper will be an eclectic mix of American and English English.

### Medical expansion in the United Kingdom

In an effort to increase physician supply, the United Kingdom has rapidly expanded medical school enrolment over the last decade from an intake of 4,499 students in 2000 to 8,111 students in 2009. This rapid expansion was achieved by increasing places in existing medical schools, creating four new medical schools in England, and expanding the number of students entering medical education after completing an undergraduate degree in another field (i.e. "graduate entry" students).

**Figure 1. Medical school enrolment, United Kingdom, 1960-2009**



Source: Higher Education Funding Council for England

The unprecedented growth in medical trainees in recent years represents the largest increase in the history of the NHS and coincides with a policy agenda to "widen access" to medical schools from traditionally under-represented socio-economic groups. Explicit in the decision-making process about where to allocate new training slots was a goal to ensure a

“distribution of patterns of training of students to effectively increase the home supply of doctors and meet the needs of the populations which are served by the NHS”.<sup>1</sup> Ultimately, almost all existing medical schools received extra training places but the four new medical schools were placed in traditionally under-doctored areas on the premise that it would increase physician supply in these areas.

### **III. A UK perspective on social mission**

In England, the cost to the taxpayer for five years of undergraduate medical training is estimated to be about £250,000 per student.<sup>2</sup> When asked about the social value received in return for this investment, medical school deans, workforce planners, researchers and government policy makers appeared puzzled by the question. The more people I asked, the more it seemed that social accountability goals were so deeply embedded in the system that they were taken for granted and not explicitly articulated or labelled as “social mission”. So next I did what any good researcher does, I turned to the literature to see if anything had been previously written on the topic from a UK perspective.

Literature searches combining the terms “social mission” or “social accountability” and medical education yielded abundant published research from Australia, Canada and the United States but very few studies from the UK. A review of published documents from the Department of Health (DH), the professional colleges, regulatory bodies and other organizations were similarly lacking in an explicit mention of social mission but clearly social accountability goals were at the foundation of decisions regarding investments in medical training. Thus, the challenge became one of using policy statements and available data to sort out what “social mission” meant from the UK context.

The World Health Organization defines social accountability for medical schools as “the obligation to direct their education, research and service activities toward addressing the priority health concerns of the community, region, and/or nation they have a mandate to serve.”<sup>3</sup> Operational definitions in the literature include orienting medical education toward improving the geographic distribution of providers and health care resources, addressing speciality imbalances (and more specifically, promoting more primary care providers), and increasing workforce diversity. While this list does not represent the full spectrum of social mission goals, these three areas are those most relevant to the UK perspective that I will focus on for the remainder of the paper.

#### **A. Geographic distribution of providers and resources**

Unlike the US, Canada and Australia, the UK does not have the challenge of serving a large, remote rural population. The distribution of General Practitioners (GPs) is problematic in some areas of England and Wales and has persisted despite increases in the overall supply of GPs.<sup>4</sup> However, the more salient issue now is not the geographic distribution of providers, but the policy agenda to shift care into the community as recommended by Lord Darzi in The Next Stage Review (NSR). Darzi suggested that: “NHS services everywhere [need] to reflect the needs of their local communities. People and communities across England have different characteristics and different needs. Yet too often, the services they receive are not sufficiently shaped around those characteristics and needs.”<sup>5</sup> To remedy this deficit, Darzi outlined a vision that describes “an NHS that will work with partner organisations locally to reach out and help people stay healthy, and, when people do need care, provide convenient, high quality care. Services will be found in the community, with family doctors, pharmacies and local partnerships taking a leading role in helping people to stay healthy. In future, the NHS will not be confined to hospitals, health centres or GP surgeries but will be available online and in people’s homes, whilst the most specialist care will be concentrated to allow excellence to flourish.”<sup>6</sup> The care closer to home programme outlined in the Next Stage Review is not just a grand vision of national policy makers—it clearly reflects British citizens’

preference to receive health care in their local geography and it creates access issues in situations where needed care is not available in the local community.

The Right Care, Right Here (RCRH) initiative which was developed in 2004 in Sandwell and the Heart of Birmingham—two areas that have some of the highest levels of deprivation in England—provides an illustrative example of one initiative underway to improve community health infrastructure and is a clear example of the degree to which social mission goals are explicitly embedded in decisions about how and where care will be delivered. The primary goal of the RCRH program was to expand “the level of provision of services in community settings, bringing appropriate elements of care closer to home.”<sup>7</sup> Key RCRH programme goals are outlined as:

- ensuring that services are extensively redesigned to meet the needs of the local population
- developing the capacity of primary care to adopt ‘whole population’ approaches
- remodelling services for patients with long-term conditions
- creating jobs in the local community

At the core of Darzi’s Next Stage Review, the RCRH programme and the UK health system in general is the commitment to geographically allocate resources to equalize life chances among the population. A brief digression into NHS funding is necessary to understand how funding streams and the organizational infrastructure of the NHS are set up to promote accountability for, and responsiveness to, population health in a region.<sup>1</sup>

England is divided into ten regional strategic health authorities (SHAs) under which sit approximately 150 primary care trusts (PCTs). Since 1977, the Department of Health has used a weighted capitation formula (WCAP) to distribute resources to PCTs based on the relative health needs of each PCT’s catchment area. The starting point, and primary determinant of the size of each PCT’s WCAP, is the population for which the PCT is responsible, and it is adjusted for the population’s age distribution, additional health care needs above those accounted for by age and unavoidable variations in the cost of providing services.

PCTs control over 80% of the NHS budget and are responsible for assessing the health needs in their local geographies. Traditionally, PCTs have both commissioned (i.e. purchased) and provided the services required to meet these health care needs.<sup>2</sup> PCTs also determine the numbers and types of health professionals needed in their local geography and feed this information to the SHA which then determines the educational commissions needed to ensure an appropriate number and skill mix of providers in the region. The exception is medical training.

**Figure 2** shows the basic structure of medical training in the UK and length of each phase of training. The number of undergraduate medical students entering training each year is centrally determined, and funded, by the Department of Health. After completing five years of medical school, trainees progress to a two year foundation programme (FP) and at the end of one year they become registered by the General Medical Council. In the second year of FP training, they apply for specialty training posts and on completion of the FP they are

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<sup>1</sup> There has been considerable reconfiguration of NHS organizational structure over the years and the degree to which these various geographic configurations have been successful at balancing the demands of national goals with local needs is debated. See Leather S and Sutherland K (2008). “The Quest for Quality: Refining the NHS Reforms. <http://www.nuffieldtrust.org.uk/publications/publications.aspx?id=145>, accessed 10 April 2010.

<sup>ii</sup> As of 31 March 2010 the commissioning and providing arms of the PCTs have been split. One rationale behind the split was to enable PCTs to be less distracted by their provider function so that they could focus more on their commissioning function and more comprehensively assessing, and responding, to local community health care needs. For more information see Imison, Candace (2009). “Shaping PCT Provider Services: The Future for Community Health” [http://www.kingsfund.org.uk/publications/shaping\\_pct\\_provider.html](http://www.kingsfund.org.uk/publications/shaping_pct_provider.html)

deemed “hospital at night safe”. Because both FP and specialty training posts constitute employment as a doctor in the NHS, these positions are created, and funded, by a combination of resources from both the Department of Health and employer contributions. The Department of Health contribution comprises two elements: the Medical and Dental Education Levy (MADEL) which in 2009/10 had a budget of £1,840,945,000 and the Service Increment for Training (SIFT) budget which provides additional funding to offset training costs for medical school student placements in hospitals, and totalled £979,271,000 in the same year. These numbers exclude substantial (but not quantified) additional spending by local NHS trusts on training, but even so the public investments alone represent an outlay of £55 per year per person on medical education in England.

**Figure 2: Medical training in the United Kingdom**



Unlike the funding of healthcare provision, resources for medical education are not allocated using the weighted capitation formula. Instead, decisions about how many specialty posts will be funded, where they will be placed and in what specialties is, in the main, based on historical precedence. When changes are needed, these changes are negotiated among a range of stakeholders including the Department of Health, the postgraduate Deaneries, the SHAs and the royal colleges. Negotiations include a number of considerations including availability of training capacity, service needs in the region and the ability to fill existing training posts.

Currently, medical training in England is skewed towards London with 27%<sup>8</sup> of undergraduate trainees entering London medical schools and 27%<sup>9</sup> of specialty training occurring there. Recent research investigating the migration patterns of the recently trained medical workforce found that 86% of registrars (i.e. residents) are retained in practice in the SHA in which they trained and that there was very little variation between SHAs in retention rates.<sup>10</sup> While surgical trainees were more mobile than GPs with 77.6% and 90.1% of registrars retained respectively, the results of this recent study suggest that moving more training outside of London may have the potential to increase supply in areas that have traditionally faced difficulty recruiting and retaining providers.

**Table 1** shows the regional variation that currently exists in the popularity of some geographies in England over others. The first column shows the weighted capitation (WCAP) by SHA which, in theory, “represents the target share of available resource [needed] to enable them to commission similar levels of health services for populations in similar need, and to reduce avoidable health inequalities.”<sup>11</sup> If doctors and trainees were equitably distributed according to WCAP, all other columns in **Table 1** would be zero. Values greater than zero indicate that the SHA has more doctors and trainees than would be indicated by the WCAP; values less than zero demonstrate an undersupply of doctors and trainees. **Table 1** clearly shows that training of junior doctors is skewed toward London and that the South East Coast has far fewer trainees than would be expected. Similarly, London has more consultants while the North West, East Midlands, East of England and South East Coast have fewer consultants. But, it is interesting to note that London has far fewer GPs than would be expected and that substantial variations exist between SHAs in the balance of consultants (i.e. specialty doctors) and GPs they use to deliver health care services in their area. These regional differences likely reflect varying models of care, referral patterns, and health care needs of the population.

**Table 1 Regional variation in distribution, England, 2008**

Strategic health authority	Weighted capitation	Junior doctors <sup>1</sup>	FY1	GP	Consultant
North East	5.60%	234	-15	-96	185
North West	14.50%	-176	4	-438	-249
Yorkshire & The Humber	10.20%	-431	-27	50	-49
East Midlands	7.90%	-185	9	37	-370
West Midlands	10.50%	-458	-39	-103	-146
East of England	10.10%	-461	-3	122	-338
London	16.60%	2,792	21	-605	1,375
South East Coast	8.00%	-1,181	25	62	-531
South Central	7.20%	-53	-14	258	20
South West	9.40%	-81	37	713	103
Total	100%	26,172	6,050	34,517	34,657

<sup>1</sup>Definition of junior doctor is a doctor in training for the full specialty training programme.

Source: IC Census 2008 for FY1, GP & Consultant numbers. Deanery Monitoring 2008 for Junior Doctors.

## B. Mix of primary and specialty care providers

In response to Darzi's Next Stage Review, a key thrust of the current NHS agenda is "Transforming Community Service" (TCS)—a programme which seeks to shift care from acute settings into primary and community ones. The TCS policy agenda aims to provide as much care as possible "upstream" and is being supported by a focused effort to move NHS staff into community settings. Concurrent with this programme, the Department of Health has planned a large increase in the number of funded General Practice posts from 2,700 posts in 2009 to 3,000 in 2010 to 3,300 in 2011. However, DH's plan that 50% of doctors entering speciality training would be in General Practice has not yet been achieved. In 2009 approximately 200 GP posts were left unfilled in England and in 2010 there were even fewer applicants to GP posts than in 2009. **Table 2** shows the number of posts and competition ratios by specialty group in England and clearly shows the relative unattractiveness of General Practice to foundation programme graduates compared to other specialties.

**Table 2. Total number of posts, foundation programme applicants and competition ratios for select specialty, 2008-2010.**

Specialty Group	2008			2009		
	posts	applicants	ratio	Posts	applicants	ratio
Acute Care Common Stem	360	4,438	12.33	362	2,483	6.86
Anaesthetics	393	1,993	5.07	378	1,364	3.61
General medicine group	1,123	7,425	6.61	1,219	4,140	3.40
General practice	2,301	2,824	1.23	2,718	2,574	0.95
Obstetrics & gynaecology	226	771	3.41	259	892	3.44
Paediatric group	372	1,028	2.76	419	1,467	3.50
Psychiatry group	459	2,011	4.38	416	1,029	2.47
Radiology group	151	1,191	7.89	172	820	4.77
Surgical group	842	7,568	8.99	882	4,720	5.35
Total <sup>1</sup>	6,362	29,495	4.64	6,973	19,594	2.81

Source: 2008 and 2009 English Monitoring of Medical Recruitment undertaken by DH and WRT

<sup>1</sup> The list of specialties included in the table is not exhaustive and does not sum to total

As an American looking at the system from the outside, the relative unattractiveness of General Practice in the UK is somewhat puzzling given that the large salary differentials that exist in the US between primary care and specialist physicians is not evident in the UK. But one possible explanation for the declining interest in General Practice is the new training structure introduced under Modernising Medical Careers (MMC). Before the introduction of MMC, 60% of doctors entering GP training undertook their secondary care training independently of formal GP training, only entering primary care training to become GPs after experiencing a wide range of specialities. The introduction of GP specialty training closed this path and as a result it is thought to be a significant contributor to the lack of willingness of FP graduates to enter GP training. To rectify this, the existing GP training scheme may need to be altered to allow lateral entry from other specialties into GP training.

### C. Increasing workforce diversity

In the US, social mission discussions have generally focused on ways of increasing the racial and ethnic diversity of the workforce. In the UK, there has been much more of an emphasis on widening access to the medical profession to individuals from disadvantaged socio-economic backgrounds. In 2004, the Department of Health published "Medical Schools: Delivering the Doctors of the Future", a report on undergraduate medical education in England that focused on the need to "launch initiatives that reach into the community to recruit a wider range of students into the profession."<sup>12</sup> The report identified that little progress had been made on the widening access agenda since the proportion of applicants to medical schools from the three least wealthy social classes remained broadly the same between 1994 and 2001. Thus, when reviewing medical schools' applications to expand enrolment or open new programs, applications were assessed according to "the extent to which the medical school's plan for student recruitment, including their admission policies, addressed the need to increase successful applications from students from social backgrounds currently under-represented in medicine."<sup>13</sup>

Because the DH report was prepared just as the four new medical schools were admitting their first classes and as other medical schools were just beginning to implement diversity initiatives, data were not available to evaluate the success of new and existing programs in attracting, and enrolling, a more diverse applicant pool. The preparation of this paper for the

IMWC conference presented the opportunity to update the data presented in the DH report and to evaluate how much progress had been made since 2004.

Between 2003 and 2008, the overall number of applicants to UK medical schools increased 22% from 12,728 to 15,539. While socio-economic background was unknown for a relatively large percentage of applicants (i.e. between 16% and 22% over the period), **Table 3** shows that for applicants for whom data were available, the percentage from non-professional backgrounds increased from 28% to 34%. Despite these gains, applicants from lower socio-economic backgrounds remain under-represented in medicine since in 2008 they comprised 57% of the population in the United Kingdom.<sup>14</sup>

**Table 3. Socio-economic background of UK medical school applicants**

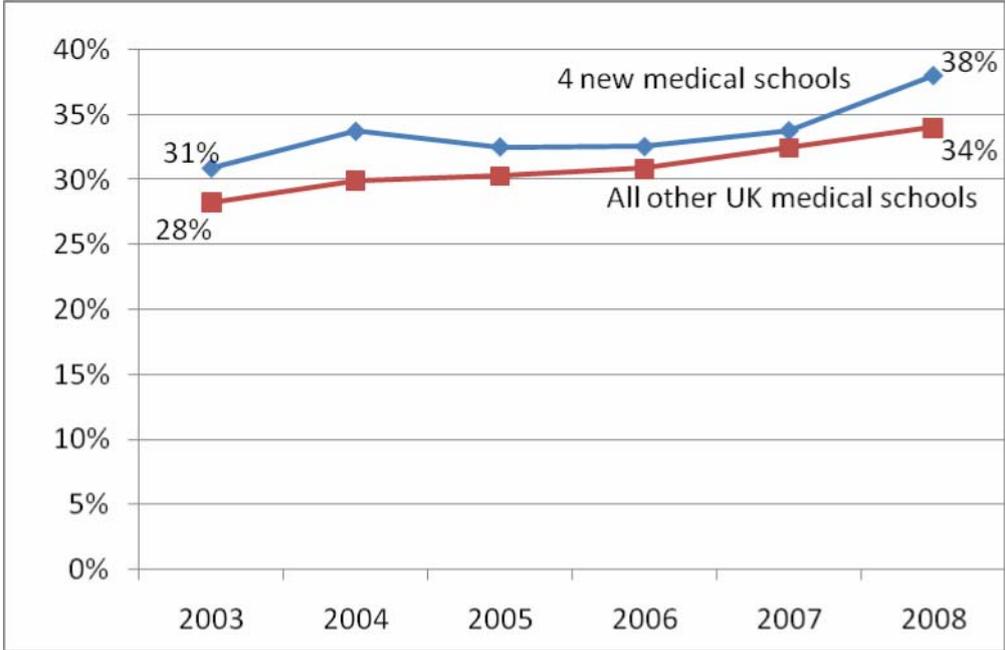
Social class	2003	2004	2005	2006	2007	2008
<b>Professional occupations</b>						
Higher managerial and professional occupations	41%	40%	39%	40%	38%	37%
Lower managerial and professional occupations	31%	31%	31%	29%	29%	29%
<i>Sub-total professional occupations</i>	72%	70%	70%	69%	67%	66%
<b>Non-professional occupations</b>						
Intermediate occupations	11%	11%	12%	12%	12%	12%
Small employers and own account workers	5%	5%	5%	4%	5%	4%
Lower supervisory and technical occupations	3%	3%	2%	2%	2%	2%
Semi-routine occupations	7%	9%	10%	10%	11%	12%
Routine occupations	3%	2%	2%	3%	3%	3%
<i>Sub-total non-professional occupations</i>	28%	30%	30%	31%	33%	34%
<b>Total</b>	100%	100%	100%	100%	100%	100%

Source: UCAS

Note: the category "own account workers" includes self-employed individuals who are engaged in any (non-professional) trade, personal service, or semi-routine, routine or other occupation and have no employees other than family workers.

In the fall/autumn of 2002 and 2003, four new medical schools admitted their first classes of students at the University of East Anglia, Peninsula Medical School, Brighton and Sussex, and Hull. **Figure 3** compares the percentage of applicants from non-professional socio-economic backgrounds in the four new programs versus all other UK medical schools. From the beginning, the four new programs have had a larger share of applicants from non-professional socio-economic backgrounds and the proportion that these applicants made up of all applicants increased by seven percentage points from 2003 to 2008. It is important to note in **Figure 3** that other UK medical schools also made significant progress in attracting a more diverse applicant pool during the same period.

**Figure 3. Percentage of applicants to UK medical schools from non-professional socio-economic backgrounds**

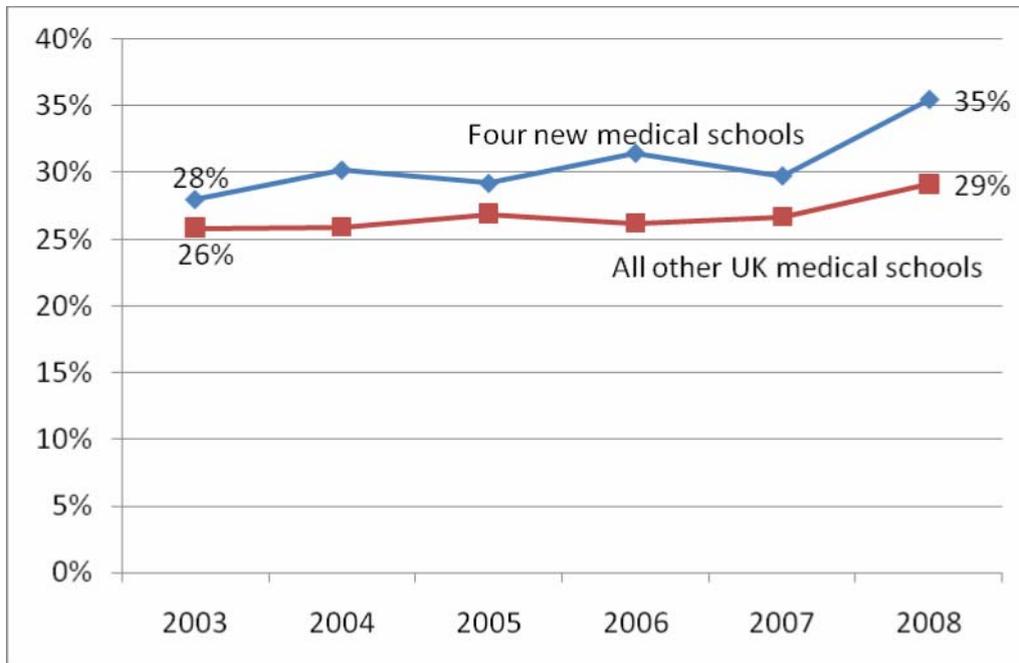


Source: UCAS

Note: Non-professional socio-economic category includes applicants from the following: intermediate occupations; small employers and own account workers; lower supervisory and technical positions; semi-routine; and routine occupations.

**Figure 4** shows the percentage of applicants who were accepted to medical school from non-professional socio-economic occupations in the four new programs versus all other UK medical schools. Comparing the data in **Figure 4** with **Figure 3** reveals that applicants from a non-professional background make up a slightly smaller proportion of accepted applicants than they comprise as a proportion of the total applicant pool. However, the percentage of applicants accepted to medical school from non-professional socio-economic backgrounds has increased over the period, with largest increases in 2008, the last time period for which data were available.

**Figure 4. Percent of total applicants accepted to UK medical schools from non-professional socioeconomic backgrounds**



Source: UCAS

Note: Non-professional socio-economic category includes applicants from the following: intermediate occupations; small employers and own account workers; lower supervisory and technical positions; semi-routine; and routine occupations.

#### IV. Conclusions

Writing this paper has been a challenging journey to make explicit a concept – social mission—that is so deeply ingrained in the UK health care system that it is not labelled or conceptualized in the same way as in other countries. Social mission concepts are embedded in the current policy agenda to shift care into the community, in the way that funding is allocated according to population health requirements, in the regional organization of health care and in the British culture more generally. The commitment to social mission goals is evidenced by policy documents that clearly demonstrate that decisions about how and where to expand undergraduate medical training explicitly included social mission criteria. The four new medical schools were placed in areas of lower doctor supply, and applications for new slots were evaluated by the degree to which they incorporated the widening access agenda. The result has been demonstrable progress in widening access to the profession from groups traditionally under-represented in the medical profession.

However, because the funding for specialty training is based on historical precedent, there is a significant amount of variation in the supply and distribution of doctors by SHA . This fact has not gone unnoticed by policy makers, and discussions are currently underway about whether to shift the funding of medical education to a mechanism that reduces variation. While such a shift may improve the geographic distribution of providers, it would take time to implement. Trusts and postgraduate deaneries in new training locations would need time to plan and secure the resources necessary to expand training capacity, including identifying sufficient numbers of:

- consultants to provide training (particularly in specialities with a small workforce)
- patients with medical conditions that span the range of acuity and breadth needed to provide appropriate training opportunities

- foundation programme graduates interested in filling these training posts.

In addition, from a London perspective, a gradual shift would be required to enable NHS London time to plan how to meet the demand for doctors generated by the Working Time Directive (WTD) with fewer trainees.

One notable aspect of medical education and training in the UK is the degree to which decisions are led by the Department of Health. This approach has been described by some as “command and control”<sup>15</sup> and is evidenced by DH’s current effort to have 50% of medical school graduates enter general practice. However, the planned shift toward general practice has been slowed by numerous factors including the attractiveness of general practice relative to other specialties and the difficulty in convincing deaneries and the service to remove specialty training posts in favour of general practice ones. This tension seems to raise the important issue of the need to balance strong central leadership on issues such as promoting primary care with the requirement to be responsive to local health care service needs. Some SHAs have made clear that they have already increased their proportion of GPs and do not feel the need to increase their numbers further given the population health needs in their communities.

Compared to the US, there seems to be greater awareness in the UK that social accountability should not just be focused on undergraduate education, but needs to be integrated across the medical training spectrum from medical school to foundation programme, to postgraduate specialty training and continuing professional development.<sup>16</sup> Such an approach is easier in a publicly funded system where changes in the funding of medical training are explicitly negotiated among a central group of stakeholders. Even in a market-oriented system such as the US, state and federal governments play a major role in allocating funding for medical training and they could play a more active role in defining accountabilities for medical education dollars spent across the training spectrum.

Looking toward the future, increasing pressure will be put on the NHS to show the value of medical training and the contribution of doctors relative to other health care providers over the coming years. In recent years, there have been generous year on year funding increases to the NHS, but cutbacks are planned in the range of 14% over the next three years. The emerging threat of these funding constraints has already caused SHAs and trusts to begin to more actively review the current distribution of trainees and medics in their geography.

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**With extensive contributions from Andy Knapton, Data Modelling Manager, NHS WRT**

The author gratefully acknowledges the expertise and contributions of Rhydian Owen and Sue Cromack at the National Leadership & Innovation Agency for Healthcare, NHS Wales as well as Martyn Dell, Caroline Lee, Heather Parnell and Irum Ossai at WRT.

## References

1. Department of Health. (2004) "Delivering Doctors of the Future". Page 4. [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_4075406.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4075406.pdf), accessed 5 March 2009.
2. British Medical Association. (2007) BMA evidence to the House of Lords Economic Affairs Committee Inquiry into the economic impact of immigration. <http://www.bma.org.uk/Archive/ImmigrationImpact.jsp>, accessed 10 April 2010.
3. Boelen C and Heck JE, (1995). Defining and Measuring the Social Accountability of Medical Schools. World Health Organization. [http://whqlibdoc.who.int/hq/1995/WHO\\_HRH\\_95.7.pdf](http://whqlibdoc.who.int/hq/1995/WHO_HRH_95.7.pdf), accessed 5 March 2010.
4. Hann M and Gravelle H, (2004). The maldistribution of general practitioners in England and Wales: 1974-2003. *British Journal of General Practice*; 45: 894-898.
5. Department of Health (2008), High Quality Care for All: NHS Next Stage Review Final Report, ([http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_085828.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085828.pdf) accessed 10 April 2010, pg. 17
6. Ibid, pg 18
7. Right Care, Right Here: NHS Bringing Care Closer to You. (2009). <http://www.sandwell.nhs.uk/documents/publications/Right%20Care%20Right%20Here%20June09.pdf>, accessed 31 March 2010.
8. Higher Education Funding Council for England, Medical School Intake 2007
9. Workforce Review Team, <http://www.wrt.nhs.uk/index.php/work/tools/96-deanerymonitoring>, accessed 14 January 2010.
10. Fraher E and Knapton A. (2010). Fraher E and Knapton A. "Migration Patterns of the Recently Trained Medical Workforce." *NHS Workforce Review Team. Unpublished*
11. Department of Health. (2009). About NHS Allocations. [http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Allocations/DH\\_076547](http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Allocations/DH_076547), accessed 31 March 2010.
12. Department of Health. (2004) "Delivering Doctors of the Future". [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_4075406.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4075406.pdf), accessed 5 March 2009. Page 4.
13. Ibid, page 6.
14. Office of National Statistics Labour Survey. <http://www.statistics.gov.uk/StatBase/Expodata/Spreadsheets/D7919.xls>  
[http://www.statistics.gov.uk/downloads/theme\\_labour/LFSHQ/19.xls](http://www.statistics.gov.uk/downloads/theme_labour/LFSHQ/19.xls)
15. Leatherman S and Sutherland K. (2008). The Quest for Quality: Refining the NHS Reforms. The Nuffield Trust. <http://www.nuffieldtrust.org.uk/pressarea/index.aspx?id=143>, accessed 9 April 2010.
16. Fleet LJ, Kirby F, Cutler S, Dunikowski L, Nasmith L and Shaugnessy R. (2008) Continuing professional development and social accountability: A review of the literature. *Journal of Interprofessional Care*; 22(S1): 15-29.

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