HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Workforce: recruitment, training and retention in health and social care, HC 893

Wednesday 11 May 2022

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Watch the meeting

Members present: Jeremy Hunt (Chair); Dr Luke Evans; Taiwo Owatemi; Sarah Owen; Dean Russell; Laura Trott.

Questions 129-197

Witnesses

I: Isaac Samuels, health and social care community campaigner and social care recipient, Co-Chair of the working group of Adult Social Care APPG; Sophie Weaver, town councillor and social care recipient; and Trevor Wright, lived experience witness.

II: Professor Roger Kirby, President, Royal Society of Medicine; Professor Colin Melville, Medical Director and Director of Education and Standards, General Medical Council; Dr Latifa Patel, Interim Chair, BMA; and Professor Malcolm Reed, Lead Co-Chair, Medical Schools Council.

III: Lara Akinnawonu, medical student and Co-Chair of the BMA Medical Student Committee, Cardiff University; Professor Hazel Scott, Dean of the School of Medicine, University of Liverpool; and Professor Scott Wilkes, Head of School of Medicine and Professor of General Practice and Primary Care, University of Sunderland.

Examination of witnesses

Witnesses: Isaac Samuels, Sophie Weaver and Trevor Wright.

Chair: Good afternoon and welcome to the third evidence session of the House of Commons Health and Social Care Committee inquiry into workforce in the health and social care systems. Today, we will be doing a deep dive into medical education, but first we want to look at something slightly different, which is the impact of workforce pressures on the social care sector. I am delighted to welcome three social care users to talk about their own experiences.

Joining us remotely is Isaac Samuels. Thank you for joining us, Isaac. Isaac is the co-chair of the working group of the all-party parliamentary group on adult social care. He receives support for personal assistance through a direct payment.

Sophie Weaver—welcome, Sophie—is a wheelchair user who has Still's disease and until recently received 24-hour care, but has now had that cut to 15 hours a day.

Trevor Wright—thank you, Trevor, for joining us—was working in social care when he was diagnosed as autistic.

We have a wide cross-section of experience. I'm going to hand over to my colleague, Taiwo Owatemi, who is going to ask some questions.

Q129 **Taiwo Owatemi:** Thank you, Chair. Thank you so much to the witnesses for coming here this afternoon to share your experiences with us.

Sophie, I'm going to start with you. Are you able to share with us your experience in accessing social care?

Sophie Weaver: My experience goes back a number of years now. I have had my condition since I was a child, so until adulthood and through a lot of adulthood my parents were my sole carers, but there comes a point when you want independence, so I went through the social care system to receive direct payments.

What I find a great positive about direct payments is that once your care package is assessed, you receive the money directly, so that you have control over who you employ. You can choose your own carers or personal assistants, and for someone like myself, that is really important. I was assessed as needing full-time care, and there have been arguments over the years about the nature of what 24-hour care means.

In more recent years, that has perhaps changed a little bit. It seems that over the years, the reviews that you have each year have become more and more—I don't like to use the word "invasive", but you have to get to the nitty-gritty of what my everyday life entails, down to all the personal care that I need and so on. Over those years, it has been great that I have had, in effect, 24-hour care, and this last year—as you said at the

beginning—it was decided that it could be decreased after looking at what I was doing day to day and so on. I had to keep a diary as to what care I had at what point and send that over. At the moment, it is still in review because of legal issues, so I have my full care at the moment. A solicitor had to be involved, and the local authority is in agreement to continue as is.

Obviously, I am happy to answer any questions about my own personal circumstances, but the reason I am really pleased to be here is that with my issues, it was decided that I could manage my life—which was quite an active life pre pandemic—and do everything in seven hours. Now, when you consider that I need help getting in and out of bed, going to the toilet, washing, showering and so on, getting up in the morning and being ready to go out takes an hour to an hour and a half, and you've got that at the end of the day as well. Out of seven hours in a day, you are left with about three to actually live—three or four, maybe—and I just could not see how that could be done. As I said, I challenge anyone to live their current life in seven hours rather than 16.

We have been going through that process. It is still being reviewed, with the solicitors talking to each other, but my experience has been that in more recent years, when you are getting reviewed, you feel like you are having to justify why you need the care that you are saying you need. For someone in my position, having had full-time care for a number of years, that has set a precedent, so why is it suddenly being questioned when you have a condition that isn't going to improve?

There are lots of areas that can be looked at within the social care system, including the managers and the social workers. I experienced that between one review and the next, you do not get the same person reviewing, so you start from scratch again. I have noticed a quicker turnover of people leaving the local authority's employment and going elsewhere, which suggests something is going wrong within local authorities. I think there is an issue, because all of my money comes from the local authority and the local authorities are under a great deal of pressure with budgets. They keep saying they do not have enough, but it is not just about the money for the local authorities.

I understand they have to save money, but if saving money means— I will give this as an example. I said, "Look, you think that for those three or four hours, I did not need much help, but I had a toilet break." And they said, "Well, we can't give that amount of care just for toileting needs. You could wear incontinence pads for that time." That is quite insulting. How would anyone in this room feel if you were told, "You can't have a toilet break this afternoon because you're in Select Committee. But here you go—here are some incontinence pads"? On a human rights level, that shouldn't be considered a solution. Things like that need to be questioned.

I know that this Committee is looking at the workforce, including recruitment and keeping people in the workforce. I went through a very traumatic period, when they said that they were going to instigate this reduction in hours, of having to tell all my team—I have a team of people

working different shifts—"I know this is a big reduction. I understand. If you feel you've got to not work for me anymore, because there are not enough hours for you, and if you need to work elsewhere, I completely understand." Fortunately, all of my workers have said that they want to continue working with me and we'll try to work things out if that scenario happens; my situation is still ongoing with solicitors and working out what the outcome might be.

Whatever is dealt with at local authority level, and the people doing the reviews, there is an impact on me, in terms of what I am being asked. Their decision also affects me and all my workers, which puts me in a position of feeling, "What am I going to do if I don't have my full team of workers because they need to go elsewhere?" It affects them, and they were really worried about the idea that they might have to leave me and find other work.

I was also worried that I would be put in a position where I would need to have some kind of managed care, which is different from direct payments because the local authority manages who comes in and who does your care. For somebody who has someone with them all the time, I would make the point that nobody would actually choose to have 24-hour care if they didn't need it. It is important to recognise that. There is a huge difference between the people you see on TV—those who complain that they cannot work because they have a back problem, and then you see them playing squash—and someone like myself, who, during the review process, can be made to feel like you are asking for the earth, but I'm just asking to live a normal, everyday life, the same as anyone else.

We have had Acts—the Disability Discrimination Act and the Equality Act—that are supposed to help with all this. However, from my perspective, it feels that we are moving further down the line from equality in terms of giving people what they need. If I'm totally honest, I think that the whole social care system needs a root and branch overhaul; it needs to be looked at from top to bottom. It is not just about throwing money at it. Yes, more money needs to be put into local authorities, because care needs seem to be a big problem for local authorities. I recently found out that 62—

Chair: Sorry, but can we come back to you, Sophie, because I am just conscious of time and I think we should get the other two panellists in, as well—if that's all right, Taiwo? We will come back to you, if we may, on that broader question.

Q130 **Taiwo Owatemi:** Thank you for your honesty, Sophie, and for sharing all that.

Trevor, having just heard about Sophie's experience, how has your experience of getting your autism diagnosis been, compared to your daughter's experience?

Trevor Wright: They are two separate but connected stories, I think. My access to diagnosis was reasonable; I was happy with the process. That was 10 years ago. After that, I was left pretty much to my own devices. I

had no access to sensory assessment, which is really important when you consider things like light and sound and how they can impact on your mental health. I had no access to mental health—no level of community mental health assessment and support. I was not considered eligible for social care.

I do work—I was working part-time—but there were some low-level things that I would have benefited from, I think, looking back. So, there was a bit of a cost to my GP and to community mental health, and I probably had higher-than-average sick leave at one point for things like environmental factors in my working environment, as well as anxiety issues. As I say, it is 10 years on, so I would say that I am fairly level as things go, compared with other people. My help is probably too late.

For my daughter, it is a different story. We went around the houses for three years, across psychology, CAMHS, education, social care—you name it, we went there. It took three whole years, despite the fact that I was working in health and care, so I know the system. It took me three years; how long will it take a parent who does not know the system? There is a major training issue. I got to the point where I had been on a couple of autism courses and felt that I knew more about autism than the professionals I was talking to. There is a strong training need across all of social care and the clinical professions.

Eventually, we struck lucky. My daughter got diagnosed, but only because they brought a retired consultant back who was trained in autism in girls, which is a big issue. We then got access to CAMHS for anxiety issues for my daughter, but it stopped after five months because she was 18, and there is no comparable service when you get to be over 18. Again, there is a lack of the right trained professionals in the right places, whether that is in under-18 or over-18 services. She actually said, when she was about 16, about to do GCSEs—a crucial adolescent period—"Everybody else has given up on me, why should I bother?" It has taken us literally four years to pull that back, without any support. It is us as a family who have done that, rather than with any external support.

Fingers crossed, she is resitting A-levels, but had to go back into college to do so. If she passes, university, but she will need support when she gets there. But that is family effort, not support from services.

Q131 **Taiwo Owatemi:** I was going to ask about that. After your daughter was diagnosed, was any other support given to help her?

Trevor Wright: Again after quite a bit of fighting, there was short-term CAMHS for anxiety issues, so CBT, but that was not autism-focused, so it took a little bit longer to work. She was coming towards the end of that—it was clear that it had partly, but not fully, worked—when she became 18 and therefore gonged out of the service, with no service for adults to carry that on from community mental health.

Q132 **Taiwo Owatemi:** So there was no transition to adult services.

Trevor Wright: No, and that is the common story, I think. Parents will describe the cliff edge that you go over.

Taiwo Owatemi: Thank you for that. I will move on to Isaac, due to time. Hi, Isaac, how are you?

Isaac Samuels: Good afternoon. I am well, thank you.

Q133 **Taiwo Owatemi:** Thank you for coming today. I want to get your experience of having a personal assistant and the difference that that made to you.

Isaac Samuels: The previous panellist talked about some of the struggles with social care and the lack of support. I found that direct payments offered me the ability not only to manage my health and wellbeing, but to find purpose and meaning. Personal assistants help me daily. However, it is really fragile. It feels like I am being assessed constantly. We have had Brexit, covid and so many things that have put so many stresses on the workforce, and I sometimes feel unable to be a really good employer.

There are no funds available for me to offer training. I want to be a good employer, because my PAs offer really good support to me. Social care has never really thought about what it means to be a good employer in terms of wellbeing. If we do not look after people who look after people like me and the other panellist, in time they will not be able to look after us. It is underinvested. There is never an opportunity to speak to what matters to me and what matters to my PA.

During covid, PAs and carers went above and beyond to really support people to stay well. However, their terms and conditions are terrible. We don't think about their wellbeing, there are very few opportunities for them to receive training and support, and it is pretty dire. I personally live in fear that at any point my care package will be stopped. I feel that I have a very adversarial relationship with systems. That is really sad, because at the heart of direct payments is personalisation, and putting people at the heart of it is so important.

Q134 **Taiwo Owatemi:** If you could make one change to the working conditions in the social care sector that would really make a massive impact on the quality of life of patients, what would it be?

Isaac Samuels: Investment in training and development, ensuring that everybody in social care has appropriate training, development and supervision. We should also create time for wellbeing. That is probably not one thing, but training and development would be my one thing. The more training and support we offer our workforce, the better they are at supporting us.

Q135 **Taiwo Owatemi:** Thank you, Isaac. Trevor, what would your answer be to that?

Trevor Wright: Can I pick two? Better recruitment and retention, in the sense of positive stories, bursaries to get people in, and career structures so that people can progress. I think the biggie, as I have said, is around

training. We have the Oliver McGowan mandatory training, but that is not for everybody who works in health and social care, and it excludes education. Education is not included. I would link the Oliver McGowan training to a national qualification structure, particularly postgraduate for clinicians, and have mandatory training in medical schools and speech and language therapy, and for all the allied professionals as well.

Q136 **Taiwo Owatemi:** Finally, Sophie, what would be the one change that you would like to see?

Sophie Weaver: For me personally, it would be to keep my care as it is, for as long as I need it. Once you have something like 24-hour care, it is unlikely that you will need less than that. An agreement that is an indefinite one, so that a review means that they just check in with you once a year and say, "Is there anything else we can do?" That would be the one for me, personally. But overall, for most people, it would be to feel more secure in their care package. Like Isaac was saying, you feel like you are on the witness stand.

Chair: I hope we are not making you feel like that.

Sophie Weaver: No, it's fine. I think that people working in social care under the local authorities doing the reviews maybe would benefit from greater awareness training of people's needs. They cannot be experts on all disabilities and conditions, but some of the language used can be a bit offensive at times, without them meaning to be. The people who are going into those jobs are obviously people who want to help, because you do not go into it otherwise. I feel that they are finding it difficult within a system, which is why there is a lot of turnover, because they go into a system to help people like myself and then find that they are having to tell somebody, "We're taking some of your care away." One reviewer, partway through all the meetings, said, "If it was up to me, Sophie, of course you'd have 24-hour care." I thought that said it all. He said, "I shouldn't be saying this, and it's just between you and me." He then had to write a letter saying what had been agreed. I think retention of those people is important, but it is also important that they are able to do the job they signed up for.

Taiwo Owatemi: Absolutely. They should be able to feel confident that—

Sophie Weaver: That they are there to help people, rather than balance the books for the authorities.

Taiwo Owatemi: Thank you all for sharing and being able to answer the questions today. It was really informative for us, and we will be looking at all the statements you have made today.

Q137 **Laura Trott:** I wanted to ask one question to Sophie and Isaac about your reassessments. Sophie, how often do yours happen? Is it every year?

Sophie Weaver: You get reviewed annually, yes. When that comes around, you are on tenterhooks, because you think, "What will happen this

time? Will they try and take some care away?" Over the last few years, those questions have felt more and more intrusive. It has felt like they are trying to find areas where I would not need so much help.

Q138 **Laura Trott:** When you are being reassessed, Sophie, do you feel that someone is going through a standard questionnaire, rather than it being someone who actually knows about your disease and the requirements of it?

Sophie Weaver: Yes. Obviously, there are all the questions that need to be asked about my everyday needs, and I get that. That is fine, I will talk to anyone about what I need and don't need, but—

Q139 **Laura Trott:** Perhaps it would make sense if they just asked you what changed.

Sophie Weaver: You get asked about what is important to you in life, what your aims and objectives are, what you hope to achieve and that sort of thing. It is great that they ask that, but then if you are faced with a cut in your hours, those questions obviously meant nothing. If you are being asked what you hope to achieve in life, I am not going to achieve normal, everyday things if I only have seven hours a day care. Just coming here today to do this will have taken more than that, and I would not have been able to do this unless I had that care package. I do not leave the house unless somebody is with me—I can't.

Asking about people's aspirations and what is important to them has got to have value in itself, as opposed to—I am just quoting forms—addressing somebody's basic needs and making sure they are covered. Aspirations are not a basic need, so that probably gets put by the wayside. I do not know what you do about that, other than look at the whole process of that review system, because it could be simplified a lot more. Some people's conditions are very fluctuating and perhaps might get better, but a lot of conditions that are long term are going to be the same for years, so why do you need to spend many hours doing reviews on the people who do not really need those reviews?

Q140 **Laura Trott:** Isaac, just briefly, are your experiences similar to Sophie's, in that you are getting annual checks and being asked the same things again?

Isaac Samuels: It is. I think the experience is really dehumanising, and I think the decisions have already been made. As long as you have a system that assesses based on "finish a task in 15 minutes of activity", you will have people like myself not getting the care and support we need. It needs to be person-centred; it needs to be human, and not about the money but about equality and having the same life opportunities as everybody. That is not a model of focusing on the deficit and providing the bare minimum. It has to be more than that, and unless we have more than that, we will have loads of disabled people not having a life with purpose and meaning and meeting their potential. That is not good for individuals, but it is not good for our society, either.

Q141 **Chair:** I just have a last question for each of you. We did a big report nearly two years ago about funding for the social care sector. In that report, the Committee agreed that there needed to be a substantial boost in funding, so we have a lot of sympathy with your comments.

In this particular inquiry we are looking not at funding but at workforce. There is obviously a link between the two, but in some of those difficulties that you have all talked about, in terms of the care packages you have been offered, to what extent is it a lack of funding by the local authority? Have you noticed that sometimes they might be willing to fund things, but they just cannot access the people who are able to do that work, so the workforce shortage is contributing to the funding issues?

Sophie Weaver: I would say it is both; they go hand in hand. People are not going into the care sector because it has now not got a great reputation in terms of pay, conditions etc. People are more reluctant to do that, so it is about money and funding, and about how you retain those people. I have probably retained my workers for as long as I have because there is a lot of consistency, because they know where they are at when they are working for me. I have flexibility with them swapping; if somebody wants next Wednesday off, one of the others will say, "I can cover that." In that respect, direct payment has worked well for me, so there are positives.

There is a lot to look at in a whole raft of areas in terms of recruitment, first off, and then retaining those people who are recruited. There is probably a lot of disillusionment. As I was saying about that particular social worker, he was agreeing that I should have my care but his hands were tied, as it were. If he is somebody who genuinely wants to help, he probably won't stay in that job because he is not able to do that.

Q142 **Chair:** Thank you, Sophie. I just want to bring in Isaac and Trevor before we wrap up. Isaac, what is your view about workforce shortages and funding?

Isaac Samuels: We have had a very difficult couple of years. We have had Brexit, which had a massive impact on PAs where I live, and we have had covid. There is a terrible reputation around social care. For me, it is really important that we see beyond terms and conditions. They are really important, of course, but actually we need to have value-based recruitment. We need to support people in their roles, because these are really valuable roles that make such a contribution to people's lives every day.

For me, I would love to be able to sort out all of the terms and conditions, but if I could do one thing, it would be to focus on recruiting the right people to understand what independent living is and to support people to live their best lives. There are some great people who sign up to social care and get into the role, but the system just bashes them up so much and they end up not doing what they signed up for. I think we need to enable those who have come into social care to be the best they possibly can, and that is through less bureaucracy and much more support to enable them to support people around their independent living.

Q143 **Chair:** Thank you. Trevor.

Trevor Wright: Like Isaac, I have come across so many people in health and social care who want to do better and are constrained by their working situation. I think there could be services that perhaps exist—perhaps voluntary services—where, if there were more funding, it would be a case of getting people skilled up. I think there are services that need to be funded that just do not exist, and therefore you have got a big recruitment and training programme, which is an issue. That is why getting people skilled up, at pace, and recruited would be the main task, along with the training that I have already mentioned.

Chair: Thank you. That has been really informative. I am very grateful to you, Trevor, Isaac and Sophie, for sparing your time today. I appreciate that it has taken a big chunk out of your seven hours. The Committee is very grateful to you for giving us that time and some very important insights. Thank you all very much indeed for joining us. That will help us greatly in our inquiry.

Examination of witnesses

Witnesses: Professor Roger Kirby, Professor Colin Melville, Dr Latifa Patel and Professor Malcolm Reed.

Chair: We now move on to our second panel. I welcome Professor Roger Kirby, president of the Royal Society of Medicine, which is one of the UK's major providers of postgraduate medical education; Professor Colin Melville, who is medical director and director of education and standards at the General Medical Council; and Professor Malcolm Reed, who is dean of Brighton and Sussex Medical School and lead co-chair of the Medical Schools Council, where he is also chair of the education sub-committee. We hope that joining us virtually will be Dr Latifa Patel, who is interim chair of the BMA representative body and a paediatric respiratory doctor. We will tune her in when she is able to join us. I want to broadly ask the same question to all of you to kick off.

Welcome, Dr Patel. Thank you very much for joining us. Can you hear me?

Dr Patel: I can, yes.

Q144 **Chair:** Excellent. I am pleased now to be able to welcome Dr Latifa Patel, who is interim chair of the BMA representative body and a paediatric respiratory doctor.

I want to start by asking you a very broad question: are we training enough doctors at the moment, in your judgment? If not, do you have any sense of how many more we should be training?

Secondly, are we broadly doing the training right? This is very broad, and my colleagues—particularly my medical colleagues—will go into more detail on this later.

Thirdly, given that we have shortages in nearly every specialty in the NHS at the moment—in earlier reports, this Committee has called it a crisis—is there any way of either reducing the time it takes to train a doctor or expanding our ability to get more doctors more quickly, given the pressures on the frontline at the moment? Perhaps I can start with you, Roger, to get your broad thoughts on those. Someone has to go first.

Professor Kirby: Thank you very much, Chair. I am from the Royal Society of Medicine, and the way we perceive things is certainly that we need more doctors—we are at least 10,000 doctors short in the NHS at the moment—so there is a strong argument for increasing the number of medical students. One of the big problems is that we are not retaining doctors. So many of our best doctors qualify and then leave. It costs something like a quarter of a million pounds to train a doctor, and so many of them leave for New Zealand, Australia and other parts of the world, and that is really a tragedy.

There are things that could be done. Around 2005, they changed medical training, and modernising medical careers controversially started. Instead of having a firm system whereby the doctors stayed in one institution, they were rotated from A to B to C to D, usually on a yearly basis. Well, a year is not really long enough to establish yourself and establish trust in you. There is a disconnect between the trainer and the trainee, and I think we could change that quite easily. We could increase the length of the rotation and have somebody overarching mentoring that person. That is No. 1.

No. 2 is pay and conditions. The BMA will be arguing, I am sure, that doctors' take-home pay is about 24% less than it was 10 years ago, but the work they have to do is at least 24% more difficult—probably 100% more difficult, I would say. Then there are elements about professional development. Although we train our clinicians in their clinical specialty, we don't do enough to develop them as people and clinicians, and with overarching things like communication and negotiation skills. That is where the Royal Society of Medicine could help.

Finally, there is also a bit of a disconnect with research and clinical medicine. Again, on changes dating back to 2005, it used to be that at least a proportion of doctors would do some research, often to get a higher degree, and you would produce clinician scientists who would link in with the universities and come up with innovative ideas that often would stimulate the economy in the longer term. That has been disbanded, so I think we need to re-establish a link with scientific research and clinical medicine, which I think would keep the best doctors in the UK instead of their leaving to go to America or elsewhere.

Q145 **Chair:** To be clear, you would support bringing back the "firm" system.

Professor Kirby: Not the old-fashioned "firm" system whereby you stay in one place for four years, but maybe two-year rotations, and maybe the allocation of a trainee doctor to one or two senior clinicians who would

take an overarching view of their career and mentor them through the process. It is so complicated getting through the system, and to expect them to find their own way through is really difficult. Everybody needs somebody, a sort of guardian angel, to help them through the system. It would not be too difficult to establish that and it would not cost much, and senior clinicians I think would be keen to do it because they feel disconnected from the trainees themselves. They often don't know who their trainees are, and they don't invest in their education.

Chair: Thank you. Professor Reed.

Professor Reed: In answer to the first question, "Are we producing enough?", the answer from my perspective is no. To go to the evidence for that, there was the report that the Medical Schools Council produced on medical school expansion, and also the Royal College of Physicians report and the Royal College of Psychiatrists report, which really go through the evidence. In a nutshell, just over 50% of the people joining the GMC register each year are international graduates. They make a phenomenal contribution to the NHS. There is absolutely nothing against international recruitment, but it is not a sustainable option and it brings problems because we invite people to join the NHS who have qualified in a completely different environment, both from a learning perspective and from a service provision perspective, so there is a disadvantage on arrival. They therefore tend to finish up in posts where UK graduates do not want to go, so it starts to build in inequalities both in terms of population health and in terms of the practitioners themselves and their health, their prospects and their risk of being referred to the GMC and so on. It starts that institutional bias that we are increasingly aware of.

We have suggested increasing by 5,000 a year. That is not quite enough to bring us up to 100% sustainable. We believe strongly that the international exchange of doctors—doctors going to Australia—is absolutely fine so long as people are coming in and there is a flux. Medicine is a global service, and most of the doctors who go to Australia come back after a few years. About 80% to 90% of them return.

Are we doing it right? I think that, from an educational perspective, we are. The thing that goes wrong and is blocking expansion is the tariff money that gets paid by Health Education England to trusts to provide clinical placements. It is 10 times as much almost for a medical student as for a nursing student, and it cannot cost that much extra. It makes up a large component of the £200,000 or so that it takes to produce a medical graduate and is a barrier to expansion from a Treasury perspective, but also in many ways from the trusts' perspectives because they get that money and it is not hypothecated. It is a top-up, if you like.

Q146 **Chair:** So you think hospitals should contribute more towards the salaries of their junior doctors.

Professor Reed: No, I am talking about undergraduate medical students and the undergraduate medical tariff, which is around £35,000 a year for a medical student. It is about £3,000, £4,000 or £5,000 a year for a nursing

student that the trust gets. At the moment HE are doing a really valiant job of making that accountable and transparent, but there is a long way to go. That additional cost to the NHS that they pay to trusts, and now that we are levelling up with general practice, is a real barrier to expansion because it makes it very expensive to expand the number of medics compared with the number of nurses. You can have 50,000 nurses or 5,000 doctors effectively.

Your last question was, "Can we do it quicker?" The great example of that is graduate-entry medicine, which is four years. But I will say that 400 conditions are listed in the Medical Licensing Assessment content map, so that's 400 separate conditions that graduates have to know about. It's fine to say, "Well, they're going to go on and practise in a specialist area," but if you're a GP, you are expected to have some knowledge of all those conditions. And those 400 conditions cover only the clinical conditions; they don't cover the underpinning science that needs to be learnt before you go on to do the clinical conditions. We don't want doctors who can just practise without the underpinning knowledge, because over a 40-year career, things change, and if you don't have the underpinning knowledge to update and build on, you will become redundant pretty quickly.

So those are my answers.

Chair: Thank you very much. Dr Patel?

Dr Patel: Thank you very much. It was really interesting to listen, just before we started, to Isaac, Sophie and Trevor.

I will go through your questions as well. Have we got enough doctors in the UK? Are we training enough medical students? The answer is simply no. I urge you, if you haven't done so already, to look at our own workforce report that we published in the last 12 months. Compared with EU nations, the OECD EU nations ratio, our doctor-to-population ratio is only 2.9 doctors per 1,000 people—2.9. Places like Germany have a ratio of 4.3 per 1,000. We are aiming for an average of 3.7 per 1,000. Our calculations are that we need 11,000 more medical students per year; we have a shortage of 46,300 at the moment. Only then will we reach that sustainable number by 2030. So we are drastically short of doctors. I remind you that at the moment in the NHS in England alone we have 110,000 vacancies.

Are we doing it right? I do believe we have a world-class education and training system for undergraduates. I do believe we have a well-respected and world-renowned system. But actually we are at risk. Right now, it is very evident and very clear that we are almost working on a shoestring, and that is throughout—from undergraduate through to postgraduate—within the NHS. So unless we really invest in tomorrow's workforce today, that problem will only get worse.

Your third question, which I think is the most important, is, "Can we do anything? Can we shorten training? Can we increase the ability of how we train?" I have told you right now we need 11,000 more medical students

per year. That is on the data collected by the BMA; that is based on our statistics.

I am going to give you a really easy metaphor. I am currently in York. You want me to get down to London. It's a good distance—a four-hour drive. You want me to get there quicker. I have one car. What can I do? I can drive faster. I can go through red lights. I can ignore motorway speed limits. And I drive all the way down. Would you trust anyone to be safe in that car with me?

You can shorten medical training. You can expect medical undergraduates to work faster. You can expect their trainers to teach them quicker. You can use prior competencies. But at the end of the day, the standard we are expecting is the same standard I went through in a five-year undergraduate degree. So we are cutting corners somewhere. The BMA is sceptical. We are concerned. We think we need more data. Because any mistakes you make at this level right now—in five years' time it will be too late. You will have those doctors who have gone through that system. You will have those patients who are being treated by those doctors. And it is then too late to rectify. So before we rush into any changes—making undergraduate training quicker or taking shortcuts—we need to make sure this is absolutely safe and it is best for medical training, best for the doctor, best for the patients and best for the NHS. I will stop there.

Chair: Just to avoid setting any hares running, I don't think there are any proposals, either by the Government or by the Select Committee, to shorten medical training. I just wanted to ask the question, because I think it's something that members of the public ask when they hear that it takes seven years to train a doctor. That, rather than any proposals that have been made, was the context of the question, and you gave a very clear answer, so let me let you carry on.

Dr Patel: It takes five years to train a doctor; then there are F1 and F2 to give them foundation training; and then they have specialty training. We have to be really clear about the numbers, but on the numbers that we are looking at in the BMA, it's 11,000 more undergraduates per year to get us on a par with EU nations. That's all I have to say on those three questions; thank you.

Chair: Thank you very much indeed. Professor Melville?

Professor Melville: I feel I may be outnumbered slightly here. My answer is slightly more nuanced. It is certainly true, as Roger said, that we need to do more to retain the workforce that we have got. It seems folly to lose people. I am sure we understand some of the reasons for that.

The second thing is that in the current circumstances, there is an immediate crisis—I think that was the word you used—and therefore, today, there is a demand for a workforce to meet the health needs of our nation. However, we cannot necessarily solve that, for the reasons we heard—it takes five years to train—but the question then is, what is the workforce that we need?

Multiple countries have a challenge. I would describe it as being slightly on the back foot: we do not have the right number of doctors for the model of care that we have adopted. Two things are probably worth looking at, and one is the make-up of the workforce. Are we using highly skilled and highly trained people to do the things that, uniquely, they can do, and what are the other components of the workforce? We know that we have MATs—medical associate professionals, such as anaesthesia associates or physician associates—who will be coming into regulation. What is their role? What is the role of other parties in this, such as pharmacists, nurses and so on? How can we meet the needs?

The third part of my answer would be that most of our health and care system in this country is based on a reactive model. As a member of the public, I have to decide that I need some intervention. Potentially, we need to shift the focus to identify where the upcoming demands are. For example, we know that the prevalence of diabetes is going up, so what do we do? We train more diabetic doctors, rather than saying, "Why has that happened, and how can we reduce that?" There is a little of both/and—something about how we address demand and something about what the right make-up of the workforce is. In the immediate term, I think there is a demand for more doctors, but we cannot produce those at short notice.

Q147 **Chair:** May I ask you to clarify that point? Are you saying that we need to be more scientific about how many specialists we train in each area, or that the core things that we teach every doctor also need to change, for example to have more emphasis on prevention work?

Professor Melville: Both of those. It is the case that, if I think about my career—I was an intensive care consultant until 2017—there were many things that I did that could be done by other people. We started to see that change. The question then is, is my role as a senior clinician adding value and using my skill appropriately, when other people could contribute to that care plan? I am not saying that I have an answer, but it is a question that we should be asking. But I also think that there is something that you alluded to in the more general skills thing, about how we can be more fluid in meeting changing demands, because clearly that is the case and the pandemic taught us that writ large.

I think your second question was, "Have we got the right training?" I am conscious that Helen Stokes-Lampard from the academy said that it is not flawed, and I would agree with that, but there is a question of whether our models of training could change. I am not sure that I agree with the answer that we cannot shorten training. Within the GMC, we have adopted five principles when we consider training.

The first and most important principle is patient safety. We are a patient-safety organisation, and patient safety should be at the heart of everything that we do in healthcare. That is No. 1. The second is maintaining standards. Several of my colleagues have referred to that. It is important that we keep high standards. The third is that we are interested in achieving outcomes, not the time served, which is where there is an opportunity to ask questions about whether we have got the

right time. The fourth is about—now I have lost my notes, which is very unhelpful—competency, not quantity. Many of our curricula say that you need to do x of such and such, and the question is, how many times? It feels like asking how many times you need to do a three-point turn before you are competent to do it—as a random example. The last one is about being proportionate and taking into account some of our colleagues who have different requirements, particularly around disability and protected characteristics.

Q148 **Chair:** Did you have another thing that you wanted to say?

Professor Melville: Your last bit was really about how we change it. We are already looking at education reform, particularly in the postgraduate area, and we are working with the academy and the Royal Colleges on whether we have created curricula for each speciality and an assessment programme that is actually fit for the 21st century. It is not flawed, but it is quite burdensome for those in training. That is contradicting the opportunity for them to enjoy the process of learning their skills, so we think that there are opportunities there.

Q149 **Chair:** Just before I bring in my colleague Dr Luke Evans, may I ask Roger, Malcolm and Latifa about the other point that Professor Melville raised, which was about the content of medical education—not the volume of people or the time it takes, but the content? Very briefly, do you think that needs overhauling, or is it broadly where it should be?

Professor Kirby: They say that the sum total of medical and scientific knowledge doubles every two years, so there is a vast amount of new information coming in all the time. It needs to be constantly updated and upgraded, and the techniques of education need to change to be modernised. There is a lot that could be done.

Dr Patel: I think we're all on the same page here, but I would urge a bit of caution in terms of how we make medical education bespoke. The needs of the population will always change—we know that—and if we are reactive in that model, we might actually be deep training a group of doctors who are quite niche. There is so much to learn, and we will never be able to learn everything, but that combination of undergraduate training and postgraduate training will hopefully create doctors today for tomorrow. But in answer to your question, I don't think we need a broad overhaul of medical undergraduate training, and I would urge caution about whether we make it bespoke in terms of what the current population needs. I hope that answers your question.

Professor Reed: I was struck by Trevor and his autism, because I don't remember learning much about autism five decades ago, when I was at medical school, and similarly for Still's disease. I definitely learned about that, and I have definitely treated patients with both those conditions. I am a breast cancer surgeon, so I need to know about that as part of what I do as a very narrow deep specialist. The breadth of education that we currently try to provide, despite the escalating size of the knowledge base that challenges students, is absolutely essential.

There are different models of learning. I don't want to say, "Definitely not shorter," as if we are blocking things, but it may be shorter and it may also need longer, because we do not currently have a viable part-time training offer for medicine. It is about the only profession in healthcare that we cannot offer less than whole time. It might take seven or eight years. A four-year course is not very long, really. If the idea is that we could get more doctors more quickly, what we need to look at is a new study state. Four years for graduate entry is great. There are really severe financial issues with that model, but it is a great model.

Chair: Thank you. I want to bring in Luke, Sarah and Dean. Over to our resident doctor first.

Q150 **Dr Evans:** I have two sets of questions for Professor Kirby first, if that's all right. You mentioned MTAS. Why do you think that, since 2005, things haven't changed? How much do you think MTAS has a responsibility for the situation we are in at this point?

Professor Kirby: It was terribly controversial, as you know, and John Tooke took it apart in his review afterwards, but quite a lot of his recommendations were not accepted. The movement of trainees from place to place to place is one of the big defects that could be corrected, but there are others as well.

Q151 **Dr Evans:** Why isn't it corrected? There are merits to the current MTAS system and the way in which it works. Is it Government stopping it? Is it NHSE? Is it yourselves or the GMC? I qualified in 2007, so I remember seeing friends above me get caught up in this. Why hasn't it changed, considering that we are 15 years on?

Professor Kirby: I cannot really answer that, but I know it needs to change. Everybody I speak to would like to see posts for a longer period, and especially this overview of clinicians by somebody more senior who they feel they can relate to in order to build trust and so on. It should be possible to change.

Q152 **Dr Evans:** We have just heard about shortening the training. What is your opinion on lengthening the training? There are many doctors who do not know what speciality they want to end up in, but they are aware of things that they would like to explore a little bit further. Is there an argument that states that if we were to lengthen some of the training and provide an opportunity for postgraduate trainees to spend more time in different specialties, they would become better-skilled doctors, provide more service, and be likely to stay in a location for much longer at the time when they are building their families, getting married and sending kids to school? What are your thoughts on that?

Professor Kirby: That is a really good question. The change in the system means they have to choose the specialty that they are going to dedicate the rest of their lives to—cardiology, urology, orthopaedics or whatever—usually before two years. After 18 months, they have to decide before they have even tried it; they have to commit themselves to be a surgeon, a haematologist, a cancer doctor or whatever. It is really hard for

them to say, "What do I want to do for the rest of my life?" when they have no experience of actually doing it in practice.

Q153 **Dr Evans:** Does the college keep figures on the number of people who join a speciality for one, two or three years as an SHO or registrar and then move into the likes of GP? Anecdotally, in my VTS training, at least a third were people who had been an ST1 or ST2 in some sort of profession, and then decided it was not for them and came back. Professor Reed, I'm going to call you in on this, because you are nodding, which seems to suggest that you have seen that yourself.

Professor Reed: MTAS tackled a problem that was a real problem at that time, because people were locked circling around in SHO jobs and not able to progress their careers. It was designed to get run-through training, and that was a good thing to tackle what was a real problem, but as a counter to it, it locked people in a bit too much and did not allow that fluidity of movement that you talk about, particularly into general practice. Lots of people start off as surgeons and realise—I have had this said to me—"The bit I enjoyed most was putting the dressing on at the end of the operation." It is not meant to be quite like that—it is not meant to be a relief that it is over—and those people do need to be able to move, so we need that balance of flexibility for sure.

Q154 **Dr Evans:** My second set of questions is to the GMC. We have heard in our litigation panel and also some of our workforce panel, particularly on burnout, about the threat of the GMC. That is felt palpably by clinicians. What is the GMC doing to address that, and does that still stand up?

Professor Melville: Can I just go back to your earlier comment about shortening and lengthening? Please understand that I am not trying to duck your question, but I think you are asking two different things. One is about the overall time it takes to train, and I think there should be more opportunity to have freer movement. There is a different question about whether the prescribed period of training in the specialty you end up in can be shorter.

Q155 **Dr Evans:** Let me pick that point up, then, because there is a question—given that you are an intensivist—about the level we should set for the number of cases before you become a consultant. There is a concern moving forward that we are having more junior consultants coming forward who may have 2,000 intubation cases, where it may well have been 10,000 to be signed off. Clearly there is a happy halfway, but are we creating a system where we are suddenly getting more consultants—fantastic, they've got more responsibility, but not the skills to be able to deal with the complexity—and creating a two-tier consultant system? Perhaps you want to answer that question, and then the GMC one.

Professor Melville: That is fine; I am quite happy to answer that question, or any question in any order.

The question we are asking is, "What is the threshold for independent practice as a consultant?" It is not so much about two-tier; I think it is more about lifelong learning. We run the risk that we have made

"consultant" the only output, or general practice if you are in that area, whereas actually, we've got a huge cadre of SAS and locally employed doctors who may not want to get to that level, but somehow feel second-class in the system. For me, it is more about how we embrace the whole of that workforce, making them feel valued. In my organisation, being a director is not the only mark of success, whereas I think in clinical practice—I do not know whether my colleagues would agree—there is this sense that somehow, being a consultant is the only gold-standard end point, and that is a shame, because it means we are devaluing a huge part of our workforce. That was on your question.

On the specific question of what the GMC is doing, can I answer in two parts? The first is that I understand the sense that is out there; I think there was a phrase some while ago about how you could be struck off for a single clinical mistake. Each year, we get over 8,000 complaints made to us, of which around 6,000 are dismissed. In other words, they are not even relevant to us; they are not part of our regulatory authority. Of the remaining 2,000, in the past few years, only a handful—by which I mean five or less cases—come to tribunal that are related to clinical practice.

The thing that gets you in most trouble with the regulator—with us—is criminal conviction, sexual misconduct and misconduct. I don't know how I get that message across, because that is a logical answer but I understand that it doesn't feel like that. That's why we're trying to get those messages across, in order to say, "We are interested in the culture that's out there. We are looking to do what we can to help support and change that. And also we are working to try and get more local resolution." There is some interesting work from the NHS in England recently—I don't know if you've seen it—about, "If you anonymise cases to a medical director, it reduces referrals to the GMC on the basis of race." So I think there are actions already happening and we want to be part of providing a solution.

Q156 **Dr Evans:** To pull that through then, and take it on to the Government policy side, it sounds like you have the answers in the GMC and that there is a disconnect, because we hear—time and time again—clinicians saying that they feel like they have the Sword of Damocles above their head. So, is it incumbent on the Government that they should do more to advertise the fact that it is a more supported role and that these figures aren't right, because surely one of the best ways that we can retain our workforce is by creating an environment where they feel valued and do not feel under threat?

The GMC is a key stakeholder and has a key place in making that environment come true. So, is there something more that the Government could do, allied with the GMC, that we can make a recommendation for, so that the Department of Health can say, "How can we help?"

Professor Melville: I think that the key thing that would help us is ongoing at the moment, and that is the reform to regulation. One of the problems is that our processes seem complicated, convoluted and long; that doesn't help those people who find themselves in our processes. Let's bear in mind that the Medical Act is long, old and has had various bits

added to it over the years. If we could make it simpler but ensure there is accountability, then I think there is a real opportunity for us to be in a different place, in terms of how we deal with those few cases that do come to us, and add more reassurance to the profession, while also reassuring the public.

The problem with a regulator is that there is not an agreed line between what is good and what is bad. You can ask a whole number of people—in the public and in the profession—and they will have a different view, and we are often stuck in the middle. So, the profession disagree about some of the decisions that we make and they agree about some of the decisions we make, while the public disagree with the ones that the profession agree with and vice versa. That is the nature of regulation, as I am sure you understand.

Chair: Although the law could clarify this, couldn't it? What you are basically saying is that the law isn't clear, whereas in many other areas the law is clear about the difference between an everyday mistake and an egregious mistake.

Q157 **Sarah Owen:** I have a question for each of you, so I will start with Dr Patel first. Are the existing workforce burnout and staff shortages having an impact on medical students currently?

Dr Patel: That is an excellent question, actually. One of the things that the BMA does really well—I would say that obviously, coming from the BMA—is that we talk to our members and send them snapshot surveys regularly. We know that burnout is a real issue among our members. We represent over 163,500 medical staff and doctors, and this is transpiring; people are walking, because they have no other choice. So, we have a real retention problem.

That is overflowing into the medical student population. We are seeing undergraduates say, "We can't take the stress; we can't take the stress that we are currently under." We know that undergraduates find themselves in financial difficulties; we know that the pandemic has had impacts on undergraduates. However, we also know that their seeing a postgraduate system—so, the training we are talking about—and seeing the current state of the NHS, and the workforce problems, is unappealing. And already medical students are starting to wonder, "Is there a better opportunity elsewhere?"

I think the answer in all of this—I know you didn't ask for it, but the answer in all of this is retention. We really need to look at how we retain our current medical workforce and make it more attractive for them to stay within the NHS than to leave.

Q158 **Sarah Owen:** Thank you very much. And if you haven't done so already, is it possible to share some of those findings from your surveys with the Committee?

Dr Patel: Absolutely.

Q159 **Sarah Owen:** On retention, Roger, you talked about it and I think it was

touched on in the previous panel as well. You talked about retention in the UK and a shortage of specialists, but the issues across the UK aren't all equal. What do you think we could do to attract and retain people in certain areas of the country where we are really short of doctors?

Professor Kirby: You could build medical schools or increase the size of medical schools in, for example, Sunderland; I think you might be hearing about that in the next panel. That's because those doctors training there are quite likely to stay in that area. So, that would be one thing that you could do.

We are short of doctors, but the doctors we have are often doing the wrong thing. At least 50% of their time, especially of trainees, is spent doing administration. You do not qualify as a doctor to do admin, but that is what you have to do.

We have some trainees at the back here, and I bet they are nodding, saying, "The computers don't work properly—they are too slow—and there is far too much paperwork." They are not in front of patients or in the operating theatre nearly enough, so we could use our workforce in a much more functional and sensible way.

Q160 **Sarah Owen:** I have a quick follow-up question. On increasing medical school places and where medical schools are, how do you match the placements for that? What is the impact on hospitals and primary care?

Professor Reed: That is probably one for me. We are getting to the point where the areas of severe shortages of doctors are where it is quite difficult to put in a medical school. That is where some of these other ideas, like apprenticeships, come through.

I don't know whether you have heard about the recent Imperial link with the University of Cumbria in Carlisle. Imperial donated 50 of its medical student places to be trained in an Imperial North, so that there is no regulatory issue because it is a branch of Imperial. The students will be recruited locally and are much more likely to stay local. The trade-off for Imperial—because 50 students a year is £500,000 a year in fees—is that it can recruit international students to fill the places. That is cost-neutral from an NHS point of view, because the international students are already paying higher fees. It is an absolutely brilliant proposal. It does require higher education, a good university at the other end, which the University of Cumbria in Carlisle is, but it is the sort of innovation that could really help.

The international graduates will avoid one of the problems that I talked about earlier, which is not being educated within the context of the NHS and in the culture of the UK. That type of thing allows us to remain open to the world while addressing some of those in-built biases, but it does not address quite so effectively the need for UK students to get into medical school. It might be seen as a bit of a barrier to that—I don't think it is, because it is new growth, and it is a very novel approach. How many examples we will be able to reproduce, I do not know—I am trying it myself.

Q161 **Sarah Owen:** Weirdly, you have just answered the question I was going to ask. How do we make it easier and remove some of the barriers for international graduates to work in the NHS?

Professor Reed: I would definitely say that for those we wish to recruit, it should be much easier, getting in on things like the CESR route. Postgraduate training is not my expertise, but I think it should be made much easier. However, I do not think that we should do that as a way of avoiding sustainable growth in our own students and in their opportunities to go to medical school. In particular, there has been a complete change from when I was interviewed, which was a bit like being interviewed for the SAS—you had to be rough and tough, and all that, which is very gendered. It is completely different now. We welcome people with illness and disease, disability and mental health conditions. The workforce is changing completely from that perspective. There is the potential for a lot more people to do medicine, compared with the traditional white male model.

Q162 **Sarah Owen:** Thank you. Colin, I was intrigued by what you said about us not using the existing experience in the NHS efficiently. I know of a number of doctors, or people who qualified as doctors, who came from overseas and are now working in the NHS, but as nurses, or we have nurses working as HCAs. Is there a possibility—or how long would it take—for that person to qualify to work in the NHS? Could we be doing more about that?

Professor Melville: It is probably a mixed answer. In order to be employed as a doctor in the UK, you need to be on the register, which we hold. Obviously, there is a set of standards to meet, which essentially is that you need to hold a degree in a country of which we approve; you need to have spoken English; and you need to have a route of access. Less than half of the people currently sit a formal assessment; more than half come in through other routes, including sponsorship, higher-level exams and so on. That is the first thing.

NHS England has been using medical support worker roles. People who are trained as doctors but are not yet on the register have been employed, with over 500 of them employed across England. Once they complete their registration process, there is then a problem: we are working with NHS England to understand why they are not therefore being recruited. Some of that may be to do with not understanding how to write a CV or an application; there may be some very straightforward things, but that would really help with trying to reduce the time lag between being on the register and being able to work, because there are, as we have heard from everybody, plenty of gaps to fill. It is about trying to help people to navigate that process and then give them a good induction, so one of the things that the GMC has been doing is Welcome to UK Practice, to try to help orientate those people. It does not matter which culture you are crossing. If I went and worked in Canada, I would do less well than a native Canadian. It is not an issue of ethnicity; it is about culture. It is about helping people to understand culture and even the norms of how the NHS works, or how you get a bank account—some very straightforward

things that, collectively, we can all work on to improve the time from registration to being employed. That would help us hugely.

Sarah Owen: Thank you.

Q163 **Dean Russell:** Let me come to you first, Professor Melville. I am interested in the age profile of people who enter to become doctors. What is the average age at the moment?

Professor Melville: That is a really good question. If it would be helpful to you, we can follow it up with some detail, so that we can look at the age profile. Typically, from UK graduation, the vast majority enter from school, so they are entering at 18 and graduating at around 23. But you have a group of graduate entry students, who will be older, and some mature students as well, so probably that profile would be helpful.

Q164 **Dean Russell:** I would be really interested in looking at the data, because what interests me is that, often in life, you might not realise that you want to do something until you are older. Is there any encouragement at the moment for people in their 30s, 40s or even 50s to say, "I've actually realised that I'd love to be a doctor"? Seven years is a long time, but it seems to get shorter the older you get—at least I find that. Is there an opportunity for people who want to change career and who might have skills that would be applicable to do that?

Professor Melville: Professor Reed might be able to speak a bit more to the recruitment, but from our point of view, age is no bar to becoming a doctor.

Dean Russell: Absolutely.

Professor Reed: We have a small number of much older entrants, as Professor Melville says, but it will be 1% or 2% in their 30s, 40s and beyond. I think it is just the logistic challenges of the cost. The important thing to know is that if you have a prior degree—even if your degree was taken outside the UK—unless you go into one of the graduate entry programmes that is supported, you are not entitled to fees and loans. Our course is a five-year course. About 35% of our students are graduates, which means they are working their way through the course. So it goes back to a lot of things. They are earning while they learn, so that does sound like an apprenticeship, which could be good if it was structured better, because they are mostly working in hospitality in the evenings and weekends, and then during the holidays. If you said, "Why not extend it to a 44-week year and get them through even a year quicker?", they would not be able to afford to do it, unless they were on one of the, if you like, authorised graduate entry programmes. There are lots of graduates who could enter, and some of them will be returning to education many years after they did their degree, which is now of no relevance.

Q165 **Dean Russell:** That is my question really. Is there an opportunity here that is being missed for people who have had careers, who have perhaps entered and dropped out after a year or two, to come back and get that training? Of course, we still have to wait five or seven years for that to

happen.

Professor Reed: The biggest group who come in through graduate entry were insufficiently networked when they were 17 to do a work placement in the local hospital or with a local GP who then got on to their form and assisted their application, because they were advantaged in their application. Picking up those people three or four years later, when they have done a biomedical science degree or similar, and getting them into medicine is a great way of widening participation, and there is a big pool of them.

The RCP report goes into this really well. At the moment, we have much too high standards. Three A*s at A-level is more than you need to study medicine, but somewhere around two Bs and a C—for someone who has not had great disadvantage—is where it starts to get difficult to get through a medical degree, because it is an academically rigorous degree, if only for the volume. There is a big cohort of students who have gone to good universities and done good degrees in biomedical science, with three Bs or A, A, B, who would be great for medicine, but unless they can get a place—

I am sorry; I am ranting a bit here. It is about 32 applicants for each place for places such as Warwick, where it is a graduate-entry programme. We have about 12 applicants for a place, which is still a lot, but as I say, a third of our course are made up of people who already have a degree and are really disadvantaged.

Q166 **Dean Russell:** Thank you. That is the nub of my point, really—that ultimately, there are lots of people who could be doctors but have been put off because they did not think of it when they were 16. There is perhaps an opportunity for the Government.

Professor Reed: Absolutely. We would have to look at that.

Dean Russell: That could help to fill the gap.

Professor Kirby: There is an awful lot of work to do to widen access. We still take predominantly middle-class kids who have all the advantages of their education.

Chair: We will come to that. We are running a bit short on time, Dean. Do you have any more questions?

Q167 **Dean Russell:** I have just one quick question for Dr Patel on education for the future. Technology and digital health are areas that I am very passionate about. Are we training people for what will come in 10 to 20 years' time? I know that we cannot predict everything, but are people being prepared for the use of AI, robotics and so on? Please answer briefly, if possible, because time is short.

Dr Patel: Probably not enough. I think the root of that is probably—well, definitely—funding. May I come back to your previous question? As was touched on by others, absolutely, we know that there is a widening participation issue. Some future doctors take a while to realise that

medicine is for them. If we want the best doctors, regardless of age, we need to invest in widening participation. I also think the NHS bursary really needs to be looked at to see whether we are supporting medical students in the best way possible, because it is a real personal expense to go through medical school.

I will not have the opportunity to answer this, but Sarah Owen asked a question specifically about IMGs. I am at the LMC UK conference here in York—a conference of GPs from across the UK. I have just heard from many doctors who are finishing their CCT—the end of their GP training—and they do not know whether they can get a job here as fully qualified GPs because of visa issues. If there were one thing that you were going to sort out for our international medical graduates, it would be their visas. It would not be visas just for them; doctors who want to work here have issues with adult dependants. Parents who rely on them are a reason why, once qualified, graduates go back to their home countries; they cannot afford not to be with and care for them. Our visa requirements make it very difficult for them to bring their parents over here. There are some very quick result resolutions that we can concentrate towards so we can get back to retaining the medical workforce. Sorry, I just wanted to slip those answers in.

Chair: Successfully slipped in. Before we move on to the next panel, I want to bring in Laura Trott and Taiwo Owatemi.

Q168 **Laura Trott:** Professor Kirby, you said that one of the biggest issues is the workforce leaving after qualification. Do you have a percentage?

Professor Kirby: Golly; I don't, but I am sure I could find that for you, Laura. The GMC would. We are losing people not only to Australia and New Zealand—some do come back, as Malcolm said—but to McKinsey, Ernst & Young and so on. We are losing some of our best people—

Q169 **Laura Trott:** Does anyone on the panel have a ballpark figure? Is it 5% or 30%, for example?

Dr Patel: I do not have ballpark figures, but I do have statistics in percentage forms. When we survey our members, we get really staggering statistics. A third say that they want to leave the NHS because of burnout, and we think that is expedited or made worse by the pandemic that we are still in. A third want to retire early—and that is a quick fix, isn't it? Our punitive pension rules are causing that. A third want to leave to take time out of the NHS because of everything that has happened over these two years and because of how short we are on workforce. These are staggering numbers. Our surveys go out to all our members; we are talking about thousands and thousands of responses. I hope that has helped in some way.

Q170 **Laura Trott:** That is helpful. Professor Kirby, I will come to you first, but others on the panel might be better placed to answer. Is there any requirement for doctors to work in the UK for a certain period after being trained here?

Professor Kirby: There is not at the moment. It is something that could be introduced. If they have had a lot of money spent on their education, we could insist that they stay for at least a number of years. Colin might have a comment on that.

Professor Melville: There is no regulatory requirement. Again, I think that would rest with the Department and with Government. I know that it has being talked about before. It is question of whether you think a stick or a carrot is the best solution.

Q171 **Laura Trott:** What is your perspective? When we have discussed what to do about the issue, that is one thing that has been talked about. Do you think it is a good idea or not?

Professor Melville: On a personal level—not speaking for the GMC—I think happy people work better, and therefore sticks are a bad idea.

Professor Reed: They do have to do the first year to get fully registered, so they are provisionally registered. We get a year out of them, and a lot of work is done. I think there is a myth that F1 doctors do not contribute to the service. If you go into the hospital in the middle of the night, that is when you see the F1 doctors; there is no one else there.

Q172 **Laura Trott:** That is very reassuring. What do you think, Dr Patel?

Dr Patel: Just to correct something, I am ST7, so I am still a junior doctor. I am 18 months off CCT on a 10-year training programme. It is not just the F1s there; it is all the junior doctors and consultants in certain specialties. In Colin's specialty—intensive care—you will find the consultant there 24/7.

What we are touching on here is flexibility. I agree with what Colin said: don't throw a stick there; make it more attractive. To give you my personal circumstances, I am a mother—I have just been on maternity leave—and childcare provisions are incredibly expensive, particularly for those working shift work. Going back into the NHS, we have very poor services, not just for mothers but for wellbeing in general. Rest facilities are not very common, are they? Parking is expensive. We don't have 24-hour access to hot food or hot drinks. I am a mum who is breastfeeding, and there aren't facilities for me to express. If you are going to think about how you want to retain the members of the workforce who are leaving and keep people within the NHS, work on our terms and conditions. It is not rocket science; it is the really simple things.

A theme throughout this talk has been flexibility. We are on this training path, and it is almost like a race to get to the end. As Colin said, the end goal should not be CCTing and becoming a consultant; it should be serving our patients. Each doctor's need is different. How one doctor trains will be different from another. Don't punish those who want to do it flexibly; support them. Absolutely don't make this compulsory. Support doctors who are currently in the system, and you may find that fewer leave.

Chair: Can I move on to Taiwo—last but not least?

Q173 **Taiwo Owatemi:** Malcolm, you said that there needs to be flexibility in the training, and you briefly touched on perhaps having a part-time course. Are you able to elaborate on that?

Professor Reed: Absolutely. There is a pilot of this in Scotland. It is a healthcare professions converting to medicine course. There is always a bit of an assumption that everyone would rather be a doctor, whereas most nurses became nurses because they want to be nurses and they enjoy it, but with the benefit of experience in a profession, some people will move towards being a doctor.

In the highlands of Scotland, they are currently doing a blended learning course—distance learning, virtual learning—with the University of Edinburgh, and then they go down to Edinburgh for the clinical part of the course later. That is a novel approach. I definitely think we should be looking at flexible options in training. Most medical courses are not modularised, so picking up modules in a very flexible way doesn't currently fit with the approach in medical schools. A more flexible approach would allow many more people to undertake medicine. It would take longer.

Q174 **Taiwo Owatemi:** What benefit would that have, in being able to retain staff?

Professor Reed: I think it goes back to the things Dean was talking about—opening up to groups of people who are not currently able to access medicine. Medical schools have done a lot of widening participation over the last few years, but there is still a lot more that can be done. That is the big advantage: you are bringing in people from different backgrounds with different experiences, who look like the population they are serving. That is probably the key issue.

Q175 **Taiwo Owatemi:** Do you think that will help to improve social mobility within the profession?

Professor Reed: I do. We are doing a lot to improve social mobility. Medicine is one of those social mobility classics, isn't it? Bringing in people from wider social backgrounds is something that all medical schools are definitely driving for. It is easier for some than for others, because of their traditional reputation. All medical schools are definitely pushing in that direction and have made great steps. We will hear more about Sunderland's and Liverpool's experiences shortly.

Taiwo Owatemi: Thank you.

Professor Reed: Can I withdraw my comment about F1 doctors being the only doctors in the hospital in the middle of the night? That was a terrible thing to say. What I meant to say was: you will find them in the hospital at night, maybe in a slightly greater proportion to the very senior doctors who are there supporting them. I can't get through this without one gaffe.

Q176 **Taiwo Owatemi:** Roger, earlier you spoke about the importance of widening training—ensuring doctors have training in negotiation, communication and other skills. Do you think that the medical curriculum

should encourage more modules in locations that might overlap with the medical professions—for example, medical policy or law—just to widen the knowledge of doctors?

Professor Kirby: Definitely. There needs to be professional development of our people to make them feel more looked after. Doctors need to work smarter, using the latest technology—Zoom and so on—but we also need to train smarter. There are all sorts of new ways of training people, and our training needs to be broader so they are able to understand and deal with all the changes in society that we are all exposed to.

Professor Melville: Taiwo, can I just add to that? In 2017, we introduced something called the generic professional capabilities, which addresses quite a lot of these things—health promotion, law, ethics and so on—because we recognised that with the colleges, many of the wider attributes of professional behaviours and so on were not included in curricula. As a result of that and linked to it, we have recently launched our consultation on a review of good medical practice, which tries to wrap in some of the challenges we have: what are the professional standards we expect in terms of, say, use of social media? How does AI fit in it? Who regulates a robot? All those sorts of things are in there, so there is an opportunity to contribute to that.

Chair: Thank you. I am really sorry; we have had a very good session, but we actually have another panel to go. Thank you very much indeed, Dr Patel, Professor Reed, Professor Kirby and Professor Melville. It has been very interesting and important evidence, and we will use it in the report we publish.

Examination of witnesses

Witnesses: Lara Akinnawonu, Professor Hazel Scott and Professor Scott Wilkes.

Q177 **Chair:** For our final panel this afternoon, I welcome Lara Akinnawonu, who is a medical student at Cardiff University and co-chair of the BMA's Medical Students Committee; Professor Hazel Scott, who is dean of the School of Medicine at the University of Liverpool and a consultant physician in respiratory medicine; and Professor Scott Wilkes, who is head of the School of Medicine and professor of general practice and primary care at the University of Sunderland. You are all really welcome. Thank you very much for joining us.

Let us just cut to the chase, because we've got half an hour now and I want to give all my colleagues a chance to come in. Lara, you are a student. Of what you have heard so far, what do you agree with and what do you disagree with?

Lara Akinnawonu: I have heard a lot so far. Dr Latifa touched on the idea of flexibility in what medical students want to see in the curriculum, and also the best way to recruit and retain medical students in the area they have trained in. In terms of what I agree with, if we are going to be

increasing medical student numbers, we have to look at other parallels—other courses that are being increased as well. We know that physician associates will also be increased, and we have to look at how that is going to impact on medical student education.

In terms of curriculum changes, medical students want to see an increase in teaching on leadership, and on public health and health inequalities. We have just had a pandemic that has exposed so many health inequalities. I am an intercalating medical student, intercalating in population medicine, and that is one of the things we discuss. There is a lot of interest in understanding why those health inequalities exist.

In terms of placements, I think Malcolm touched on the money that is given to clinical placements in hospitals. That is really important, because it is money that contributes to students' travel reimbursements and placements. Having free accommodation and having their travel reimbursed is a key issue for students and a key part of the medical student placement experience. Those are the kinds of things I agree with.

There is not necessarily anything that I disagree with, but I think there needs to be more clarification of how medical apprenticeships will be formed, and how they are going to impact on recruitment and potentially widen access. Those are my thoughts.

Chair: Thank you. Professor Scott—agree or disagree?

Professor Scott: I absolutely agree that we need more doctors. You have heard a lot from the BMA and others in previous panels about the numbers and the fact that we are way under average in terms of the number of doctors that we need. I agree that we are doing training well. Indeed, our degrees are recognised globally. One of the benefits of having the regulated environment is to provide those core standards that the public expect.

I disagree with the concept of shortening curricula. I believe our public are right to expect a quality of trained doctor. As we have heard on a number of occasions this afternoon, there are lots of new areas where medicine continues to need to develop and areas that we need to prioritise. We have heard about neurodiversity, technology and various other aspects of healthcare. We have heard about communication and new ways of approaching that and ensuring that graduates are properly trained. In all sorts of ways we need to continue to focus on the quality of what we produce as graduates.

There is the potential to look at shortening postgraduate training in terms of an outcome-focused training curriculum. However, for both undergraduate and postgraduate training, it only works when the NHS prioritises education to the same degree as it prioritises service delivery in respect of medicine.

On what we were hearing about foundation burnout and senior doctor burnout, and the impact on medical students, it does indeed impact on

medical students in terms of role modelling and supervision—on spending time with them and reviewing the cases they have seen, and making sure that they are learning the competences that we expect them to have. It is similar in respect of postgraduate training. There needs to be time for senior colleagues to mentor and nurture our foundation trainees.

One thing we have not touched on in terms of recruitment or retention of doctors—although we have heard about them going overseas—is the number who need a break after foundation. It was about 17% in 2010 and 65% in 2019. Goodness knows what the pandemic has done to that, but that is to do with the rotas that are only just viable in terms of foundation training and delivering a working time directive.

Chair: That is very helpful. A much trailed view from Sunderland—Professor Wilkes.

Professor Wilkes: Chair, can I open by saying thank you for your insight in 2016 and starting the process to establish the new medical schools, of which Sunderland is one?

There are a few things I would agree with—

Chair: It wasn't planned that way, by the way.

Professor Wilkes: And there are a few things I disagree with. First, we do need more doctors. That has been well articulated by colleagues today. On shortening the course, we get a lot of requests to put additional material into courses and different curricula. There are over 30 medical specialties and over 400 MLA conditions that we need to fit into our curricula. The undergraduate process is to create a potential doctor who can specialise thereafter, so the idea of shortening it is really quite difficult. To then create the specialists thereafter, when we go into foundation specialty training— That is where we gather all the additional information.

In terms of widening participation, we have had a success story in Sunderland. In siting the medical school in a place where we had difficulty recruiting and retaining doctors, we have managed to recruit from our local population. We have some 900 triple A students, and half of our intake is from that cohort, so it is recruiting locally. We are seeing in the city the impact of the medical school on health and wealth. It is seeing that investment in the city itself. We are recruiting local students, but we are also recruiting students from socioeconomically disadvantaged backgrounds. So the experiment, if you like, has certainly succeeded. The bit that I would challenge is a medical school putting students into other geographies. I would question whether students would continue to work there. What we do know is that students generally work where they train, or where their families come from. We've certainly seen that siting a medical school in Sunderland is already beginning to have a significant impact on those sorts of metrics.

Q178 **Dr Evans:** We like to think more radically sometimes on this Committee.

To that end, and it may be a vested interest that you run medical schools but, Professor Scott, should medicine become a postgraduate American-type system—so you do a degree somewhere else and then move into it?

Professor Scott: I think that would be counter to the widening participation that we're trying to drive. Looking at the school leavers that I met as part of our recent applicant discovery day, they understand fully what the commitment is, and they are strongly motivated, and we want to produce doctors quickly. So I think it would be not very helpful to do that.

Q179 **Dr Evans:** The reason I ask this—I put my hand up; I did anatomy demonstrating at the University of Birmingham for a year and I managed to teach both graduate medical students and undergraduates, and there was always a maturity that they naturally brought to the way in which they approached both their book work and their clinical work as well. Is that something that could be fostered more, or run more in parallel? Should we be upscaling graduate medicine courses to get more people through? Is that something that the Government should be putting more emphasis on?

Professor Scott: If the driver is about maturity and the benefit of maturity to medicine, I think there are other ways to equip younger individuals with a professionalism and with an understanding.

Q180 **Dr Evans:** I mean it more from the widening access side—people who have come from other areas. We heard earlier the evidence that people may come to this decision later, but it becomes much more pragmatic. In my head I'm wondering, is there an allied system that we could put in place that the Government can back, to say that people who want to step in from different areas have that opportunity to go fast-track through the graduate entry course system? It can be quite a challenge. You see lots of people go through the GEC system and then actually end up doing an undergraduate medicine anyway because they can get in that way. I am just wondering if that is reflected.

Professor Scott: We do have graduate entry programmes across the country. I think what we may need is more of them, but more of them as part of an overall increase. We need a large increase in order to deliver what is necessary. We've heard about early retirement, we've heard about the pressures of burnout, we've heard about the demography of our student intake. I personally think it's wonderful that over half of our graduate intake is female, but if you think about what that means as people move through the profession, we will lose proportions of FTE commitment. We need more numbers and certainly graduate entry, as part of that, would be embraced.

Q181 **Dr Evans:** Professor Wilkes, I gather you are still practising as a GP as well. Is that correct?

Professor Wilkes: That’s correct.

Q182 **Dr Evans:** I’d like to move on to the placements of medical students and then postgraduate students as well. One of the issues tends to be that there aren't enough places so people get put further and further away.

You must see that on the GP side of things—GPs making a decision on, "Is it worth our while having a medical student? Is it worth our while having an FY1? Is it worth our while having an FY2?" What is the situation on the ground? There is a calculation to be made between time you can spend with your patients as a clinician versus doing the education.

Professor Wilkes: Yes. We're coming out of the pandemic, and we're also in a slightly challenging situation in general practice. Where I work in the north-east of England, something like one in five GP posts are vacant, so we have got a challenge there. Role modelling is very important in creating more GPs and we do attempt to do that at Sunderland medical school. The challenge that we've had is, as you say, trying to persuade our colleagues to teach whilst they are trying to do the day job.

That said, by siting the school in a place where there was need, we have found and tapped into additional placement resource. But it hasn't necessarily been easy. The tariff, of course, as you know, flows to secondary care and primary care. That has recently been levelled for general practice, so we do hope to see a big impact there. Looking forward to expansion of medical school places, I think it's about tapping the areas of the country where we haven't necessarily seen that. We have the five new medical schools that came in 2018, the so-called 2018 group, but there are additional schools, in other parts of the country, that are also trying to establish themselves—again, to take advantage of potential placement capacity.

Q183 **Dr Evans:** My final question on this is as follows. We heard earlier that it's a slightly strange profession, in that everyone aims to be a consultant. That is the end objective. When people go in, they mostly try to get to be a consultant. It's also slightly strange that every doctor is supposed to be an educator, to teach medical students; they are put with a firm. Some might not have educational skills, yet they are required to show people—"See one, do one, teach one." Is that a failing, something that the profession is missing? Should we be looking internally at saying, "We should be identifying educators within the profession and specialising within the profession"? As you rightly pointed out, GPs will look at this and say, "Is it worthwhile? Do we have the skills to do it? What about our day job?" What's the feel from you, as the leader of a medical school, about what the profession should be doing on that basis?

Professor Wilkes: I think all doctors are leaders when they eventually qualify, and they lead on many different areas. What I have experienced is that researching general practices or education general practices generally perform that much higher. For that reason, we do see reasonable engagement, fairly good engagement, with the practices that want to really deliver a good standard of care. It comes back to that championing and role modelling. So I would say that we have managed to reach into and champion that among GP practices in order for them to become educationists for our medical school.

Dr Evans: Dr Scott, do you have a point on that?

Professor Scott: I think we have moved beyond the "See one, do one, teach one"—

Q184 **Dr Evans:** I was using it as a general metaphor. But again, each doctor, even as an ST1, is expected to teach medical students, potentially, all the way through. I am just wondering—should that be more formal and should it be strengthened for the individuals? Have we got it right to leave it as it is and not focus it? We're just trying to squeeze out as much as we can with the NHS, because it's in a difficult time.

Professor Scott: There is the complement of being able to blend the teaching that is done as part of service delivery, if I have a student with me in clinic or if somebody has a student with them in theatre. There is the expectation that they will be able to explain, show and give some feedback, together with a focus on being an educator in terms of the support and development of the individual. We are focusing on developing educational supervisors, for both undergraduates and postgraduates, who can do just that, and they are receiving additional training to support that. But the issue really is the time availability within their job plan. Often, the very best people for education are also excellent at their clinical job, and we need to be able to carve out time for education to do this thing properly.

Q185 **Sarah Owen:** I have just two questions. The first question relates to something that was mentioned by the previous panel. Professor Reed said that it is not necessary for students to have three A*s at A-level to go on and study medicine. The very, very excellent Luton Sixth Form College offers BTECs in biomedical science. Do we need different routes to get into medical school in order to widen participation and diversity even further? That is to Professor Scott or Professor Wilkes.

Professor Wilkes: Let me take that first. Do we need different routes, to widen participation? I guess the answer to that, based on Sunderland's experience, would be no, because we have achieved it. We have achieved it on three A's, not three A*s, but also with contextual offers. And what we have noticed is that the performance of our students, who are well supported—there is no difference between groups of students in terms of where they come from, their backgrounds and ethnicity. We haven't noticed any differentials at all so far. So again, it may be about culture and how you attract students to come to your particular institution.

Q186 **Sarah Owen:** I think you are probably coming from a slightly different perspective, given you have a medical school on your patch. Professor Scott?

Professor Scott: I don't think we need totally different pathways, but we need to do what we do a bit better. We need more in the way of outreach to schools to kindle the sense that medicine is possible, with a system that would enable us to apply contextual offers a little more easily. As schools, we are very much judged in league tables that don't take account of our commitment to widening participation, but instead look at our entry criteria, in terms of A grades.

Equally, when you have students holding four offers and trying to pick one, working in a capped system can make it difficult to make the most of the opportunity of contextual offers. I believe we are not currently considering, as a country, PQA or PQO, but from a medical point of view there are areas where that might enhance widening participation. Equally, there is already a consideration that we should be looking more at things like differential attainment and nurturing individuals as they go through school, and indeed into foundation, to look for any areas where we may be disadvantaging.

A point was made about the cost of working in medicine, and the comparison of medical degrees with other degrees. That is an issue, and perhaps there may be some consideration of how we enable people to work in the health service, and what the bursary routes are.

Q187 **Sarah Owen:** Lara, from your perspective as an undergraduate, are you finding that the burnout of existing staff and staff shortages are impacting your experience? On a more positive note, what would you say to somebody to encourage them to choose medicine?

Lara Akinnawonu: On the first question about medical student burnout, the BMA has done a survey on mental health for students, and we can show those findings. I think it was done in 2019, and you can see that the majority of students experience burnout early on in the course—even before they start on placement and have direct contact with clinicians. Part of it is to do with the mental health provision. If I could have it my way, every medical student would have pastoral support or counselling from the moment they start, because it is so heavy. It is a completely different way of learning. A lot of those who come into an undergraduate degree are 18-year-olds, and it can be a whirlwind of education and handling so many different things, as well as being a fresher and having to deal with living away from home. Mental health burnout starts early on in the course.

The experience of clinicians trickles down to students. For example, if your GP can't teach you while you are on placement, that is going to impact your likelihood of choosing GP as a specialty, because you have not had the experience that you want. In terms of students choosing specialties to go into, their experience on placement forms their opinion. If you have had a good experience on a haematology ward, you say, "Oh, that sounds really cool," and you are more likely to look into that. If you have had a negative experience in GP, you are less likely to consider that as an option.

I have heard of students who do not want to continue to do the foundation programme. A lot of students are already thinking, "I'm going to take an F3 year because I don't know how I am going to continue going into specialty training." It does trickle down. Mental health for medical students in particular is really niche and needs to be tackled specifically.

On what I would say to spur someone on to do medicine, I would definitely say that as a medical student you are in a unique position to have an impact on a patient's life. A lot of the time, clinicians may not have the

time to go into a full, in-depth social history, and a lot of the time you find that, as a student, you can sit there with a patient and just talk to them and find out a bit more background. Patients and doctors really appreciate that, because you have that time on placement to get that extra background and social history. As a medical student, you can sometimes feel like a spare part on placement, but you are in a unique position to have an impact on a patient's life. That is why I would definitely say that you should study medicine.

Q188 **Laura Trott:** First, I want to ask a couple of questions about your medical school in particular. What you said about the impact that it is having in the local area is very interesting. Will you expand on that a little, in terms of some of the data and statistics that you have seen as a result of setting up the new medical school?

Professor Wilkes: The data and the statistics? I will produce a paper and send that after the meeting, if that is all right, but I will give some of the highlights now. We are seeing the investment of the local hospital trust in a brand-new eye hospital; an increase in small and medium-sized enterprises coming into the city; an increase in hotels in the city; doctors being attracted to the area, into the acute trust; GPs for the first time putting their hands up to be medical educators, who did not necessarily educate for other medical schools in the area. Those are just a few examples of what we are seeing. I am sure I have missed out others.

Q189 **Laura Trott:** That was very interesting. It would be helpful to have some of that information for the Committee. On the applications per place, what kind of figures are you looking at? I know you are quite early into your life as a school, but how is that looking at the moment?

Professor Wilkes: It is very healthy. It is seven to one—seven applications for every place. We take in 100 medical students, so we could easily accommodate more. There is a lot of appetite out there, as there is across the United Kingdom. A lot of students do the entrance exams, but do not get a place—we have sufficient talent in the United Kingdom to create more doctors in the United Kingdom; there is no doubt about that—and many will seek opportunities overseas in other medical schools.

Q190 **Laura Trott:** Do you have any information on the costs of your course, versus some of the more established institutions? The reason I ask is that, as a Committee, we are looking at how to solve some of the workforce issues. It seems that your institution has been a huge success, which is great news. We are thinking about the recommendations to take forward and potentially expanding the number of institutions in the country, so I am interested in some of the figures around that.

Professor Wilkes: We took advantage of the infrastructure that already existed in the university—there are programmes for nursing, pharmacy and paramedics—and, in there, there was already clinical education, mock wards and lab-based work. When you add that to the clinical training in years 3, 4 and 5, which were already there in so much as the local education providers, the trusts, existed and were indeed delivering for a local medical school, much of the infrastructure was already there. The

culture in our institution is that the facilities are very much shared. There is a big focus on interprofessional learning, because that is how medicine really works in the real world. There was, and is, no ivory tower as such. That is how the broad headlines of the economy work for us.

Q191 **Chair:** May I jump in for a moment, Laura? The BMA was saying that we needed to train 11,000 more graduates every year. If we were to have a big expansion in the number of doctors we train, should that be by putting more students through institutions like yours, or opening more medical schools, so that we can have more transformation along the lines that you have just described happening in Sunderland?

Professor Wilkes: If you made me Health Secretary for the day, because I would like to see investment in the parts of the country where we still have gaps, I would advocate investing in the 2018 cohort, in new schools that are coming online—the likes of Chester, Brunel and Three Counties—and, indeed, in other areas in the country. We are experiencing the benefit and impact of that investment in Sunderland.

Q192 **Laura Trott:** I want to ask you all a final follow-up question. Professor Wilkes, you were kindly here for the previous panel, when I asked about a requirement for medical students who are trained here to stay and practise in the UK for a certain time. I think it is fair to say that reactions in the previous panel were mixed. What are your views on that proposal?

Professor Wilkes: I would answer that from the point of view of medics who want to work for the Army. The Army invests a certain amount of money to train doctors, who then commit to a minimum of six years in the Army. I can see that that is the model that you are suggesting. What's my view there? I think it is more about encouraging, role-modelling and keeping our workforce, rather than using a stick to beat them to stay.

Q193 **Laura Trott:** Yes. I think the idea is that there has been a huge amount of investment by UK taxpayers, who obviously may not be earning as much as doctors, or MPs or anybody else who is earning that much, and that they need to see some return on that. It's not necessarily a nasty idea, but one that says there should be fairness in terms of the investment that has gone into those degrees.

Professor Wilkes: Okay then. I suppose the answer is yes, you could put a metric around it like that, but I think you should also consider the effect of less-than-full-time working as well, because we are training more doctors now than we ever have done, yet we are still short on the frontline. In my speciality, general practice, we have a significant female workforce less than full-time working and we are still trying to plug the gaps. It's linked to that, so I think that needs some thought.

Q194 **Laura Trott:** Thank you. Professor Scott?

Professor Scott: I think it wouldn't address the fact that the graduates, particularly at the end of foundation, who are choosing to do something else, have a reason for choosing to do something else. Whether they do that overseas, or they do something else in the UK, I think they would still look to choose to do something else. That might be a more moderated

post within the NHS that has more teaching within it, for example, but if you cut off them going overseas, they would find ways to do something else, so I don't think it would particularly help.

I think we should be looking at how we make the most of their time in foundation. I mentioned the issue about foundation, with rotations and rotas, and how the numbers to actually be in a rotation and still have a personal life are difficult, and the fact that we currently have a system that can send them quite far away from where they have been previously at medical school. One thing we could look at is better aligning the foundation allocation to the medical schools they have been at, and therefore where we are investing in schools around cadres of deprivation, in order to attract doctors to work in deprivation, to extend the time that they spend in those areas of deprivation.

Q195 **Laura Trott:** That is very helpful, thank you. Last but not least, Lara, what do you think? Would it have put you off, do you think?

Lara Akinnawonu: I wouldn't necessarily say it would put me off. Similar to what Professor Scott said about the reasons why people are choosing to go elsewhere, the reasons why students would choose different foundation places include that area being where their family and support networks are, the work-life balance they can have and the social life, as this is where they are going to build their life for the next two years. I would definitely say that it is about their welfare and the community of individuals around them, particularly for students who are from ethnic minority backgrounds who may want to be in an area where there are ethnic minority groups, where you can find your community and really integrate. So I wouldn't necessarily be against it, but it has to be matched with investment, looking at the reasons why people would leave the profession.

Laura Trott: Thank you.

Chair: Two final questions. Taiwo?

Taiwo Owatemi: I actually only have one question.

Chair: One question from you and one from Luke.

Q196 **Chair:** My question is about mental health support. We have heard Lara talk about the impact it would have on medical students if they were given more mental health support, so I wanted to know first, what is the drop-out rate of students from medical courses due to not being supported enough? Secondly, what support is being put in place to support students, because it is quite a tough course?

Professor Scott: It is a tough course, and I think that is recognised. I would expect the other medical schools, like ourselves, to have systems of support in place. We have the equivalent of personal tutors—academic advisers—who work regularly with students from the beginning when they enter medical school. We also have wellbeing support services, which are actually separate from and additional to the services for universities, to

recognise the additional pressures that they have as medical students. But we have very low rates of drop-out related to things such as burnout. We have some issues where people feel that they have picked the wrong career, and there will always be those, but we also have people who have maybe had some health issues and need to suspend for a while until those health issues improve, and then come back.

Q197 **Taiwo Owatemi:** Just on that point, what reassurance is given to students that if they go to a counsellor, that information will not be shared with their course tutor and their confidentiality will be kept, so that they feel confident enough to speak freely with the counsellor?

Professor Scott: Absolutely. We are doctors looking after potential doctors, and confidentiality is highly valued. That said, there are areas where what an individual is experiencing may impact on patients, so there is normally a process of agreeing with students any transfer of information that would be necessary in that respect and keeping it very much on a need-to-know transfer of information. You may do better to ask students, but they should not feel in any way that they cannot come forward with something, either because the school would not understand their need for support or because it would impact on their potential career development.

Chair: I am afraid we have timed out, but it has been a really good session. May I thank you all? Thank you for your glowing career ahead in medicine, Lara—we look forward to inviting you back as a fully qualified doctor in due course to give evidence on whatever it is. Thank you for your heroic efforts to turn us from being an under-doctored into a fully doctored nation; this Committee will try to give more power to your elbow. We are really grateful to you all for sparing your time. Thank you very much indeed.