Written evidence submitted by Dr Liz Brewster, Dr Michael Lambert, Dr Luigi Sedda, Dr Euan Lawson, Mr Barry Rowlingson, Dr Cliff Shelton and Professor Jo Rycroft Malone (EPW0007)

Profile and Reason for Submission

We are an interdisciplinary academic research team at Lancaster University based in the Faculty of Health and Medicine. We are have recently received favourable opinion for funding our Health Research (NIHR) Health and Social Care Delivery Research (HS&DR) proposal, to begin October 2022. This proposal, entitled 'Mapping underdoctored areas: the impact of medical training pathways on NHS workforce distribution and health inequalities', directly speaks to the questions asked in this Health and Social Care Committee's Expert Panel. The research team is led by Dr Liz Brewster and comprises Dr Michael Lambert, Dr Luigi Sedda, Mr Barry Rowlingson, Dr Cliff Shelton, Dr Euan Lawson and Professor Jo Rycroft-Malone.

Submission

This written submission provides evidence derived from existing exploratory research that has informed the basis of the above NIHR research project. The commitment to ensure that the NHS and social care system have the nurses, midwives, doctors, carers and other health professionals that it need is vital to the sustainability of the healthcare system. Our research focuses on medical education, doctors-in-training, the recruitment and retention of doctors, and their uneven distribution. Here, our focus is the adequacy of medical workforce planning in meeting the outlined objectives of developing a sustainable NHS. We aim to address assessment of whether the commitment was appropriate, effectively funded, achieved a positive impact for patients and service users, and whether it was met overall.

The 2017 increase in medical student numbers has led to more student places being made available, yet recent estimates highlight that these are insufficient to ensure that the NHS will have adequate medical staffing in terms of a global figure for national requirements.[1] The 2017 allocation of 1500 additional medical student places recognised that current locations of medical schools had impacted inequalities, aiming to ensure 'sufficient supply of doctors in all areas'.[2] This has not yet been realised and there is no policy mechanism in place to achieve this at present. The 2021 annual report of the Chief Medical Officer identified deeply rooted clinical workforce shortages which reverberate across local health economies, particularly in socioeconomically deprived coastal communities. Our initial research has exposed how these have long histories that require sustained policy foci in order to achieve the necessary health outcomes.[3] This commitment has been met in principle, but may not be considered adequate or ambitious enough to enable meaningful improvement outlined in relation to workforce shortages.

Funding of places must also translate into Foundation School places and employment opportunities that reflect population needs and service equity. Our exploratory research, which we will investigate further in three case studies of 'underdoctoring', highlights the interdependent relationships between the geographic distribution of medical education, the recruitment and appointment of doctors, retention, service provision and quality. In particular, to ensure that the commitment to 6,000 more doctors in general practice is met, careful consideration of training pathways and place need to be made. Locum rates remain very high, and unequally distributed across the UK.[4] These inequalities, again, reflect areas where workforce shortages have been persistent and embedded despite recurrent policy interventions.[5]

Alongside considerations of 'how many', our research also demonstrates that *where* students train is also vital to sustainable practice within the NHS. Impacts have not been experienced equally across the system, leading to an accumulation of disadvantage in some communities and health systems. We posit, based on current UK evidence and recent comparable analyses from the US context[6], that this manifests in two ways. First, on the number of doctors in an area, with more deprived communities likely to have fewer doctors. Second, on the quality of training experienced, with doctors in more deprived communities more likely to have trained in places less able to support their development.[7] In addition, we have emerging evidence that where doctors choose to work is more than just a matter of personal preference and shaped by organisational and training structures which are reinforced over time.[8] This in turn, leads to the recruitment and retention of fewer doctors in terms of quality and quantity in socio-economically deprived areas where they are most needed at a national policy level. This is system-wide, and evident in primary, community, and secondary care services.

This leads to issues with the quality of care experienced by patients. Recent analysis of medical student outcomes acknowledges that differential attainment exacerbates potential issues with quality of care.[9] Graduates who require more educational support are allocated to locations which are less able to prepare them for future success.[10] To date, there has been little successful intervention in practice to help to support these trainee doctors.[11] Although educational performance measures may not accurately reflect the level of skill and quality of doctors, they are currently used as a proxy guide to allocate doctors to post-qualification training places. This means that there is a further accumulation of disadvantage which requires attention in any future medical workforce planning framework.

Consideration of the impact of training medical students on those already working in clinical practice also needs further attention. The Covid-19 response has significantly affected access to training, particularly for medical students whose courses include early clinical experience which could not be prioritised throughout the pandemic response. Health and health service inequalities have increased and intensified during the Covid-19 pandemic, rendering this symbiotic interrelationship more visible. Declining numbers of GPs, rising waiting lists, and their consequences for patient care have been vocalised during the course of the pandemic.[12]

While the impact of commitments to workforce should, in theory, have a positive impact on patients and stakeholders, at the moment the commitment to increased medical training places will not be visible to patients and stakeholders. To ensure that there is a closer alignment between medical education and workforce planning which benefits patients and stakeholders who are most in need of meaningful improvements in service outcomes, further intervention is required which recognises these accumulated and interconnected disparities.

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