Written evidence submitted by Professor Rachel Jenkins, Kings College London (EPW0022)

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I have tried to respond to each of your questions in turn, but as I am not employed in the NHS, you will appreciate that there are a number of questions that I am not in a position to answer. However, I have aimed to include essential points for workforce planning.

1. **PLANNING FOR THE WORKFORCE**
   A. **Was the commitment met overall**
      1. **Does the commitment have a deadline for implementation?** NO
      2. **Are there any mitigating factors?** NO-it has long been clear from the data that UK training numbers do not meet UK needs.
      3. **To what extent has Covid affected progress on targets.** The pandemic and its aftermath has highlighted our shortage of doctors and has aggravated the shortage as staff burnout and leave the NHS. Covid has not had any deleterious effect on training numbers, and indeed more people than ever are keen to train as doctors and nurses…the problem is a lack of training places**.**
      4. **How has this commitment been interpreted at LA/care provider/trust level.** My response is in relation to medical training-here the numbers in preclinical and clinical training are decided at government level and imposed on the universities; the overall numbers in training are not primarily decided at trust level. However, trusts do host clinical medical students and as bed numbers fall, this can become more difficult until/unless clinical training is reconfigured to include much more experience outside hospitals, in general practice, community settings, schools, prisons, care homes etc. as well as hospital settings.
      5. **Does data show achievement against the target.** The number of medical students in training is increasing but not nearly enough…we are only training half the number of students we need. Last year, over 50% of new medical registrations on the GMC database were doctors who had trained overseas, huge numbers from very poor countries with far lower doctor /population and nurse/population ratios and much higher mortality rates than the UK. Furthermore, if large numbers of our foreign trained doctors were to leave (for whatever geopolitical or pandemic related reason), the UK has no health security. The UK has 30% of its doctors recruited from and trained by low and middle income countries (LMIC), approaching double the OECD average of recruitment from LMIC, and with the situation escalating fast.

The NHS faces considerable difficulty if it does not recruit from LMIC because of the major shortfall in its own domestic medical training programme. But the source countries experience disaster because of our active recruitment of their trained doctors, as such recruitment undermines their fragile, underfunded health systems. The doctor/population ratios in LMIC are very much lower (generally between 0.1 and 10 doctors /10,000 population) than in the UK (28 doctors /10,000 population), and the LMIC health indices are very much worse than in the UK. Indeed, there is an inverse relationship between national doctor/population ratios and maternal and childhood mortality rates.

If the UK is not to continue contributing to this parlous and deeply unethical situation, and if the UK is have some health security in the face of increasing geopolitical and health threats, it urgently

needs to double the number of medical students trained in the UK, so that within the next decade, we will have a self-sustaining medical workforce.

B. Was the commitment effectively funded or resourced?

1. **Were specific funding arrangements made to support the implementation of the commitment.** I am not aware of any.
2. **What factors were considered when funding arrangements were being determined.**
3. **Do health care and social care stakeholders view the funding as sufficient?** NO. Working above and beyond remit happens all the time- especially lower paid staff should be remunerated for this. I was told this wasn't possible because of the banding structure. Health Care support workers acting as care coordinators should be paid for the level of work they are doing. The acknowledgement of this and recompense would help morale and at a level where it may be easier to recruit, as these people have less training.

4. **Was any financial commitment a new resource stream? If not, did reallocation of funds result in any unforeseen consequences /undesirable work arounds at local level.** There were no new resources. New staff frequently take at least two weeks for induction including acquisition of a computer, therefore losing two weeks of work. There should be a system that makes this much smoother. IT kit is very old and frequently breaks- a consultant colleague was given laptops which were secondhand and had been refurbished - I was told they were seven years old, and had to be replaced 4our of five times within a twelve month period, so days of work were lost when working from home through covid due to lack of access to patient records . A Community Psychiatric Nurse will spend approx a fifth of their time (probably more) inputting the outcomes of their assessment onto very poor systems. These should be streamlined. More proactive work should be done to see areas of difficulty and act before they become dysfunctonal.

5. Did the commitment achieve a positive impact for patients and service users (indirectly through impacting workforce) It might have done eventually if it had actually been met by serious increases in staff. However, it is important to note that the systems in place to look at outcome measures are reducing the actual patient outcomes because they take up so much front line staff resources to fill in the outcome forms . Large numbers of people manage the outcome monitoring systems when there are not enough front line clinicians doing the actual work they are monitoring- it is demoralising for a health worker to be told a certain piece of data should be filled in quickly when one wants to prioritise clinical care.

C. Was it an appropriate commitment ?

1. **Was the commitment likely to achieve meaningful improvement for health and social care staff and/or the health system as a whole.** The commitment for expansion of medical students was not nearly high enough. As mentioned above, numbers need to be doubled.
2. **Is the commitment specific enough?** The commitment needs to address the continued expansion of the NHS, and hence the growing demand for medical

staff, alongside the losses due to retirement, part time working, sickness, emigration and return of foreign trained doctors to their home countries. Thus HR planning needs to be adjusted/expanded every year in the light of forecast needs.

3. **Has the commitment had unintended consequences?**
4. **Was the level of ambition set by the commitment reasonable?** NO, as explained above, we need to double the number of medical students in training.
5. **Is the target contained in the commitment an effective measure of policy success ?**
6. **How has working to those commitments affected other aspects of care?**

IT systems are very clunky and frequently crash- help is hard to come by.

Specialists often have no access to GP systems (EMIS) or blood results requiring phone calls to liaise.

Active management of bullying and staff complaints needs to be a priority. It is generally not managed by HR professionals and it should be.

Efforts need to be made to keep staff as well as recruit. At every level of the MH team I worked in staff were asked to do much higher workload for longer and at a higher banding, than they should be to cover staff shortfalls- they therefore leave.

Strategy should take into account the local variations such as demographic, degree of rurality or urbanization, access to staff and other resources.
One size doesn't fit all- there should be a better mechanism for those at the coal face of work to have some input into planning. The hierarchy within Trusts are too wedded to the model they are using and pay lip service to 'listening' to those doing much of the clinical work. Huge disconnect between aspirations of the Trust and what is possible and little thought or specific plans about how such aspirations could be attained.

Retired staff - I think there are many people who would help with services from retirement (as during the recent public health emergency). The factor that helped this was the reduction in the paperwork needed to practice. Whilst everyone would need to be up to date in their practice, perhaps other aspects of CPD/revalidation might be 'slimmed down' to reflect working a reduced number of hours.

2. BUILDING A SKILLED WORKFORCE

A. 1. Does the commitment have a deadline for implementation.

2. Are there any mitigating factors or conflicting policy decisions that may have led to the commitment not being met or not being on track to be met? How significant are these? Was appropriate action taken to account for any mitigating factors?
3.To what extent has the Covid response affected progress on targets?
4.How has this commitment been interpreted in practice at local authority/care provider/trust level
5. does data show achievement against the target?

B. 1. Were specific funding arrangements made to support the implementation of the commitment? If not why not? If so, what were these , when and where were they made?

2. What factors were considered when funding arrangements were being determined?

3. Do health care and social care stakeholders view the funding as sufficient?

4. Was any financial commitment a new resource stream? If not, did reallocation of funds result n any unforeseen consequences /undesirable "work arounds "at local level

C.1 Has there been a meaningful improvement in measurable outcomes, reasonably attributable to the commitment?

2. Will staff, patients or service users benefit?

3. What category of staff, patients, service users have benefitted and why?

4.Have some staff, patients, service suers been adversely impacted by the commitment and its implementation?

D.1.Was the commitment likely to achieve meaningful improvement for health and social care staff and/or the health system as a whole?

2.Is the commitment specific enough?

3.Has the commitment had any unintended consequences?

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paperwork needed to practice. Whilst everyone would need to be up to date in their practice, perhaps other aspects of CPD/revalidation might be 'slimmed down' to reflect working a reduced number of hours.

3. **WELLBEING AT WORK**

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4.HAVE SOME STAFF, PATIENTS, SERVICE USERS BEEN ADVERSELY IMPACTED BY THE COMMITMENT AND ITS IMPLEMENTATION?

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May 2022