Written evidence submitted by the Royal College of Surgeons of Edinburgh (EPW0038)

Introduction to the Royal College of Surgeons of Edinburgh.

The Royal College of Surgeons of Edinburgh (RCSEd) is the oldest of the medical Royal Colleges. First incorporated as the Barber Surgeons of Edinburgh in 1505, the College is now one of the world's largest surgical bodies, with almost 30,000 members and fellows in over 100 countries worldwide.

Despite our Scottish roots and international reach, around half of our members and fellows are based in England. We therefore support the professional development of a significant part of NHS England's surgical, dental surgical and perioperative capacity.

The sole focus of RCSEd is patient care, so we actively engage with policy makers and influencers to improve outcomes for clinicians and patients, providing valuable clinical expertise and frontline experience alike. This forms the basis for our response below.

Our remit covers surgery, dental surgery and the perioperative team. This includes theatre nurses and others involved in the surgical process, and we do therefore have some knowledge and experience of the situation for those staff. However, our primary remit with regards to memberships are surgeons, and our comments below should be taken to reflect that unless otherwise stated. We will not be commenting on the situation in the Social Care sector as that is not within our purview.

Summary.

The Royal College of Surgeons of Edinburgh has grave concerns with the current state of the healthcare workforce in England and the wider UK. We do not believe that the government is meeting or on course to meet the commitments it has made in this area, which will be discussed in detail below.

Many of the commitments referenced are vague and do not have the level of detail required to offer a meaningful evaluation. Where possible we have sought to offer commentary on government actions linked to the topics of the commitments. We have also sought to evidence our response with our own expertise and that of others.

Overall, we believe that the current workforce crisis, coupled with the backlog of elective care both from before the pandemic and as a result of the Covid-19 response, pose the gravest threat to healthcare in England since the creation of the NHS. Measures to aid the recruitment of new clinicians are welcome, but pointless unless matched with meaningful and extensive measures aimed at staff support and staff retention. The urgency of the situation requires far more attention, resourcing and focus than it is currently receiving.

Planning for the workforce.

Commitment: Ensure that the NHS and social care system have the nurses, midwives, doctors, carers and other health professionals it needs.

The NHS is chronically understaffed, as the government has recognised, and has been for many years. It is worth reiterating the current state of play with the NHS workforce. There are currently 110,192 full-time equivalent (FTE) vacancies in England (NHSE/I, December 2021). These include 8,158 medical vacancies (5.8% vacancy rate) and 39,652 nursing vacancies (10.3% vacancy rate).

In addition, only 29% Trusts are confident that they have the right numbers, quality and mix of staff in place to deliver high quality healthcare to patients and service users (NHS Providers, September 2020).

Staff themselves also recognise this. 52% of NHS frontline staff say they cannot do their jobs properly because of a shortage of staff (NHS Staff Survey, 2021) and 76.5% said they have unrealistic time pressures caused by a lack of staff (NHS Staff Survey, 2021).

The NHS also needs to enlarge its workforce to meet the demographic challenges of an aging population. Research estimates that NHS England needs annual workforce growth of 3.2% over the next 15 years (Health Foundation, February 2021). That means a projected 179,000 additional FTE staff by 2023–24 rising to 639,000 additional FTE staff by 2033/34.

It is quite clear from this data that the current levels of staffing are woefully inadequate, and that workforce targets set for doctors and nurses have not been met.

It is difficult to judge whether the workforce levels match the requirements of the NHS. No up-to-date assessment of the workforce needs of the service exists. An amendment to require the government to have regular independent assessments and projections of current and future workforce needs across the NHS and social care, although passed in the House of Lords, was rejected by the government. This is unfortunate.

The below will comment on the commitments laid out in the 2017 and 2019 Conservative Party manifestos, which were as follows:

- Increase medical student places by 1,500 per annum. (2017)
- Hire 50,000 more nurses. (2019)
- Hire 6000 more GPs. (2019)
- Hire 26,000 more primary care professionals. (2019)
- Hire 7,500 extra nursing associates. (2019)
- Address the 'taper problem' in doctor's pensions. (2019)

Was the commitment met overall? or (in the case of a commitment whose deadline has not yet been reached) Is the commitment on track to be met?

1. *Does the commitment have a deadline for implementation?*

None of these commitments included 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?*

The most significant impact has come from the austerity agenda imposed from 2010 onwards. Whilst healthcare spending was ostensibly ringfenced it did not increase in line with inflation. In addition, cuts elsewhere had major impacts.

The scrapping of the Nursing Bursary in 2015 saw a 40% drop in the number of applications to study nursing. Although it was restored in 2020 it was set at a much lower rate than previously. The NHS bursary for medical students is also woefully inadequate, especially when the amount drops in the final year.

Government rhetoric around immigration and Brexit may also be contributory factors which have made the UK a less desirable destination for globally mobile medics. However, the pandemic means that we do not have anything other than anecdotal data on whether or not this is the case.

3. *To what extent has the Covid-19 response affected progress on targets?*

Perversely, the Covid-19 pandemic may have improved the situation during 2020 and 2021. This is because many senior clinicians put off the decision to retire or leave the service to serve during the pandemic. Others returned to the NHS from retirement out of a sense of duty. This has helped on the retention side of the equation (a more in-depth discussion of staff retention, as opposed to recruitment, can be found below in the section on whether the commitments were appropriate).

However, as the pandemic has begun to wind down, we are seeing more and more signs of burnout, stress and poor mental health and wellbeing, and this is leading more of them to leave the workforce. This is discussed in more detail in the Wellbeing at Work section below.

4. *How has this commitment been interpreted in practice at local authority/care provider/trust level?*

This is not something which we are in a position to comment on.

5. *Does data show achievement against the target (if applicable)?*

The Office for Students (Office for Students, 7th December 2021) has declared a medical school intake for the 2021-22 academic year of 10,543, up slightly from 10,461 for the 2020-21 academic year. These are up on previous years, with 9,450 in 2019-20 and 8,615 in 2018-19. However, these represent an increase of 1,928 in three years, rather than the 1,500 per year pledged.

Between January 2021 and January 2022 the NHS in England added 20,737 more FTE professionally qualified clinical staff (NHS Digital, January 2022), representing an increase of 3.3%. This group includes all Hospital and Community Health Services (HCHS) doctors, qualified nurses and health visitors, midwives, qualified scientific, therapeutic and technical staff and qualified ambulance staff. This is obviously less than the numbers identified in the commitments. As per the introduction, as of the most recent figures available, there is currently a shortfall of 8,158 medical vacancies (5.8% vacancy rate) and 39,652 nursing vacancies (10.3% vacancy rate).

Was the commitment effectively funded (or resourced)?

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

With the exception of the nursing bursaries none of the commitments as announced included any funding figures, and the bursary did not give an overall cost simply that *"students [would receive] a £5000-£8000 maintenance grant every year during their course"*. As discussed above neither this bursary nor that for medical students is adequate.

£1.5bn has been made available towards recruiting 6,000 new GPs (DHSC press announcement, 6th December 2020).

However, the workforce crisis cannot be fixed in the short-term regardless of the resources applied because of the length of time it takes to train a clinician. It will take a decade or more of sustained and well-targeted funding to resolve the workforce issue.

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

We cannot answer this question, only the Conservative Party and/or the DHSC can.

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

No. It is widely perceived across the NHS that the service has been chronically underfunded for over a decade.

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?*

Every hospital has had to implement 'work-arounds' around inadequate funds and staff. Regrettably this has usually been 'staff just have to work harder' which has caused a mental health and wellbeing crisis in the NHS, driven out many doctors and exacerbated the problem by seeing many clinicians leave the workforce early.

Did the commitment achieve a positive impact for patients and service users? (Indirectly through impacting workforce)

1. *Has (or will) there been (or be) a meaningful improvement in measurable outcomes, reasonably attributable to the commitment?*

Any increase in staff will be an improvement for patients and colleagues, and the numbers of staff have increased. However so has the workload, in particular the backlog of elective care. It is important to remember that this backlog long predates the pandemic and is principally a result of the underfunding and staff shortages over the last decade. The pandemic has however increased the waiting lists and exhausted and burnt out staff, reducing their capacity to address the backlog. New staff coming into the workplace do help, however this is not happening in sufficient numbers to really make a difference.

2. *Will (or have) staff, patients or service users benefit(ted) directly, indirectly or both?*

All staff and patients benefit both directly and indirectly from increases in staff. More staff means more patients can be seen, reducing waiting lists. It also means safe levels of staffing on wards can be implemented and maintained, and workloads on existing staff can decrease, improving their mental health and wellbeing and giving them more time and attention to devote to individual patients.

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

All staff and patients benefit from more staff in hospitals. Patients can be seen quicker, and more thoroughly, and staff have less workplace pressure. However, this is dependent on the numbers of new stuff being sufficient to more than replace those leaving and doing so in sufficient numbers to reduce the workloads. It is not yet apparent that this is the case.

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

We do not believe so, no.

Was it an appropriate commitment?

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

Increasing the number of staff will improve the situation, the question is how meaningful that improvement will be. More staff will both allow the backlog to be better addressed but also

The limiting factor is not so much money as the length of time it takes to train new clinicians. There is simply not a large reservoir of trained, medical staff from which to recruit in the short term, and overseas recruitment also has limitations. Money is important to increase numbers but that will not be seen or felt on the frontlines until the latter part of this decade at the earliest.

2. *Is the commitment specific enough?*

The overall commitment has no specifics whatsoever, simply as many staff *'that* [the NHS] *needs*.' The commitments made in the Conservative manifestos for the 2017 and 2019 elections do include specific numbers, however there is no indication of how these numbers were arrived at, whether they are sufficient, which specialities they will be (with the exception of the commitment on GPs) or, crucially, which areas of the country they will be focused on. The numbers, bluntly, seem to have been plucked out of the air. Had the government accepted the workforce planning amendment to the Health and Care Bill passed by the House of Lords these commitments could have been better judged.

3. *Has the commitment had unintended consequences?*

None that we are currently aware of.

4. *Was the level of ambition as expressed by the commitment reasonable?*

For the majority of the commitments it is not possible to judge, due to the lack of workforce planning assessments. However, for the commitment from the 2017 Conservative Party manifesto regarding medical students, we believe the ambition, if it could be realised, is sufficiently ambitious at present. The Royal College of Physicians of London has called for an increase in the number of undergraduate foundation years for medicine to 15,000 per year – at a calculated cost of £1.85bn – and we support this. Therefore, an increase of 1500 per year would have met this target within four to five years, which would have been reasonably ambitious.

These measures are entirely about recruitment of new staff, rather than the retention of existing staff, with the exception of resolving the pensions taper issue, which has not been done. This is a problem and will be discussed in more detail in the section on wellbeing.

5. *Is the target contained in the commitment an effective measure of policy success (if applicable)?*

Sufficient staff in the NHS and Social Care sectors would be a policy success, because of the impact this would have both on the health of the nation and the ability of the staff to perform their duties to the best and safest extent. However, the measurement of that success would have to be in the form of procedures conducted in a timely manner and staff satisfaction, rather than simple numbers.

We have seen early anecdotal evidence in diagnostics of job fragmentation. That is where a number of tasks which used to be performed by a single, highly skilled individual, are broken down and performed by a number of lower skilled individuals who each do just one bit, with the whole then being presented to the more highly skilled individual at the end for assessment and interpretation. This prolongs the journey for the patient as they have to have multiple appointments with multiple technicians but may (there is little evidence in either direction as yet) be a method to deal with the volume of cases. It does however increase the number of staff involved by far more than the number of cases dealt with. As such, an increase in staff which came about via job fragmentation could not meaningfully be described as a policy success.

6. *How has working to those commitments affected other aspects of care?*

Every single aspect of healthcare is reliant on having sufficient numbers of staff. Therefore, resolving this issue is paramount. It is the inability to meet the commitment for the NHS to have the number of clinical and other staff it requires which is detrimentally affecting all other aspects of care.

Building a skilled workforce.

Commitments: Help the million and more NHS clinicians and support staff develop the skills they need, and the NHS requires in the decades ahead.

£1 billion extra of funding every year for more social care staff and better infrastructure, technology and facilities.

Supporting moves towards prevention and support, we will go faster for community-based staff. Over the next three years we want all staff working in the community to have access to mobile digital services, including the patient's care record and plan, that will help them to perform their role. This will allow them to increase both the amount of time they can spend with patients and the number of patients they can see. Ambulance services will also have access to the digital tools that they need to reduce avoidable conveyance to A&E.

(As the second commitment relates to social care and the third relates to community-based care these are not within our remit to consider. Our expertise relates to surgery and the perioperative environment within a hospital setting.)

Was the commitment met overall? or (in the case of a commitment whose deadline has not yet been reached) Is the commitment on track to be met?

1. *Does the commitment have a deadline for implementation?*

No.

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?*

The pandemic has had a major impact on medical training and education in surgery. Trainees were reassigned and elective care was paused. In addition, surgery which did proceed often did so in private hospital settings under the block contract. It is exceedingly rare for private healthcare providers to allow trainees to be present at surgeries conducted in their hospitals.

3. *To what extent has the Covid-19 response affected progress on targets?*

As above, the pandemic has delayed training. The most recent GMC report on The State of Medical Education and Practice in the UK (GMC, December 2021) stated '*the impact of the pandemic is evident: a greater proportion of trainees and trainers are at high risk of burnout than ever before, and workloads in several specialties are increasing, especially in general practice.*

Furthermore, trainees are facing challenges around meeting curricula requirements and finding opportunities to backfill missed training. Some trainees are struggling to gain required competencies and experiences, often exacerbated by the need to catch up on missed opportunities while working in the wider context of the ongoing pandemic and recovery. Trainees in medicine, surgery, and obstetrics and gynaecology programmes are finding it particularly tough.'

We would wholeheartedly concur with that opinion.

4. *How has this commitment been interpreted in practice at local authority/care provider/trust level?*

This is not something which we are in a position to comment on.

5. *Does data show achievement against the target (if applicable)?*

The commitment is exceedingly vague, which makes this difficult to judge. There have been improvements in the management of the effect of rota gaps on training this year, with 55% of trainees saying that training opportunities were rarely lost to rota gaps, up from 49% in 2019 (GMC, December 2021).

Was the commitment effectively funded (or resourced)?

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

The Treasury did announce, prior to the pandemic, an increase to training funding of £210m (DHSC press announcement, 3rd September 2019) for the financial year 2020-21. However, because of the pandemic, this did not proceed as envisioned.

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

This is not a question we can answer.

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

Lacking strategic workforce planning which can identify skills gaps in a focused and data-driven manner it is difficult to answer this question. In addition, the full impact of the pandemic on training is not yet completely known, and therefore nor is the required resourcing to rectify it.

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?*

The funding announced in 2019 was a new resource stream.

Did the commitment achieve a positive impact for patients and service users? (Indirectly through impacting workforce)

1. *Has (or will) there been (or be) a meaningful improvement in measurable outcomes, reasonably attributable to the commitment?*

Upskilling the NHS workforce and training new clinicians would make a meaningful improvement to patients both in terms of reducing the elective care backlog and in increasing the number of clinicians and therefore the amount of time each clinician is able to spend with patients. However, this commitment is extremely vague and does not give any details as to how this is to be achieved. In addition, the government voted against the amendment to the Health and Care Bill that would have

required a strategic assessment of workforce shortages, including skills shortages. That would have made measuring the outcomes from this commitment easier.

2. *Will (or have) staff, patients or service users benefit(ted) directly, indirectly or both?*

An upskilled workforce would benefit staff and patients both directly and indirectly.

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

An upskilled workforce would benefit all staff and patients.

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

Not to our knowledge or belief.

Was it an appropriate commitment?

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

It is a positive to make a commitment to upskilling the NHS workforce, however without more detail on which skills, in which proportions and in which locations and without a strategic approach to workforce planning and training it is unlikely to make as meaningful an improvement as it could be.

2. *Is the commitment specific enough?*

The commitment is not at all specific and does not include details of which professions or specialties it seeks to upskill, nor how this will be done, nor the geographical spread and application of the commitment, nor the costs or resources expected.

3. *Has the commitment had any unintended consequences?*

There have not been any unintended consequences to this commitment that we are currently aware of.

4. *Was the level of ambition as expressed by the commitment reasonable?*

It is a reasonable ambition to look to upskill the NHS workforce and to do so in a manner which meets the skills requirements the service needs.

5. *Is the target contained in the commitment an effective measure of policy success (if applicable)?*

It is not possible to measure whether the skills requirements of the NHS have been met without a strategic workforce plan which identifies what skills are required.

6. *How has working to those commitments affected other aspects of care?*

Not to our knowledge.

WELLBEING AT WORK

Commitments: Introduce new services for NHS employees to give them the support they need, including quicker access to mental health and musculoskeletal services.

Reduce bullying rates in the NHS which are far too high.

Listen to the views of social care staff to learn how we can better support them – individually and collectively.

(As the third commitment relates to social care it is not within our remit to consider. Our expertise relates to surgery and the perioperative environment within a hospital setting.)

Was the commitment met overall? or (in the case of a commitment whose deadline has not yet been reached) Is the commitment on track to be met?

1. *Does the commitment have a deadline for implementation?*

No, neither commitment contains a deadline or timescale. Although the first commitment states 'quicker access' it does not offer any details as to what that means in practice. There was rapid access to mental health provision made for NHS staff during the pandemic. It is desirable that this would be continued. However, it is unclear whether there is the capacity to do so now that appointments with regular patients are back to pre-pandemic levels.

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?*

With regards to the first commitment, it is possible that granting quicker or preferential access to NHS staff to in particular musculoskeletal treatment could come into conflict with the government's aim to reduce the backlog of elective care on the waiting lists. This is however a theoretical possibility, rather than something which we have seen any evidence of. Orthopaedics as a field has some of the highest waiting list backlogs in the NHS.

There are not, to our knowledge, conflicting policy decisions with the second commitment. However, without more detail as to the practical steps to be taken to reducing bullying it is difficult to judge what they could be. It is not possible to legislate for culture change, this can only be done by national and local NHS leadership, and it is not clear what support structures for assisting local leadership to lead cultural change are envisioned by the government with this commitment.

3. *To what extent has the Covid-19 response affected progress on targets?*

The pandemic greatly increased the pressure on staff. As above support was put in place during the pandemic. Our internal surveys of our members and fellows indicated that this was greatly appreciated by staff, as were additional measures that they found supportive. Free parking and the availability of hot food and drink at all times were other support measures which were wanted according to our internal surveys. Those surveys also showed an increase in staff morale during the first wave because of a sense of 'all in this together' and of 'Blitz spirit'.

However, as the pandemic ground on, staff began to get burned out, causing mental and emotional trauma which can manifest as bullying and lashing out at colleagues. The moment of greatest risk for this is actually the one we are in right now, as the pandemic – although by no means at an end – winds down and the media, politicians and general public move on to other topics, leaving NHS staff feeling forgotten about.

There was already an issue with bullying in the NHS, which our campaign #LetsRemoveIt has been aiming to address since 2017, but the pressures of the pandemic may have been a contributing factor.

4. *How has this commitment been interpreted in practice at local authority/care provider/trust level?*

This is not something which we are in a position to comment on.

5. *Does data show achievement against the target (if applicable)?*

Our internal survey data does show an appreciation for the additional support in terms of the availability of mental health support particularly during the pandemic. However, there are concerns at the sustainability of this.

Bullying and undermining is hugely underreported, but the data we have does not show any marked shift towards improvement.

Was the commitment effectively funded (or resourced)?

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

The additional support for staff that was applied during the pandemic was funded from resources dedicated to the health service to deal with Covid-19. We are not aware of proposals to continue to fund it with any new arrangements as the pandemic winds down.

We are not aware of any new funding stream dedicated to combating bullying and undermining in the NHS.

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

This is not a question we can answer.

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

The funding that was given during the pandemic to support staff was sufficient at the time, but as above there are concerns over the long-term capacity of mental health and particularly musculoskeletal teams to support NHS staff alongside their greatly increased patient load caused by the backlog of elective care.

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?*

The funding allocated to the support systems during the pandemic were from new resource streams created as part of the covid-19 response. We are not aware of other new resource streams.

Did the commitment achieve a positive impact for patients and service users? (Indirectly through impacting workforce)

1. *Has (or will) there been (or be) a meaningful improvement in measurable outcomes, reasonably attributable to the commitment?*

The NHS is reliant on exploiting acts of goodwill from staff who are prepared to work longer than their contracted hours and go above and beyond their calls of duty. This has been the case for so long however that staff often feel taken for granted. Any measures which support them and show gratitude, understanding and a desire to make genuine improvements to their situation is vital for improving staff morale.

These do not have to be dramatic gestures. Some of the measures which our internal surveys highlighted included free parking, availability of hot drink facilities, availability of hot food, the availability of rest and respite spaces away from patients, alongside rapid access to mental health support. Staff also want an adequate pay settlement that recognises their skills, commitment and the sacrifices they have made during the pandemic.

According to the GMC State of Medical Education and Practice report cited above more clinicians surrender their medical licence for reasons of stress, burnout, bullying or poor workplace culture, and the average age for retirement has dropped from 61 to 58. These are indicative of potential, measurable outcomes which could be used to track this, but they are currently worsening.

If these can be delivered, a happier NHS workforce would be a positive in many ways. The Francis Report in 2013 (HoC library, 2013) showed that poor staff morale is an early warning sign of problems that lead to poor outcomes for patients. Research by the National Nursing Research Unit at King's College London shows that higher staff morale leads to better outcomes for patients, as does the Illing report.

2. *Will (or have) staff, patients or service users benefit(ted) directly, indirectly or both?*

Both. There are multiple benefits to a happier workforce, from more pleasant subjective experiences to more focus on patient care.

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

All those involved would benefit from more support and less bullying.

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

Not to our knowledge or belief.

Was it an appropriate commitment?

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

Both commitments, if implements, would lead to large and meaningful improvements for both staff and the health system as a whole. However, the commitments are light on details. There was rapid access provided to NHS staff to mental health support during the pandemic, but it is not certain how easily this can be maintained alongside increased patient loads. This is even more true of musculoskeletal services.

There are no details at all on how the government propose to address the problem of bullying and undermining in the NHS. In addition, the commitment is to reducing bullying rates. The problem of underreporting means that any successful attempt to address this issue would see the recorded rates of bullying increase, as people began to trust the system enough to report it.

Without details on what, practically, the steps the government wish to take on this are it is not possible to provide a judgement on how meaningful any likely change would be.

2. *Is the commitment specific enough?*

The commitments are very vague. The only forms of support mentioned are quicker access to mental health and musculoskeletal services, but 'quicker' is not defined. No measures to attempt to reduce bullying and undermining are given.

3. *Has the commitment had any unintended consequences?*

There have not been any unintended consequences to these commitments that we are currently aware of.

4. *Was the level of ambition as expressed by the commitment reasonable?*

The ambitions expressed are laudable, the issue has been the lack of detail as to practical measures by which to achieve them.

5. *Is the target contained in the commitment an effective measure of policy success (if applicable)?*

There are no measurable targets expressed in either commitment.

6. *How has working to those commitments affected other aspects of care?*

If these were successfully implemented, they would positively affect all aspects of care. However, lacking meaningful actions to judge we do not believe we can say that these commitments have in and of themselves affected other aspects of care.

May 2022