Written evidence submitted by Professor Hazel Scott, The University of Liverpool (RTR0155)

Are we training enough doctors?
No. The current ratio of doctors to the population being served in the UK is below the OECD average and second bottom in the EU. This is despite the fact that 25% of doctors in the UK are non-UK nationals, often drawn from low and middle income countries. This is an unsustainable and arguably irresponsible approach to NHS staffing, within a global context.

New factors impact further on the future conversion of the current medical student intake numbers into trained NHS staff FTE.

- Staff leaving because of the tax arrangements in respect of NHS pensions.
- Staff taking early retirement, especially post-pandemic.
- A service that depends heavily on medical trainees for delivery, yet one where large numbers of Foundation trainees step away for at least a year, before taking up specialty training posts, because of their Foundation training experience.
- A medical school intake that is designed to replace retiring trained staff, yet has a much higher F:M ratio than that of senior staff, and a resultant anticipated future shortfall in working FTE.
- The growth in demand: care expectation, patient need and new types of care (through technology and genomics).

Regular, regional, and nationally monitored work force planning is important.

Is there capacity to train more doctors?
Yes. This may require adjusted modes of training, e.g.,

- Integrated immersive simulation, to moderate an expanded student footfall in placement settings
- Placements provided on an NHS working week rather than a teaching week model, with greater use of shifts.
- Use of accommodation and travel funding, such that students could be placed further from medical school bases.
- Alignment of NHS trust service and educational management, such that trained staff time to engage with student competency assessment, portfolio review, feedback and support is sufficiently recognised and set aside from service delivery to be effective.

Placement capacity numbers should be considered as part of medical training capacity planning. Such planning should take account of all programmes that depend on the same NHS placements. This includes UK capped medical school numbers, but also uncapped private medical school numbers and UK Physician or Anaesthetic Associate programmes. Priority access to the limited supply of NHS placements should be managed as a whole and directed to the target needs required of expansion of the UK workforce.

Apprenticeship may provide opportunities that support widening participation. However, an apprenticeship model is not a solution to placement capacity. An apprentice needs to be based in a placement, just as much as a student. The total number that can be accommodated does not change. Apprenticeship also critically depends on being set within a defined team, with regular natural contact between the apprentice and trainer. This is not the current NHS training environment.

Where should doctors be trained?

As close to the greatest patient need as possible. Deprivation scores, rather than geography should be key to the consideration of additional medical school places. As deprivation drives ill health, deprived areas will provide the greatest concentration of experience from which students can learn, while also ensuring they appreciate the key drivers of ill health. Additionally, student connections with such areas of health poverty will make it more likely that they choose to work in such areas for the longer term.

This latter benefit is negatively impacted by the dispersal of students away from their parent medical school location, such as is inherent in the Foundation programme allocation scheme. This dispersal also limits the degree to which the supportive networks, on which the student has depended during their undergraduate studies, can offset the intensity, fragmented team relationships and stress they experience during Foundation training. An alignment of the majority of new graduates' Foundation posts to their Medical School of training would provide a context for greater support of early trainees, as well as maintaining the connection between students and key regions of health concern.

What should be in the medical course?
Doctors should be trained to understand the reasons for ill health, to recognise ill health, to implement initial investigation and management, to support and communicate with patients and carers so they may understand, manage and nurture their health, and to work effectively in clinical teams. However, as well as being trained in delivering excellent care, it is also vital for the future of UK health, that they are trained to seek, interpret, explain and apply perpetually evolving clinical research findings relevant to their patients, and that a significant proportion of students are encouraged to commit their careers to discovering the new care of the future. Growth of the medical workforce should be sure to address the supply of clinical academics on whom this depends.

May 2022