Written evidence submitted by Scarlett McNally (EPW0075)

I enjoyed being part of the roundtable event about workforce on 5.5.22. I put some references in the chat. I wanted to make some other points. Please let me know if I should submit these in a different format. My points are:

1. Doctors (and some other very senior clinicians) are the staff able to cope with complexity, multi-morbidity, polypharmacy and they exercise clinical judgement. They carry risk. For example, deciding with a patient that an incidental scan finding might not be worth pursuing. Other staff are far more likely to be risk-averse and to get more investigations or keep patients in hospital. This difference is increased by the other regulators being very critical if a nurse or Allied Health Professional does not stick to a protocol.
2. The quantity and efficiency of doctors in particular is highly important to shoring up the workforce. This needs several strategies:
    a. The pensions mess needs to be sorted out. Many consultants have a disincentive from doing any extra work. Many have reduced hours or retired. Those who have been doctors for longest are best at managing risk and using least resources.
    b. We have lost secretaries. Ward clerks do not work for doctors. On the wards, 50% of doctors' time is spent on administrative and other tasks that do not require a medical degree. Health Education England (HEE) and other organisations have built up careers of Advanced Clinical Practitioners, Physician Associates, etc. but these take the complex tasks away from doctors and these staff require expensive lengthy training. What is needed is staff to take on the simpler and administrative tasks, to free up doctors. I led a pilot of the role of 'Doctors' Assistant' in East Sussex (at pay Band 3), which worked well and is now a Level 3 Apprenticeship. I wrote a BMJ leader paper on it. The weblink is: https://bmjleader.bmj.com/content/5/1/62
    c. There are several specialties where there are too few training places to keep the supply going. Excellent doctors are turned away because there is a limit on postgraduate specialty training posts. The number of training posts and the type of training needs to change:
        i. more Anaesthetic training places need to be made available
        ii. training in Emergency Medicine currently requires 9 months in Anaesthetics and 3 months in Intensive Care Unit. This makes the package very expensive as the doctors cannot work unsupervised, so they have to be funded as additional when installing these programmes. (I know - I installed 10 of these in East Sussex in 2009 when I was Director of Medical Education. The limit was money.). It would be better to re-design "Acute Core Common Stem" to include Geriatrics and Orthopaedics (so a hospital would just convert a Locally Employed post, with minimal additional funding) and massively increase the numbers of this critical bottleneck for training in Emergency Medicine.
        iii. Training numbers have still not adjusted to the number of women doctors. Many go part-time during training. Many also leave because they are not supported to continue training. Additional funding should be made available to the employing organisation anywhere there is a postgraduate doctor in training who is Less Than Full Time, to put in any support needed for retention. Many training rotations are geographically big, so postgraduate doctors spend far too long commuting - this contributes to less efficient training and worse retention.
3. 70% of NHS spend is on long-term conditions many of which have a large preventable component. All healthcare staff should be trained in 'Making Every Contact Count'. This

should include unregistered staff at pay Bands 1-4. There is a lot of scope for 'care navigators' 'health advisors' etc, to talk about nutrition, exercise, smoking cessation, phycological empowerment, etc. These are interventions that tackle some inequalities in health. I was lead author for the Academy of Medical Royal Colleges' report 'Exercise the miracle cure' https://www.aomrc.org.uk/reports-guidance/exercise-the-miracle-cure-0215/ showing that exercise works for prevention and treatment of common conditions. There is still a tension between generalism' and 'specialisation'. All training should include these 'simple' interventions, both for students and for established staff Continuing Professional Development. I have been helping OHID and Sport England on some of this. It needs to be led and demanded at inspections.

4. Perioperative Care is a new way of looking at the patient's journey through some very complex interventions (requiring a lot of staff and resources). this is hugely variable. There is duplication and waste. Staff with any role in the perioperative pathway need to understand what other staff do, so issues are identified early, patients are optimised and care needs are anticipated. At www.cpoc.org.uk we have shown that this approach reduces complications by half and length of stay by 1-2 days. Only very simple training and different ways of working are needed.

I would be happy to expand on any of these or explain. Feel free to forward my comments.

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