HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Workforce burnout and resilience in the NHS and social care, HC 703

Tuesday 17 November 2020

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Watch the meeting

Members present: Jeremy Hunt (Chair); Paul Bristow; Rosie Cooper; Dr James Davies; Dr Luke Evans; Neale Hanvey; Barbara Keeley; Taiwo Owatemi; Sarah Owen; Dean Russell; Laura Trott.

Questions 71 - 119

Witnesses

I: Dr Chaand Nagpaul CBE, Chair, BMA Council; and Denise Crouch, Macmillan Lead Cancer Nurse.

II: Dr Adrian James, President, Royal College of Psychiatrists; Paul Farmer CBE, Chief Executive Officer, Mind; Professor Dame Clare Gerada, Medical Director, Practitioner Health; and Vic Rayner, Executive Director, National Care Forum.

Examination of witnesses

Witnesses: Dr Nagpaul and Denise Crouch.

Chair: Good morning. Welcome to the House of Commons Health and Social Care Committee. Today, we have our second evidence session on workforce burnout in the NHS and the social care system. This morning, we are particularly looking at the issue of mental health.

We are delighted to welcome some very important witnesses, including Vic Rayner, who is executive director of the National Care Forum. She has spoken to us before. Dame Clare Gerada runs a support service for doctors experiencing burnout and other mental illnesses. Dr Adrian James is president of the Royal College of Psychiatrists. Paul Farmer, as well as being chief executive of Mind, is also representing Our Frontline, a coalition of organisations manning a free, confidential 24/7 text messaging support service for those working on the frontline.

First, we are going to hear from two witnesses who are very close to those on the frontline experiencing burnout. The first is Denise Crouch, who is a Macmillan lead cancer nurse and manages a number of nurses who have been experiencing extreme fatigue. The second is someone well known to this Committee, Dr Chaand Nagpaul, who is chair of the council of the British Medical Association, which represents doctors and has a particular responsibility to make sure that the concerns of doctors facing burnout are addressed by Ministers.

Denise Crouch, thank you very much for joining us. One of our Committee members, Neale Hanvey, who is himself a cancer nurse, is going to ask you a few questions.

Q71 **Neale Hanvey:** Good morning, Denise. Thank you so much for coming along to share your experiences with us this morning. Could you set out for us some of the pressures that cancer nurses face as they deal with day-to-day activities in normal times, and move on from there to how that has changed?

Denise Crouch: I have been in cancer nursing for several years. Part of my role is professionally linking with nurse specialists. Macmillan recently did a report on the number of clinical nurse specialists we had for cancer. That report, earlier this year, in January, showed that we were at least 2,000 *[Inaudible]* to deal with today's activity of cancer nurses and the pressure that they are under, offering one-to-one care to individuals and emotional and psychological support. Not only that, there is the day-to-day chemotherapy, radiotherapy and financial support that they are all looking for and need. Nurse specialists play a key role for the individual, and their significant other, when they have had a cancer diagnosis.

As you know, it is a traumatic experience when you get a cancer diagnosis and the individual needs support. When the first round of the pandemic hit, the number of emotional telephone calls that people were getting from individuals not knowing whether they could continue with

their treatment was second to none. From speaking to other cancer nurses, we know that we were quite lucky in our organisation that we managed to keep our Macmillan information centres open, purely to help individuals who needed support. Some of them did not know if they would get treatment. They did not know if it was going to be delayed. Some of them needed support because their specialists were redeployed and a lot of work stopped. That was added pressure on individual nurses.

As a cancer lead nurse, I was also redeployed, but, as you know, my job does not stop. I still managed staff, so I continued to do my job but I went to work in the discharge lounge, discharging patients. At one stage, I was doing a 60 or 70-hour week, purely to keep the wheels on the bus.

We have a shortage of nurses, as it stands at the moment, to look after these patients. We know that in a few years' time there will be an increase in cancer diagnoses, and it is going to be one in two people. We have an ageing population of nurses who are likely to be retiring very soon. We need people support soon to help us, to start to train individuals to take that forward. A lot of the nurses—

Chair: I am sorry to interrupt, Denise, but could I ask anyone who is not speaking to make sure they are muted because we are getting a bit of interference on the line? Carry on, Denise.

Denise Crouch: The other thing is that nurses were worried about their patients and what was happening to them. Having that initial emotional support while they were working in other places caused quite a lot of concern. People are Covid fatigued. That is the word we use.

Q72 **Neale Hanvey:** Thank you, Denise. I really feel that experience. I understand how challenging it must have been, particularly when a CNS plays such a pivotal role across all the different services that a cancer patient will touch during their journey. They were plucked out, for valid reasons because it was an emergency, but the consequences must be incredibly tough for those individuals. Can you give us an idea of how their co-ordinating role with the cancer wards and the cancer nurses downstream changed?

Denise Crouch: Obviously, a lot of people had to be retrained—a lot of the nurse specialists. From talking to the national lead nurses who are part of the group I am in, and even locally across the east midlands, I know that a lot of people had to be retrained and redeployed. A lot of those nurses had probably not worked on a ward or in an individual area for a lot of years. I know from my personal experience that it is a long while since I have discharged patients. The principle is the same, but it was a long time since I had done that.

On the hours of working, normally a clinical nurse specialist role is more of a Monday to Friday-type job. With changing roles and being redeployed, there were longer hours, shifts and *[Inaudible]* to contend with. Personally, I have been nursing for 43 years. I am 62. I was

absolutely shattered and exhausted at the end of each week dealing with all that extra workload and emotion, and the support we offered. I also felt very privileged, I have to say, that we were able to do our bit and help.

Q73 **Neale Hanvey:** Within your practice and within the practice of the nurse specialists, how would you describe burnout? What does it look like to you?

Denise Crouch: It is difficult because we work on adrenaline a lot of the time. We just go on and we want to give. That is why we come into nursing; we want to care and give all the right things. For me, I was tired. I was fatigued. It very much seemed like Groundhog Day every day. It was anxiety. I do not know whether I am defining burnout very well at all, but it felt as though there was nothing to look forward to, because every day you had to come to work and the anxiety was there. There is still anxiety. We are in a big second wave, and that anxiety is there. Thankfully, we are able to continue in the roles we do, but we are fearful for the people in the second wave in our intensive care and respiratory wards.

This is not going away for cancer patients. They have the fear of their cancer treatment. They have the fear of what is going to happen next. They are living with that big black dog on their shoulder all the time. When is it going to come back? Interestingly, I was talking to a patient last week whose cancer came back in the pandemic. He said, "It was a battle the first time, but it feels like a war this time. I don't know how I am going to get to the end of it. I'm so worried and so frightened."

Q74 **Neale Hanvey:** That sounds like an emotionally difficult experience. You have to deal with what is in front of you, but you also have that group of patients in the back of your mind. That is not going away. How do you guys find the emotional capacity now to go back to that work when the time is right? What is the impact of that?

Denise Crouch: My organisation has put on a lot of wellbeing events, activities and different things to help support us, and we are talking. I know from Macmillan, as a professional, that we were given lots of avenues. We did some action learning with a psychologist; we spent some time with a psychologist, talking to them on a weekly basis, and that was really helpful. Macmillan have put lots of other mechanisms in place to help support us. That is great if you are a Macmillan professional, but not everybody can access those courses or has the time. It is about time to listen to other people and other colleagues across the country. They are experiencing the same things as you are, so it does not feel as though you are on your own.

Q75 **Neale Hanvey:** What is your view beyond your immediate group of staff? Do you get a sense that there is fatigue in the workforce? How do you see that in the staff? How do you read that?

Denise Crouch: I am quite fortunate that I am part of the national lead cancer nurses group. As I said before, I am also part of the east midlands cancer lead nurses group. We speak on a weekly or every other week basis about how we can help to support each other and support the staff. Some of them are talking about PTSD and how that will look, and what we need to put in place for the future.

We are going to need to support those nurses a lot more in the future, and the workforce. It is not only the patients; it is the staff. We are lucky in Derbyshire to have a community trust with Derby and Burton football clubs. They run a really good health and wellbeing programme for our cancer patients, and an activity programme. We managed to continue with that all the way through the pandemic, although virtually. For anybody who did not have access virtually, they were able to supply laptops and different things for those individual patients. We offered coffee mornings. They also allowed our staff to join that, if we wanted to take it forward. We were able to join the active recovery programme.

The other thing we did in Derby was to devise a cancer app. It was not just for the patients and significant others; it was for staff as well. It gave links to different places you could go to get some respite and do an active programme like yoga or some mindfulness. We tried to cover all avenues to support people.

Q76 **Neale Hanvey:** What impacts have you seen? You mentioned working very long hours at quite a physical job. The King's Fund used the term "chronic excessive workload". What impact have you seen on staff? What are the consequences for patients and how do you think it would be best to support staff in the future? We are taking a look at how things are and how they could be improved. What would your suggestions be?

Denise Crouch: We need to look at a people programme and the work that we need to do. We are 2,400 staff, CNSs, short. By 2030, it looks something like 3,600 staff short. We need to look at recruiting more staff to support that. We know that one in two people are going to get cancer, so those one in two people are going to need more support in every avenue.

A lot of the stratified work we have been doing for people to take over ownership and management of their care takes time and confidence. We need the staff to be able to do that with the patient. That programme needs to carry on. We introduced the cancer strategy in the five-year plan, and then it changed to a 10-year plan. We need to revisit that. Due to the pandemic—it is nobody's fault—it will take us longer to get to where we need to be than the 10 years that we first initiated. We are seeing late referrals coming in. Those people need more input and more support. We need to look at our staffing levels and do a review.

Q77 **Neale Hanvey:** Do you think there is enough capacity more generally in the nursing workforce to meet the challenges of a pandemic such as this?

Denise Crouch: Probably not. It is difficult—

Q78 **Neale Hanvey:** You can be as frank as you like. You do not have to measure your comments for us.

Denise Crouch: I would say no, because the one thing we did before was to stop all work. Yes, okay, we gave some chemotherapy and radiotherapy-type cancer things, but lots of other things stopped. It all stopped. How long is it going to take for us to get that work back and get to a level playing field? We were never meeting the 62-day target across the country. If we were not meeting it before the pandemic, what is it going to be like now? Everybody is trying, and everybody is committed to making a difference, but we are going to need more capacity. I do not know whether it is capacity so much as working differently. We need to accept that other people can help us outside the NHS. It does not all have to be done in the NHS.

Chair: I am going to move on, if I may, but we are definitely going to come back to that workforce question, Denise. That is a very important issue. Please mute yourself now until you are asked the next question. Thank you very much for that evidence.

I want to bring in Dr Chaand Nagpaul, who has made it a very important priority to champion the needs of the many doctors who feel under extreme pressure on the frontline this year. You have heard Denise talking about some of the pressures facing cancer nurses. Would you start by telling us about some of the reports that you have been getting on what doctors have been experiencing on the frontline?

Dr Nagpaul: I represent doctors working in all specialities in hospitals, general practice and public health. All types of doctors are represented by the British Medical Association. It is important to start by reminding ourselves that doctors, nurses and healthcare professionals work in an extremely challenging environment in the NHS, with significant constraints. Before the pandemic started, we had about 10,000 doctor vacancies and about 46,000 vacancies in total, including nurses, with 80,000 across the NHS.

In real terms, that means that we have far too few doctors. It is one for 360 members of the population compared with one for 288 in Europe. That is tens of thousands fewer compared with France or Germany. France has three times as many hospital beds, and Germany has four times as many. With facilities such as scanners—the things you need for cancer diagnosis—we are very much at the bottom of the league for CT scanners, MRI scanners and so forth.

When you consider that we all go into medicine to do our best for patients, that kind of pressure can be quite demoralising, when you know you cannot do your best to look after patients. Even before the pandemic, we carried out a very major piece of research among the medical profession about wellbeing. It was published last year and showed that

80% of doctors reported being at high risk or very high risk of burnout; 40% said that they were already experiencing severe anxiety, depression or burnout itself. We started at a very stressful starting point before the pandemic.

Ninety-five per cent. of doctors told us that they go into work every day afraid that they will make a mistake; 50% say that is very frequent. When we ask them why, the reasons are fourfold. Over 90% of doctors say that lack of staffing is the biggest contributor to not being able to provide proper care, and compromises patient quality and safety. When we asked them what that actually means, they described trying to be in two places at once, which they couldn't do. They did not have enough time with patients. They talked about lack of doctors on wards and in GP practices. They listed the lack of nurses and other healthcare professionals. Remember that we work as a team, so there is an overall issue of—*[Inaudible]*

Q79 **Chair:** We questioned Prerana Issar, the NHS chief people officer, about the fact that the NHS and the Government have still not published their 10-year workforce projections, which are the independent assessments of how many doctors we are going to need in 10 years' time, how many nurses and how many AHPs and so on. How important is it for morale for doctors to know that, even if we do not have enough doctors now, we are at least recruiting enough for the future?

Dr Nagpaul: It is vitally important that, while we acknowledge the constraints of today, we know that there is a very clear plan to address the shortfalls. It plays a huge part in reducing burnout if you know that there is not just a plan but some specific detail as to what is needed. It needs to be done effectively. As I said, we have good information about other nations and the sorts of levels of workforce that we need. Of course, we need to factor in the way in which doctors work with other professionals and the role of technology, but ultimately that is what we need. We need to start now because, if we do not start now, my worry is that the impact of work burnout will result in the reduction of the workforce and exacerbate further burnout.

The culture in the NHS has to be addressed. That will be fundamental to recruitment and retention. As I say, not only are doctors worried about making mistakes, but they say they are in a culture where they get blamed when things go wrong that are outside their control; 55% of doctors say that. As a result, they do not speak out. We have seen a very definite and worrying impact on BAME doctors, who feel particularly unable to speak out and are more likely to be blamed. There is a lot of evidence that they experience worse inequalities in the NHS.

That was all before the Covid pandemic. Remember that when Covid started it was an experience that no doctor or nurse was prepared for—to see so much illness and death in their workplaces. Imagine that you have a hospital that has no visitors. We were doing tracker surveys throughout the pandemic. When we asked about mental health, we had a huge

response, with 2,000 free text responses. Doctors were describing the emotional impact of having to hold a smartphone or an iPad as the vehicle of contact between patients in their last days of life. For relatives, just imagine a whole hospital without any visitors.

Many doctors had to do different jobs from those they were trained to do. They had to work in critical care. They were afraid of getting infected themselves. They are human. They were afraid of getting infected. They saw their colleagues getting ill. A junior doctor told me of the stress and emotional impact it had on her to be treating her own consultant—the consultant who was training her—in intensive care. That is what doctors and other healthcare professionals have had to work with.

We have carried out tracker surveys throughout the Covid pandemic. My biggest worry is that we are finding that 40% of doctors say that their stress levels and levels of burnout are now higher; 59% say they are severely fatigued; and 40% have not even been able to take an adequate break or leave from work since March. They have been working flat out. The worst thing is that, when we did the most recent survey in October, about 50% said that, once the pandemic is over, they plan to reduce their working hours. A fifth plan to retire early. A fifth plan to do a job other than being a doctor. This is a serious situation. We must find solutions and address this level of fatigue.

Q80 **Chair:** There is a lot to unpack. We had a whole evidence session looking at the issue of blame culture in our inquiry into maternity safety. We are doing separate investigations into BAME issues, which I am sure other Committee members will want to follow up on.

I have one more question. There is something very unique about what doctors and nurses do compared with other professions. You are required to show and give compassion to your patients. Denise talked earlier about talking to someone whose cancer had returned. But because you work very hard, you are in need of compassion and support too. Do you think that the mental health support that is available for doctors on the frontline is adequate at the moment?

Dr Nagpaul: Unfortunately, the feedback that we have received from doctors says it is not. We did surveys throughout the pandemic, and significant numbers said that their workplace was not offering them support for their wellbeing. They could not turn to their employer to seek support. In parallel, we have other services, of course. The British Medical Association offers a 24-hour counselling helpline. Clare Gerada, who will be speaking to you, runs a national practitioner health programme. There are other services available, but the NHS itself is not providing adequate support. That is of real concern when you consider the context and the pressures that doctors and nurses are working under.

By the way, our helpline has had an 80% increase in contacts in the last few months. That is the scale of the pressure. Don’t forget that this impacts on the families of doctors and nurses. In our own helpline, we

extended wellbeing support and counselling to loved ones—spouses and other family members. Doctors and nurses go back to their homes with enormous stress. With Covid, they have worries about being infected and infecting others.

Chair: Luke Evans wants to ask a bit more about that, so I will hand over to a fellow GP at this point.

Q81 **Dr Evans:** Dr Nagpaul, on that line, if we can go back pre-Covid, you have been qualified for 28 years. Could you comment on how the intensity of the workload has changed in the work that you have been doing over that 28 years?

Dr Nagpaul: I became a GP 30 years ago. When I started, I was on call every third night. I worked weekends. I worked throughout the night visiting patients at all hours and went back to work the next morning. Although the work in terms of hours was far greater, I can honestly say that the intensity and pressure now is incomparable. Speaking as a GP, we now provide very direct care in a range of areas that were previously done by specialists in hospitals. It is very realtime. We have far more facilities to manage patients with technology, investigations and results. There is a huge realtime pressure to get it right.

The biggest constraint is not having time and not having the space to properly care. It upsets and demoralises healthcare professionals—doctors—when they cannot do their best and they are working under extreme pressure. I hear this in general practice and in hospitals. Doctors in hospitals say that they cannot be in A&E and on a ward at the same time. Equally, they do not have the time to be compassionate, and that is extremely distressing because that is what we want.

Q82 **Dr Evans:** In your clinical practice, how many contacts would you have in a day? That would be on the telephone, interaction with a patient or meeting someone. How many contacts are you on, roughly, at the moment?

Dr Nagpaul: It varies, and we have some good information of late. I will speak about general practice because there has been a misunderstanding about the work of GPs during the pandemic. The first thing is that, throughout the pandemic, GPs always needed to see people who were seriously ill. What you cannot have, and rightly, is a waiting room full of vulnerable patients mixing with perhaps asymptomatic carriers. That is why the door appears to be shut, but GPs are seeing ill patients.

They have a huge number of telephone consultations. In a recent survey we carried out, we had results showing that there are about 20% more contacts. It could be something like 30 contacts in the morning and another 30 in the evening. It varies from doctor to doctor, but the one thing they all said is that the consultations are taking longer. It is much more difficult to do a video or telephone consultation. I would much rather see patients face to face. It is quicker. There is more administration.

The second thing is that they say they are working longer hours. They go in earlier and come home much later. They report much more fatigue. The current ways of working in the pandemic have significantly added to the volume of work, contacts and fatigue.

Q83 **Dr Evans:** If we go pre-pandemic, with the number of contacts rising and the intensity rising, would you either personally or as the BMA be in favour of having a national limit on how many contacts you should have?

Dr Nagpaul: We think there should be a specification of workload limits. It is the best thing for patients, because they would have a doctor who is more alert and who has more time. We have tried to do some stats. We know that in Europe doctors see between 25 and 30 patients in a day. In the UK, although it varies from practice to practice, you have as many as 100 contacts a day, especially when you consider telephone access. I think we must remember that a telephone contact is not not work; it is very real work. It is the alternative to seeing someone face to face. Whichever way you look at it, it is significantly more than the 25 to 30 contacts we see in Europe. The average would probably be between 50 and 60 a day, which is double what we should be seeing.

Q84 **Dr Evans:** You have talked about the intensity and the number of contacts. Do you have a gut feeling or any data on how many GPs are taking on more work? We have heard from your survey that a quarter are looking at retirement. I believe that 25% of the medical workforce is above the age of 55. It clearly creates a problem if we have to train doctors over the next five years. It is going to take a long time. We need the workforce to be taking more on. Could you try and unpack that for us?

Dr Nagpaul: Yes. We know that it will take years to train more doctors, but we certainly need to be doing that now, which we are of course. Retention and recruitment is critical. Even if you do not lose doctors but they reduce their hours, you are in effect reducing workforce capacity. The reason why they reduce their hours is the pressure they are under. That is something we need to focus on.

Q85 **Dr Evans:** Do you know any doctors who are looking to increase their hours?

Dr Nagpaul: No. I will be frank; I have not met any. We have increased our hours during the pandemic because, like all healthcare professionals, doctors are very committed to serving patients and the nation at this time of need. We have plenty of evidence that doctors are working well beyond their contracted hours from a rightful sense of duty. If you are asking whether I hear from doctors that they are looking to add to their workload, no. What we hear is that doctors want to reduce their workload. I cannot say that no one wants to increase their workload; there may be some who have come back to work after a break, but in general terms, no, that is not what I am hearing.

Q86 **Dr Evans:** I have a vested interest because all my family are doctors, so

I understand the pressure they are under. It is clear that across the world, this virus has hit everyone. There is pressure on businesses and livelihoods. We cannot forget that. Resilience is important both now in the pandemic and going forward more long term. What three things would help support resilience not just in the short term but also in the long term?

Dr Nagpaul: The first is to make sure that doctors can work in an environment that is as safe as possible. I know that we are under huge pressure, but there are things that can be done, such as being clear about the limits of what the NHS can offer at the moment and making sure that doctors are able to focus their energies on the most urgent priorities and the patients who need to be seen urgently. I know that we talk about resources, but you cannot carry on a health service that has such a workforce shortage and such lack of facilities and where there is lack of community facilities. That has to be addressed moving forwards.

The other thing is to invest in wellbeing. We have not highlighted the point that there is plenty of evidence that, when doctors are under stress and pressure, they make mistakes. Investing in wellbeing is actually investing in patient care. Last year, Michael West was commissioned by the GMC to do a report and showed that there was an increased chance of between 45% and 63% of a doctor making a mistake when they were under pressure and feeling stressed and anxious. The Mayo Clinic showed that surgeons are three times as likely to make mistakes if they are under stress. Investing in wellbeing should be seen as an investment in patient care.

The third thing is that we have to improve the culture in the NHS. Doctors and other healthcare professionals do not feel valued. They feel afraid, targeted and scapegoated for an environment that is not of their making. We must be much more visible. Ministers right at the top need to highlight that we are all trying to do our best. We need to be valued. We need simple things like having hot food at two in the morning if we are working a night in hospital. We need a much more positive message to the public, to explain the difficulties we are facing when we are trying to do a day's job. Value, compassion and having a supportive culture are vitally important.

Q87 **Sarah Owen:** I have a few questions on black, Asian and minority ethnic doctors. You started to talk about that, but I wondered if we could dig a little bit deeper. The first 10 doctors to die during the pandemic were black, Asian, minority ethnic doctors who had come from other countries to work in the NHS. Could you elaborate on some of the reasons why you said that BAME doctors had reported higher levels of burnout, and on some of the solutions that you think might help?

Dr Nagpaul: That was a shocking statistic and it alarmed us. To date, over 90% of the doctors who have died have come from a black, Asian and minority ethnic background. That goes beyond any statistical variation. It is a stark statistic.

Before the pandemic, we already knew that there were issues. A large BMA survey showed that black, Asian and ethnic minority doctors were twice as likely to report bullying and harassment in the workplace. They were half as likely to report patient safety concerns because they felt that, if they did, they would be blamed. They reported a higher fear of being blamed. We know that we have twice as many BAME doctors referred for disciplinary procedures. When the GMC commissioned work on that, there was clearly workplace bias operating, where the same error by a non-BAME doctor may not have been looked on in the same way.

We have a backdrop of considerable inequality affecting BAME doctors. During the pandemic, we carried out surveys every couple of weeks; we did 10 surveys. When there were severe PPE shortages and in fact doctors were working in some settings where they should have been wearing masks but the policy at the time was that they did not need to, three times as many BAME doctors told us in the surveys that they were under pressure to see patients without adequate protection. They reported to a much higher level that they were unprotected. That was in the months when the NHS seriously did not have the levels of masks, especially in aerosol-generating procedure environments.

We also asked doctors for their experience of being able to raise concerns about working in pressurised environments during the pandemic. Again, BAME doctors reported higher levels of bullying and harassment during the pandemic. They were afraid to speak out and so forth. There is a context that BAME doctors have historically felt worried about career progression if they speak out, against the backdrop of already knowing that they do not do as well or go higher up the medical ladder. There are fewer BAME doctors who become consultants, for example.

For the overseas workforce, it is even worse. They have come from other countries, and they are trying to work within an NHS culture that is so different from where they come from. They are worried because they want to make sure that they can get a job and can progress. They are less likely to want to rock the boat. All those factors have an impact on the BAME workforce and did have an impact during the pandemic.

Risk assessment is another thing. When we found that the first 10 doctors who had died were from a BAME background, we called for risk assessments and an objective way of identifying doctors who were at the highest risk so that they could be redeployed or do non-patient facing work; there is plenty of remote work that the NHS has needed to provide. That took too long to implement. When it is implemented, it is not just a tick-box exercise of risk assessing; it is about what you do thereafter to allow a doctor to work in a safe environment that protects them. Again, we had high reports from BAME doctors that they were not satisfied with the risk assessment. There is a cultural issue that the NHS must address for our BAME workforce.

Q88 **Sarah Owen:** Thank you, Dr Nagpaul. You mentioned that staff shortages are a serious problem. Do you think that all the issues you have just highlighted will be a barrier to overseas recruitment of the doctors we clearly need?

Dr Nagpaul: I am very worried about that. The last GMC statistics showed that over 50% of new registrants on the GMC register were doctors from overseas. We need to understand that the NHS's new medical workforce depends on overseas doctors. We have, of course, the constraint of the pandemic and international travel, but now there is a market out there. Doctors from Asia—the largest number of doctors who come to the UK—have a choice of going to Australasia, Canada, the USA or other European countries. One of my biggest concerns has been that we have not, as a nation, properly valued and welcomed our overseas doctors. In fact, they have faced hurdles.

During the pandemic, we had to write to the Home Secretary to say that the dependants of overseas doctors who died in the pandemic should have indefinite leave to remain. It is that sort of concern. Doctors who came from overseas had to pay a health surcharge to receive healthcare in the very service where they were providing care to others. It is that sort of obstacle that we have had to face. Visa charges have been hurdles. I could go on; there are lots of bureaucratic hurdles.

As a nation, we should recognise that we are severely short of doctors. We owe a debt of gratitude to those who come from other nations to work in our health service and serve our nation. We need to go out of our way to provide them with a proper induction and a proper welcome, giving them time to adapt and understand the NHS. They do not get that at all. They get half a day in a GMC induction and then they are thrown into a ward or a GP practice, and have to cope. Then they run into difficulties. It is a major issue.

Q89 **Laura Trott:** Thank you, Dr Nagpaul, for coming in front of us today. I want to pick up on a point you made to Dr Evans, around the fact that in your long experience of being a GP your hours used to be longer, but now the intensity of the work is much more. I want to understand a little bit more about why that is. Maybe there are some recommendations that we could make as a Committee to address that. Obviously, you have talked about some of it in terms of patient work and that type of thing, but I would like to give you a bit more of an opportunity to expand on that point.

Dr Nagpaul: When I became a GP 30 years ago, we were called gatekeepers. That meant that GPs would see patients and then refer large numbers to hospitals that provided specialist care. That has been turned completely upside down. Now we manage patients and the whole complexity. When I started out, diabetes was largely managed in hospitals. We now almost exclusively manage type 2 diabetes in the GP practice. We see multi-morbidity. Even in the 30 years I have been a GP, we have seen a significant improvement in life expectancy, but people

have multiple illnesses—diabetes in older age, together with heart disease and mental health issues, maybe dementia. Those all come together.

You are not referring those patients, but you cannot provide that care in 10 minutes; it is impossible. When you try to do that, you are working extremely hard. You are trying to organise tests, which we did not have access to before, but now we are managing those patients. Then you worry about getting it wrong. You worry about missing something. To do it properly, you probably need half an hour. Clinics in hospital traditionally had much longer consultations. It is that impossibility and that intensity.

We are now using telephones to a much greater extent in consultations. That was not the case before. The day has become packed. I do not think there is even such a thing as having lunch. Lunch is having a sandwich while going through about 100 hospital letters and results. That is what lunch has become. The intensity is full on and exhausting. I do not think it is sustainable, which is why we need to look at the workload, the work plan and the way in which doctors work.

The ultimate solution will of course be addressing the work shortages, but in the short term there are things that I believe can be done. Technology is a huge barrier, in the sense that there is a lack of technology. So much that we do could be automated and done much more smoothly, especially between primary and secondary care. We do not have interoperability. We are wasting far too much time on those deficiencies. The barriers between primary and secondary care mean that we have to duplicate a lot of work and do a lot of additional administrative work. It certainly adds to the workload of doctors, both in hospitals and in general practice.

Q90 **Laura Trott:** That is incredibly helpful. Presumably, it is thinking about the slots and what you are likely to be doing in them, and the increased responsibility, rather than just treating them as a one size fits all.

Dr Nagpaul: Absolutely. The biggest transformation is that general practice is now a specialty in its own right. It is managing patients in their entirety. We have seen significant movement of patients from what were traditionally hospital environments and clinics into general practice. We manage the entirety of certain patients for full episodes of care in multiple contexts.

The other thing is that we are providing much more care for the social contacts of patients, which I believe is right. For example, there is the increase in mental illness in the community, with more patients in the community now. When I started out there were psychiatric hospitals, but we now, rightly, look after patients in the community. That is a source of significant work. It takes time, and it is emotionally challenging. You are not only looking after patients in the community with mental illness; you are looking after their families. We are looking after the carers of patients

with dementia. I could go on. It is a very different world today from when I started out. It is a far more challenging and pressured environment.

Q91 **Paul Bristow:** Thank you very much indeed for your evidence, Dr Nagpaul. You said in answer to my colleague, Sarah Owen, that you feel that those who work in our NHS from BAME backgrounds feel less able to report incidences of bullying, and less able to progress in their careers. You said that there are more investigations taking place against NHS professionals from BAME backgrounds, and the NHS, or at least this country, is not welcoming of bringing in doctors and NHS professionals from overseas. Are you saying that you think the NHS is institutionally racist?

Dr Nagpaul: I will phrase it in a more accurate way. There are definite structural factors that result in inequalities for doctors from a BAME background and are added to for doctors who come from overseas. There is no doubt about that. I am not speaking from a point of view or from an opinion. I am only describing the evidence that we have received, both through the BMA and in commissioned work that has looked into the issue. Those structural factors undoubtedly mean that if you come from a black and ethnic minority background you will have both a worse experience and disadvantage in your career.

The evidence is striking. The Royal College of Physicians showed that, if you are from a black and ethnic minority background, you are less likely to be shortlisted for a consultant post. You are less likely to get the job even if you are interviewed. There is something called differential attainment. I am very happy to send you data that shows the impact, and how doctors from black and ethnic minority backgrounds do not progress up the ladder in the NHS. Even for doctors who have trained in the UK, there is a significant disparity in progression between white doctors who have trained in the UK and black, Asian and ethnic minority doctors who have trained in the UK. The disparate effect is not just on those who come from overseas; it is also on those who are trained in the UK.

Q92 **Paul Bristow:** I am very happy to receive some of the evidence and the stats you spoke about. Cutting to the chase, what you are actually saying is that you think the NHS is an institutionally racist organisation.

Dr Nagpaul: I am saying that the NHS institutionally has structural factors that mean there are race inequalities and race inequalities of experience. That is what I am describing under the heading of racist, yes.

Q93 **Paul Bristow:** I am going to take it from what you said that you think the NHS is institutionally racist. It is quite a claim because the NHS is probably one of the most diverse organisations and much valued institutions in this country. Would you believe it is because of that institutional racism, in your view, that more black and minority ethnic NHS professionals have died than those from white backgrounds?

Dr Nagpaul: I will say that we have looked at this in detail, and there has been work commissioned to look at it, as you know. There is no one answer as to why black and ethnic minority doctors, or in fact nurses as well, have died from Covid. What I can say is that the factors would include greater exposure to the virus. We do not have the stats. I was asking for the stats right back in April to try to understand. Is it that black and ethnic minority healthcare workers are more exposed because they are facing patients to a greater degree? Is it that they were in rotas that meant that they were in Covid wards more than others? We do not have that data, but that is one suggestion.

The second is protection, which of course means PPE. We went through months when we really were short of PPE. I have some anecdotal examples of doctors who told us that they were asking their managers for protection and for equipment but it was not forthcoming.

Chair: Chaand, I am sorry, but we have to finish by 11.30 this morning. The PPE issue is very important. To conclude, we are doing an inquiry into maternity safety, and I would be interested in any evidence that the BMA has about the issue of BAME doctors finding it harder to speak up and being over-represented among people who face disciplinary proceedings in GMC tribunals. If you were able to write to us with that evidence, it would be very helpful. We are looking very closely at the issue of a blame culture. That is a very important angle.

I am so sorry to cut you off. There is so much to talk about on these issues. Both you and Denise Crouch have given us absolutely superb evidence. We are incredibly grateful to you for sparing the time. Could you please pass on to your members our thanks as a Committee—indeed I think we speak for the whole of Parliament—for the extraordinary work that you, and the doctor workforce, and, Denise, and the nurse and social care workforce, are doing at this incredibly stressful time. Thank you very much for joining us this morning.

Examination of witnesses

Witnesses: Dr James, Paul Farmer, Professor Dame Clare Gerada and Vic Rayner.

Q94 **Chair:** In our next panel, we have some more fascinating and very expert witnesses. Dame Clare Gerada, as well as being a former president of the Royal College of GPs—I very much enjoyed working with her when I was Health Secretary—is someone who helps a lot of doctors suffering from burnout and other mental health conditions with a service called Practitioner Health Service, or PHS. Dame Clare, what evidence do you have from your work with PHS about the extent of burnout?

Professor Dame Clare Gerada: Thank you very much, and thank you, panel, for taking on this very important issue. I am so grateful to you for doing it.

I have been running a service for 12 years. It was established following the suicide of a young psychiatrist called Daksha Emson, who, before she killed herself, also killed her three-month-old baby. What was called a double suicide led to an inquiry. The inquiry led to drawing out the issues around doctors and mental illness. What I say also applies to a large extent to nurses. It found that while doctors do not have different illnesses—their illnesses are much the same: anxiety, depression, burnout and post-traumatic stress disorder—where they differ is in the accessibility and the ability to seek help and the barriers they have in seeking help. Many of those led to Daksha not seeking appropriate help and ending up killing herself.

Over a decade or so, my service has seen around 13,000 doctors. Since October 2019, we have become England-wide. Up until then, we were only in London. We have seen nearly 13,000 doctors. We currently have about 5,000 active patients on our books. They are doctors with mental illness, not necessarily with burnout; only 2% of our doctors would recognise themselves as having burnout. These are doctors with anxiety, depression, post-traumatic stress disorder and a new problem—moral injury—of which I am sure you are aware: severe emotional distress caused by thinking they are going to be put into moral or ethical conundrums in their workplace.

All specialties come to us. The most frequent and rising specialty is general practitioners. The evidence that Dr Nagpaul gave is absolutely spot on. Most of the support and services during Covid has been predominantly put into the hospital environment leaving—as ever, I have to say—primary and community care to find their own way. It is all specialties, but GPs make up 50% of our workforce. Of note is that pre-pandemic we were seeing about 60 new patients per week, and we are now seeing 120 new patients per week. That is a significant increase in our workload.

Finally, all age groups present, but the predominant age group are younger doctors between about 30 and 35. They are predominantly women, who are over-represented to a certain extent in medicine anyway. We are predominantly seeing young women. As Dr Nagpaul said, we also see increasing numbers of doctors trained overseas. We peaked at 25% of all our new referrals being international medical graduates. It has dropped slightly, but that is indicative of the serious problems that many of them are facing.

That is it in a nutshell. I come at this with significant experience of seeing thousands and thousands of my own kind, and listening to them tell me what you have heard so far from the witnesses, including Denise, Chaand and many others, about the intensity of the workload. It is not the hours worked. In fact, there is some evidence dating back to the 1980s, but continuing, that it is not hours worked per se; it is the intensity of the hours that are worked.

You asked Dr Nagpaul a question about his intensity. Like him, I have been in my own practice for 30 years. You barely finish your morning surgery by the time you start your evening surgery. There is no gap. My father, who was a single-handed GP, way back when, at the start of the NHS, used to go home, have a large lunch, half a bottle of wine, a siesta and then go back for the evening. Please do not quote me on the siesta, although as he is now, sadly, deceased, he cannot be referred to the General Medical Council. But that puts it in context. He was a one in one. His workload was clearly nothing like the current groups.

Q95 **Chair:** Could you paint a picture for non-doctors who are listening to this session? A lot of mental illness is triggered by something that happens in your working day. Paint a picture of what the triggers are for doctors working in a pandemic that push them over the edge.

Professor Dame Clare Gerada: That is a very interesting question. Clearly, everybody comes with their own predisposition and their own risk factors. We all have risk factors. Whether you lost your mother before the age of five, your father abused your mother, or your great-aunt had schizophrenia, we all come with a series of risk factors. On the whole, doctors have fewer risk factors. We tend to be highly intelligent. We tend to have good social networks. We tend to have a good job that is well paid, so we should have lower rates of mental illness than the general population, but we actually have higher rates.

What is going on at the moment in the workplace are constant encounters with death, as you have seen. I have had young doctors telling me that they have seen more death in the last month than they have seen in their entire lifetime. There is the moral injury issue; not being able to see relatives who are dying or having their hand held by their own relatives, in comparison with one's own family where you would be surrounded by family. They have been put into impossible decisions. There are situations such as having to don PPE before doing an emergency caesarean, for example. We see the trauma of Covid re-exposing previous trauma. I am not so convinced that Covid is going to create a lot of post-traumatic stress symptoms. I think it is exposing what doctors already had.

For hospital doctors in the first wave of the pandemic, a lot of trusts put together really good welfare support, as you heard from Denise in Macmillan. There were welfare decompression rooms and teams came together. That tended to act as a buffer. Where we have not seen the same sort of buffer is, for example, in primary care. My colleagues are contacting patients from their own bedrooms and living-rooms. They do not have the support of teams around them. They do not have people delivering doughnuts or whatever, which is what you get in a hospital. The individual risks are much the same as ever, but what we have now is an environment that is primed either to reopen previous wounds or not to give you a chance to recover from what you are exposed to.

Q96 **Chair:** I want to ask you the same thing that I asked Dr Nagpaul. How

important is it for morale for doctors to know that we are training enough doctors for the future, and do you think that is happening?

Professor Dame Clare Gerada: That is probably the single most important thing. You asked Dr Nagpaul whether it is getting worse, or something like that. There have been tracker studies done by the University of Manchester over the last 20 years. It is most certainly getting worse. The intensity of the workload and the amount—this is just on GPs but I suspect the same holds for hospitals—and the fact that you are doing 12 or 15-hour shifts, as well as the fact that you get no rest during that period and you have to do double shifts, particularly our consultant grade doctors and our partner grades where there is nobody to mop up the workload, means that it is vital that we recruit more doctors. It is vital that we get the workforce issue correct. It is vital that we invest in our nursing colleagues. It is vital that we allow people to work to the top of their licence, so that jobs can be done by others and we can start to spread the load.

Q97 **Rosie Cooper:** Good morning, Clare.

Professor Dame Clare Gerada: Good morning. It is nice to see you again.

Rosie Cooper: I was about to say automatically, "Are you well?" Forgive me.

You have described the scale of the impact on doctors. I was wondering if that impact of stress and burnout is felt equally across all levels of staff, and whether those at the bottom, who have the least ability to control their environment, are impacted as much or in different ways. How would you address that?

Professor Dame Clare Gerada: It is different. What I say equally equates to nursing staff, if not more, because nursing staff are much more involved in what I call the emotional work—having to get really stuck in and do the jobs that nobody else wants to do.

Where it is important is for those who have front-facing patient contact. That is where there is most intensity and where most levels of burnout are found. Again, I am very happy to send you evidence. It goes back to the early studies in the 1950s that look at having to create emotional defences against the work that you, the public, task us to do. The closer you are to front-facing patient care, the more likely you are to suffer from emotional exhaustion, lack of compassion and depersonalisation, which means that you have had enough of patients and you become blocked to their emotions.

By the way, Rosie, I always talk about the porter. The porter who has to wheel a dead baby to the mortuary is just as much in need of space and time to talk about that and what he has just done as is, for example, the consultant in ITU who has lost a patient. It is anybody who is doing front-

facing emotional toil. It is more so if you are involved in clinical work, of course, but it should not leave behind all the others.

I am sure you are going to ask me about solutions. The two most important solutions are, first, to address the intensity of the workload, which means addressing the workforce; and, secondly, to allow spaces in protected time where people can come together to talk about the emotional impact of their work, whether those are Schwartz rounds, Balint rounds, reflective practice groups or whatever you call it. We have to come together to do that.

I run a group for those bereaved following the suicide of doctors. If you start to unpick all of that, the lack of spaces to talk about sometimes quite trivial things like complaints or bullying—not that bullying is trivial—and things that happen in the workplace is the single most important thing. It seems ridiculous that we are all working in that emotionally charged space and we have nowhere, unless you pay for it or happen to be a psychotherapist, to talk about what we are doing.

Q98 **Rosie Cooper:** The NHS does not like to think of itself as command and control, but that is exactly what goes on. We hear that people struggle with bullying. I have dealt with many cases of whistleblowing and all the rest of it. There is lots of command and control and bullying, and the pressure mounts. Then you have burnout and the situation we are in now. Do you think we should build in more training to help people with resilience?

Professor Dame Clare Gerada: Please, no more training. If there is anything we have too much of in the NHS, it is mandatory training. We have to be very careful about resilience. Resilience is about bending with the pressure, bouncing back and learning from that. No amount of resilience training or psychological or physical PPE will protect you from a toxic environment. What we actually need at a very senior and very high level is a national wellbeing leader to look at the impact of policies and practices that are put in place in the NHS that make the situation worse. There are many of those. At local, hospital level we need to learn from the Army and what they do in terms of teams, line management and psychological first aid.

I am sure that you do not mean training as a sort of mandatory thing. We need to learn from others and put in place some of what we know is effective from other environments, and give people the time and the space to sometimes vent that it is a horrible place. Not every day is a good day, but if you are given the time and the space, the people and the support to do that, I think we will go a long way to addressing bullying. You will still have bullying in the workplace. I once learnt—I will have to find you the reference—that any space can accommodate 11% of people being bullies. There will always be bullies. It is when they become predominant that it is a problem.

Q99 **Chair:** Dame Clare, a lot of colleagues want to ask you questions, but I

am going to come back to you because I want to bring in our other panellists.

Dr Adrian James is president of the Royal College of Psychiatrists. Dr James, I start by asking you to send our best wishes to Sarah Wollaston, the previous Chair of this Committee, who happens to be your wife and showed a lot of interest in workforce burnout issues.

Life on the NHS frontline is always stressful. What is it about a pandemic in particular that makes it high risk for mental health?

Dr James: Thank you, Chair. I am delighted to be in front of the Committee. Thank you for taking this very important topic so seriously. I would like to frame it as a patient safety issue. I think it is really important that it is seen as something that is primarily an issue for patients rather than for staff.

What is it about a pandemic? I guess that there are the primary stressors and the secondary stressors. There is not much we can do about the primary stressors; there has been a huge increase in the volume of work, particularly for some workers in emergency departments, anaesthetics and psychiatry as well. There has been more uncertainty, and the nature of the work is dealing with people who are in the most stressful circumstances, with people dying in large numbers and in circumstances that we have not seen before—for example, not being able to be with your loved ones at the point at which you die.

In many ways, the secondary factors are more important because we can do something about them. All the people who have spoken so far have made the point very well. It starts with a doable job. It starts with having enough staff. Unless you have enough staff, you could put all the wellbeing processes in place, but if people do not have time to access them and you are putting them back into a job that is simply undoable, they are not going to work. In fact, they can have a very negative reaction.

Q100 **Chair:** Can I interrupt you on that particular point? To take your specialty, you need to know that we are training enough psychiatrists, but we do not have any published projections as to how many psychiatrists we are going to need in 10 years' time. Is that something that you think is important to do so that we can absolutely make sure we all know that we are training enough?

Dr James: It is incredibly important for morale. If people feel that you are going to put in two or three things that are designed to improve wellbeing, but actually the volume of work is just going to carry on increasing relentlessly, it is going to have a very negative effect.

We have a comprehensive spending review coming up. We have put in figures that we believe are realistic on the right ambitions for the NHS in mental health. We have shown that we can recruit more psychiatrists. We have had a Choose psychiatry campaign. We have 100% recruitment now

at the first rung of the training for psychiatrists. We have shown we can do it, if we have the resources. We need to fund more psychiatrists in training.

Chaand made points about our reliance on people from overseas who have done a fantastic job. They have been the backbone of the NHS, but we need to increase the number of medical school places so that we are training our own ourselves. The Royal College of Physicians feels that we need to double the number of medical school places. Those are the sorts of Government responses that we need before we do anything else, in my opinion, because otherwise the demand will continue. The public want the NHS, rightly, to do more and more, but if we do not have the staff, it just puts more pressure on staff and it makes their wellbeing deteriorate even more.

Q101 **Dr Davies:** Dr James, you have rightly focused on the impact on patient safety of the pandemic. This inquiry primarily concerns the wellbeing of those who are working in the NHS itself. Have you seen any discernible struggles? Have you seen examples of colleagues really struggling during recent months?

Dr James: We do a regular members' survey. We did it right at the beginning of the pandemic, and at stages within the pandemic. What we found was that about half of our members said that their wellbeing had deteriorated as a result of the pandemic. As has already been said, there was also a differential impact on black, Asian and minority ethnic doctors and staff generally. We responded to that. We set up a special group that looked at their needs and looked at the particular response that we needed. That included a risk assessment to understand why they are at higher risk of contracting the virus and why we needed to put in special protective factors to ensure that they were safe at work. Feeling safe at work is another prerequisite for good wellbeing at work.

Q102 **Dr Davies:** Absolutely. Have you seen any positive impacts of new ways of working or the general pressures that you have been put under?

Dr James: What we know is that morale at work improves if people have a sense of control over their immediate environment. I do not know anybody who comes to work wanting to do a bad job. You want to improve everything that you do for patients.

One thing about the pandemic was that there was a lot of energy, particularly at the beginning. We had a very clear task that we needed to meet. I am a practising frontline clinician. We had to prepare a part of the hospital for patients who were Covid positive. Everybody was brought together. We knew what we had to do, and solutions were found. I think that was energising. On the part of management, there was renewed interest in the wellbeing of staff. People were much more visible. There was a response from the public. It has always been a very challenging job, but suddenly there was this response and there was free food arriving. People were suddenly arriving with a box of choc ices. It was the

symbolism; people were saying, "We know that you're really up against it." There was that very positive response and a level of innovation.

The other important thing is remote working, which, for many people, has been positive. There is a downside to it. I think we will experience digital burnout. We need a new set of rules around how we actually manage the digital offer, but there is no doubt that it is cutting down travelling and accessibility. At the royal college, our meetings have gone pretty well all online. We found that we had an increase in the number of people joining meetings and things like webinars. It has improved access, so there have been some positive things.

Q103 **Chair:** I want to bring in Paul Farmer to develop the theme of mental health support. Paul, as well as being chief executive of Mind, represents Our Frontline, which runs a text helpline as part of a collaboration between Mind, the Samaritans, Hospice UK and Shout 85258.

Paul, you have done a lot of thinking about mental health policy over the years and helped to craft a number of the reports that have formed the basis of policy. What do you think needs to be added to the support that we currently offer frontline doctors and nurses?

Paul Farmer: Our starting point was the work we produced for the Government: the "Thriving at Work" review, which highlighted the importance of placing mental wellbeing at the heart of any organisation, whether it was in the public, private or voluntary sector. In 2017, Theresa May, as Prime Minister, adopted on behalf of the NHS the recommendations of that review, which I co-wrote with Lord Dennis Stevenson. What has happened in the last six, seven, eight or nine months, in the context of Covid, as you have heard from many colleagues and witnesses already in this session, is that Covid has provided the most enormous wake-up call to the NHS, and to the wider social care sector, about the fundamental importance of looking after the mental wellbeing of your staff.

A number of key elements are proven and shown to have an effect in different employers, different sectors and indeed in the NHS and the social care sector. Some of those have already been referred to by previous witnesses. Clare Gerada and Adrian James have both mentioned these points. Our work with the blue light programme, looking at ambulance, police and fire services, highlighted four or five key elements, and they could become the checklist for any system. A lot of it is about culture change and practice approach as well as individual components. Individual components in and of themselves are really important for individuals, but they are not going to resolve the bigger challenges that individual organisations face from a culture point of view.

A key element is leadership: what is happening on the board of every NHS trust around the mental wellbeing and support of their staff? Secondly, are there enough champions inside the organisation? In that context, we have to think about both acute and mental health trusts and,

as Clare rightly says, individual GP practices, which are essentially small businesses. We know that small businesses can look after the wellbeing of their staff incredibly well. You need champions inside those organisations who give permission for people to speak. In the blue light programme, we found 4,000 or 5,000 people in blue light services who were prepared to act as champions.

Thirdly, you need to tackle the stigma within organisations. Quite a lot of work has happened in the NHS and other organisations around that, but there are still some barriers and challenges that staff face. Finally, do you have a really clear set of offers in place that every member of staff is aware of? That has to be across the full range, not just the clinical support that is going to be hugely important for people who need clinical care but the help that is in place for people who are struggling, to enable them to thrive. Everybody should know what is on offer and what is available.

When we came to the Covid crisis, we worked, as did a number of charitable organisations, very closely day in, day out with colleagues in the NHS and wider frontline workers. We were hearing that people were not clear about what the offers were. This is a classic example of what has happened in the Covid period. It took us six days to pull together something that used to take six months; four charities—Samaritans, the Crisis Text Line service Shout, Hospice UK and Mind—brought together our existing materials to create a simple and easy independent front door for people to walk through. We think that has to sit in parallel to the really important services that are available inside organisations.

Well over 150,000 people have contacted the Our Frontline service over the last seven or eight months. What we heard from people was that they valued the support that was available when they knew about it. They did not necessarily always know where that support was. They also valued the importance of an anonymous space where they could talk openly. One of the texters on the Our Frontline service told us very clearly in their message: "Such a relief to have a non-judgmental, supportive and kind conversation. Text is good because it is discreet and I'm able to express myself better. Volunteer was very kind and helpful and understanding." A second one reads: "Felt very low and our text conversation was enough, a virtual outstretched hand, to pull me up. They asked if I had forgiven myself for my human mistakes. I have taken that into this. Feels okay being me. More than okay. So glad I texted."

It is about how you provide support for people who need a space. It is the combination of all those elements being pulled together into as coherent an offer as possible for every NHS staff member, whether they are the most important doctor or somebody, as Clare said, who is working as a porter in a hospital, and, critically, for people in the social care sector where some of the infrastructure support—I know Vic will talk about this—is harder to find.

Q104 **Dean Russell:** Thank you, Paul, for the outline. My questions relate to the emotional burnout for staff. People often talk about fatigue. It has been an incredibly long year for our incredible NHS and social care staff; they are tired, fatigued physically and mentally but also emotionally. What is the wraparound support over the next few months that you see to help them get through both the second lockdown and what might come afterwards in terms of tiered systems?

Paul Farmer: I do not think there is any doubt that the mental health consequences of Covid are almost certainly going to last a considerably longer time than the physical health consequences for many people. It is important that the approach that is taken takes a long-term view because there are short, medium and long-term issues that people will be facing.

In the first instance, it is important for people to have permission to seek help. You have heard a lot from other witnesses about workload, job control and so on and so forth. Those are really important elements. Permission to seek help is going to be key. Other witnesses have also highlighted the importance of clarity about future workforce arrangements. That is important. At a granular, individual level, can we answer, "Does every single employee of the NHS, and indeed people who are subcontracted by the NHS, and every employee of the social care system, know where they can go to get help?" I wonder whether everybody really does. That is the first thing.

The second thing is that managers and supervisors, in whichever context we are talking about, have the tools to be able to spot the signs when somebody is struggling. You have heard from other witnesses that many NHS and social care staff have extraordinary levels of resilience. A lot of people thrive on the situations that they face on a daily basis, but everybody has their limit. Does everybody know where their individual limits are? Are supervisors and line managers able to spot the signs of the person in their team who may be struggling? Perhaps they become a bit less social. Perhaps the consequence of the digital space is that you have your Zoom face but you do not necessarily show your real face. That is the second question.

The third question, systematically, is, "Does each employer have the right set of metrics in place to understand the quality of wellbeing of their staff at this particular time?" Do we know, from pulse surveys or whatever it might be, how people are feeling, and what additional tools we might need to put in place to support them? We work with many employers across public, private and voluntary sectors. We have seen many employers step up to the mark in the last few months.

Finally, is there a clear pathway for access to clinical care? Does everybody know where Clare's service is, if they are eligible for that? If you are not eligible for Clare's service, where do you go for clinical help and support from the rest of the NHS.

Q105 **Dean Russell:** One of the things we raised as a Committee with Claire

Murdoch previously was about support for NHS and social care workers' families and helping them provide guidance. They may well be spotting the signs in their mothers, wives, husbands and sons and so on. What guidance is being given to those families? With regard to those four points, I appreciate that it is a much lengthier time than we have in the Committee, but are the questions you have just raised being addressed?

Paul Farmer: On your question about families, there is a wider issue, which is the very significant surge that we are seeing in demand for our services from across the public. That is happening at the moment. Shout, the Crisis Text Line service, who are our partners in this, have seen a doubling of contacts in the last three weeks. Our Mind infoline saw a doubling of calls in the last two weeks. That is everyone—friends and family of people working in the NHS and beyond. I think it is important. We have seen services expanding their offer in companies to family members. It would be great if some of the services that are offered through the NHS—some of the apps that have been put online and others—were extended to family members of people who work in the NHS. I am particularly concerned about the social care area.

Q106 **Chair:** Paul, I am going to come back to you if I may. I am sorry, but we have to finish at 11.30, and I am very keen to bring in Vic Rayner to talk about exactly what you have just said, which is the social care angle.

Vic is the executive director of the National Care Forum. We heard from Denise Crouch about some of the stories of Macmillan nurses. Could you talk about the social care sector more broadly in the context of burnout and stress, particularly the pressures on people who may be on the national minimum wage?

Vic Rayner: Yes, of course. Thank you very much for the opportunity to focus on social care. I will start off by talking a little bit about what burnout looks like, particularly in the context of what has been happening with Covid. The starting point is probably to recognise that this is not a new thing for social care. In a sense, there has been quite significant focus on it over recent years. The Care Workers Charity and the National Association of Care and Support Workers have both done very recent research, prior to Covid. The Care Workers Charity highlighted that 42% of care workers felt stressed often or most of the time; 51% considered leaving their role because of the effects of the job on their mental health; 72% had experienced bereavement as a result of their work and saw it having a subsequent impact on their mental health; and 79% of workers in the NACAS survey felt they were close to burnout. We went into the pandemic with very high levels of pressure and stress.

In the context of what has been happening in Covid, a number of things mirror what previous witnesses have said. I also want to pick out some things that are slightly different for care workers. At the beginning of the pandemic, particularly in the care home sector, there were very high levels of death, very sadly, in homes. There was huge pressure around care home staff, particularly in relation to the work that they had been

doing in association with end-of-life care. Often those workers, very sadly, were having to shoulder on their own a lot of end-of-life care that they would previously have done with families, who were not able to be part of that. Often, of course, they were supporting people through the very last period of their life, which is incredibly stressful and emotional for everyone. Many of the things that they might have previously been able to do in terms of going to funerals and having time to grieve after a bereavement were not possible because of the pressure to continue.

I want to mention, as well as the pressures, the positives that, in a sense, have come towards care workers. There has been very specific recognition of them in the pandemic in a way that the role had not previously been acknowledged. We have heard huge amounts about some of the extremities of that: the incredible people who moved into care homes and people who were separated from families in order to protect both their family and the people they were looking after. Of course, those are the stories that hit the headlines, but each and every one of those care workers would have been thinking very carefully and hard about how they could protect the people they were working with, and would have made decisions about isolating themselves and keeping well away from family and friends who might have been their pressure valve or opportunity to connect with to get additional support. That informal support was taken away.

Of course, there is the notion that comes from that of everybody being in this together. It is a wonderful sentiment in many ways, but it is a very pervasive sentiment. If you do not feel part of that, and you do not feel that you can be part of the team because of the pressure you are under, it creates an enormous challenge for people who feel unable to speak out.

There has been lots of focus on vacancies and staff pressures in many of the other witnesses' statements. Of course, that is a pressure that the Committee is very aware of in relation to social care staff and the high levels of vacancies. Skills for Care research that came out last month talked about the percentage of sickness days that people were experiencing. Between March and August 2019, there were 2.7% days of absence through sickness. By 2020, in that same period, it went up to 7.5%. There is huge pressure on people wanting to cover for colleagues and adding extra hours. We have Government recommendations about minimising staff movement, which means that people are working far longer hours than they previously would have been, through overtime and changes to their contract. The things that they might have had in place to rebalance their life and have some wellbeing are disappearing as well.

There was a focus from some of your earlier witnesses on the risks and concerns for their own wellbeing. Of course, that has been very present for care home staff. The Committee is probably aware that care staff generally are often drawn to the profession by caring for people themselves in their own family and life. They often care for very

vulnerable people too. The pressure of, "Will I bring the virus home?" is exacerbated hugely in that context.

I want to mention something that probably has not come up, and is one of the unique situations for social care staff.

Chair: We need to move on to a few questions, so could you mention that briefly?

Vic Rayner: It is about the position of personal assistants and schemes such as Shared Lives Plus. Under the pandemic, those staff will have had almost no respite because additional schemes such as day centres and other areas have been out of play. Those staff, particularly when we begin to think about solutions, are really challenged because that kind of infrastructure is not there, either in a small organisation or indeed in the larger social care sector. It is particularly important that those people get recognition.

Q107 **Barbara Keeley:** Thank you for outlining the mental health challenges for people working in social care. I would like to ask you about a very current point. There has been a great deal of media coverage of the issues in the care sector about lack of visits and the impact it has on the residents of care homes. We have even seen some awful tussles with people trying to remove their loved ones from care homes. What issues is that causing for care staff?

Vic Rayner: Good-quality care is what all the staff want to do. Person-centred care has relationships, connections and communication at the heart of it. Having to stop visits or prevent people from accessing services is hugely stressful for staff. Particularly in the end-of-life context that we talked about, having communication about the impact of the death of a loved one is very emotionally draining. Very unhelpfully, it pits care staff against relatives, when actually the reality is that those staff desperately want to be able to bring in relatives and to enable that support to continue.

Q108 **Barbara Keeley:** Absolutely. You said today that the promise of pre-Christmas visiting and testing visitors at 16,000 care homes will certainly need some extra resourcing and funding. Do you see problems in raising expectations about that visiting taking place, given what you have just said about the impact it is already having when visits do not take place?

Vic Rayner: The point I was trying to make in that context is that it is unhelpful to have something put forward as an opportunity without being clear about the plan that sits behind it to make it possible. Yes, the instant reaction to those statements about visiting by Christmas is that the care home managers and care home organisations that I was talking to were inundated with relatives who wanted to know when it was going to happen and when they could get in. Clearly, there is a real resource issue. In order to administer tests on site, you need to be trained and supported. You need to be able to communicate to people who test

positive and are unable to carry out visits. It is not a straightforward process.

The mass testing sites in Liverpool had very significant support from the Army, for example. I am not suggesting that is the resource route we take, but it gives an indication that there is a significant additional role to be played. You cannot flex staff and organisations never-endingly to take on new roles. They want to do it and they want to make it happen, but we need to get the plan really clear, so that everybody is clear in their expectations and understanding of what the reality will be.

Q109 **Barbara Keeley:** To go back to the point that Paul Farmer made, do care staff know where to go to get help? Clearly, 1.4 million people are a very big workforce, spread across many thousands of organisations. Do care staff know where to go, and are there indications that they are getting any of the help they need?

Vic Rayner: We have been talking with our members about that. There are some great practice examples out there where individual employers are taking the lead and thinking about bringing in mental health first aid training, for example, for all their staff. They are thinking about doing pulse surveys and being clear what the metrics are. Those organisations, in essence, become the best practice examples—the shining lights. There is absolutely not a clear understanding of what that kind of almost occupational health support should be across organisations.

I was co-chairing the workforce advisory group for the Government taskforce on Covid. One of our clear recommendations was that we needed some significant investment from Government in an occupational health scheme that would enable all care staff to get access to things that are currently seen as best practice. As the Committee will be very aware, lots of very small organisations do not have the ability to put in place wellbeing schemes and the things that are so vital.

Paul's point about leadership is important. We have 22,000 managers out there, and we are very reliant on them being able to pick up the signs and signals, knowing what to do when they pick up those signs and signals, and then, in essence, being properly resourced and funded as organisations to do the right thing. If what you find out from that is that people need long-term mental health support, how are you going to access it? How are you going to pay for it and how are you going to create a work environment for them to be able to come back successfully to carry out their role?

Q110 **Dr Evans:** I have a very quick question for Professor Gerada. With me and James both being GPs, we are probably the only two who could ask this question. I am interested in the professional side. Having seen the general public and now dealing mainly with doctors in terms of their mental health, is there a type of personality that is vulnerable by choosing to go into medicine and the stress that comes with it? Is there any evidence to back that up? You have the added advantage of being

able both to see them clinically and to work with them. The simple breakdown is that a lot of medics are type A personality. Do you think that fits?

Professor Dame Clare Gerada: Yes. Doctors are chosen for certain personality traits. We are perfectionists. We are obsessional and we tend to be slightly narcissistic. Actually, those three personality traits make us into the good doctors that we are, because it means that you do not leave behind a patient for your own needs. You try to make sure that you do your absolute best. There is also evidence by the way, not just in doctors, that perfectionism is increasing among younger people. There is a fabulous study that looked at perfectionism over 16 years, not just medical students. It has increased. We see that in our own culture.

Can you predict who is going to become mentally unwell? No. Should you even try? No. The only predictive factor is if you have had mental illness in the past, but then you would hit against serious discriminatory processes.

Thank you for asking the question. Can I quickly come back, because I struggle with this as well? Where do the rest of the staff go to get help? There is this thing called general practice, with which 55 million people are registered. What I am concerned about is, first, that we are not investing in occupational health for primary care; we do not have it at all. Secondly, my practice is within a quarter of a mile of a large teaching hospital, and we see a lot of NHS staff. If you take services far away from where people know, no amount of comms or information is going to let them know they exists. A call service is fabulous, but if you are going to invest money in mental health services, we have to look at primary care.

Q111 **Dr Evans:** You mentioned perfectionism, and I would agree with that. We have heard in the past that one of the biggest problems is that we are not allowed to make mistakes in the medical world. How do you think that factors into burnout?

Professor Dame Clare Gerada: We are not allowed to make mistakes, and you put perfectionists into a place where we positively want perfectionists, so there is an ever-diminishing circle of people trying harder and harder.

We have to learn from Winnicott. He was a fabulous paediatrician who talked about the good enough mother. He did not mean that you were a bad mother. He said we had to be good enough. We have to ensure that we deliver our best, but you can never deliver perfection. One of the biggest problems that we see in our service at the moment is the rise of perfectionism among younger doctors who stay longer and longer in order not to make errors. We know, and you know as a fabulous GP, that general practice by its very nature is imperfect. The diseases we see are just not clearcut. We get into the swampy lowlands with patients, where there are no technical solutions. We have to create a culture, as you heard from the rest of your speakers, right across the board, not of

accepting imperfection—I am not saying let's be sloppy—but where perfectionism itself is ironed out of the system. It is impossible.

Q112 **Chair:** Thank you. I wonder if there is going to be a sequel called "The Good Enough Politician".

Professor Dame Clare Gerada: There should be. We should all be striving for good enough. The Fat Man said the same thing in "The House of God".

Q113 **Taiwo Owatemi:** My question is for Paul Farmer. You spoke a lot about the effects of stigma and healthcare professionals being able to access support. Last year, a BMA report found that staff are more likely to seek support outside the workforce than internally. What can be done to address stigma?

Paul Farmer: The example we found from working with the blue light programme was to encourage each organisation—in that case, individual fire services, ambulance trusts and police forces—to adopt a pledge at leadership level. In that case, it was the "Time to change" employers' pledge. We would recommend the mental health at work commitment that organisations can sign up to very easily. It is a very clear sign of intent.

Secondly, from all the work we have done across both the time to change programme and the blue light programme, we know about the active ingredients of tackling stigma within the workplace. This has been well discussed in other areas, but it is best done at individual employer level by employers. As a result, for example, of the blue light programme, which was essentially an employer anti-stigma programme for blue light staff over a four-year period between 2015 and 2019, the number of people who said, "I can openly talk about mental health in my organisation," went from 29% to 64%. The number who said, "My organisation supports people who experience mental health problems," went from 34% to 53%.

I think we have shown that we can do that with a tailored programme that specifically thinks about particular aspects of a particular workforce. The support from leaders is brilliant. The BMA takes a lead. Professional royal colleges and NHS management absolutely see it as important. That leadership, backed up by being able to answer the questions that I outlined earlier and being able to measure that, would give every NHS organisation a good chance of being able to address the issue.

Q114 **Taiwo Owatemi:** You spoke about the importance of its being organisation to organisation. What metrics and additional tools should organisations be using to understand the mental wellbeing of their staff? How should they be looking to implement it?

Paul Farmer: Like Clare, I have a bit of an allergy to mandatory training. It is something we have to be very careful about. Quite often, people suggest that you need mandatory training in these situations. However, I

think there is a role in looking at the organisation and thinking about a scorecard approach that looks at the negative factors. Sickness absence around poor mental health is often cited as the most obvious factor. I think because the stigma is diminishing—it is not eroding completely—people are more honest about reporting mental health sickness absence. That is an obvious metric.

We need to look at more positive indicators. There are examples in staff surveys: "Do you feel that you are in control of your workload? Do you feel you are well supported by your line manager?" Those kinds of indicators are also important. The civil service has put together a really effective scorecard that looks at the mental health of their workforce, and others have done similar things. Adopting a similar kind of approach at individual NHS employer and indeed social care employer level would be really helpful.

People have found it helpful. It must not be a stick for organisations. It needs to be an incentive. We have found from all the organisations that we have worked with that standing over people and saying, "You will behave better around your wellbeing," does not work. It is about creating a culture of encouragement and bringing in best practice.

Q115 **Taiwo Owatemi:** All members of the panel have spoken about the importance of NHS staff knowing how to access the mental health services that are currently in place. Given that we are going through a second phase, how do we ensure that all mental health staff know exactly how to access the services that are available in their own trust?

Paul Farmer: A number of employers are doing brilliant work around that, but it is a leadership issue for each individual employer in the NHS system, as well as the NHS as a whole entity, to promote it and encourage people to be aware of what is available for them. We have seen real progress so far, but we worry that at the moment there is not quite enough visibility of the support that is available for people.

Q116 **Neale Hanvey:** Dr James, I would like to explore some issues with you. Certainly, in my experience in the NHS there is unrelenting pressure to find savings and keep costs constrained: "That's the financial envelope and there's no more money." We have heard this morning that you can implement many support services, but if you do not have enough staff when you return to the ward, it creates pressure.

We have spoken to folk, and I have experienced it, who, for lack of a better description, put a brave face on things. They do not acknowledge the problems that they face. In the context of the pressure that it is never going to get any better than this, so you just have to put a brave face on it, what is the consequence for someone who is facing that unrelenting pressure but feels that they just have to behave in a way that is together?

Dr James: Clearly, it has a major emotional impact on them. They will be much more likely to develop a mental illness, particularly anxiety or

depression. If they are also subjected to some of the greatest trauma, they might develop post-traumatic stress symptoms. If you look at post-exit interviews, 11% of people cite burnout and stress at work as a reason why they left. Dr Nagpaul said earlier that higher numbers of people are thinking of leaving the profession. It has an impact on them; it has an impact on patients, and on staffing levels altogether.

There has to be a hierarchy of response. First and foremost, as we said, it is the workforce. Do we have enough people there? Then it is safety at work. That may be physical safety in relation to Covid. Is there enough PPE? It is psychological safety as well. Are you in an organisation that is positive and does not have a bullying culture, and can you speak up? Do you actually have the basics? Do you have an opportunity to have a break? Do you have a safe space where you can talk about how it feels to be working in social care or in the health service? Do you have reflective space? Can you talk with people who are having the same experience, maybe with someone working with you to say, "Look, let's reflect on what is happening"? Most importantly, do you have the time to do that? The people plan is amazing. Chapter 2 about looking after yourself is very positive, but if I am honest I think a lot of staff will look at it and say, "We just don't have time for all of that."

I was thinking of the programmes we used to have when there was a new building in the NHS. There was 1% for art. I do not know if we still have that programme. The trouble is that the wellbeing offer can often be lost, and I wonder whether we need to have something like 5% for wellbeing, and its being seen as a contributor to patient care and not taking away from it. There are pressures on the NHS. As politicians, you drive us to do more for patients, and that is right, but it is not just the numbers of people being processed. It is how the doctor, healthcare professional or care worker, when they put their head round the curtain, feels about themselves, so that they have the ability to provide the best possible care for you.

Q117 **Neale Hanvey:** How do we get to a place where frontline staff and senior managers, and even chief executives, feel that it is okay and safe to say, "This is not enough," or, "This is a problem"? How do we get to that place?

Dr James: I am a great fan of quality improvement initiatives. We have had some real success in the mental health world, for example in reducing restrictive practices. We tend to have a system in the NHS whereby we identify a problem—it could be lack of wellbeing; we identify some of the issues and send a directive round saying, "Do this and do that," but we do not actually have a process to follow through on it. Using quality improvement science is a good way of doing that.

It starts with having board-level sign-up that it is something important, maybe with a board sponsor. In the end, it empowers staff on the ground, perhaps with a quality improvement coach, to look at what works for them. I have two children who are junior doctors. I speak to lots of

trainees in psychiatry and across the whole of medicine. They generally know what the answers are.

To answer Paul's question about whether people know how to access help, they know what they actually want to access, and you need to empower them to be able to do so. They also know the simple things that make a real difference, such as access to reflective space, as I said, and a safe space, whether online or in person, to reflect on what is happening. Again, there are the important cultural issues. If you empower staff working together on the frontline, they have a sense of control and mastery over what they are doing. They generally have the solutions, but they need high-level backing. I would like to see the people plan being underpinned by methodology to ensure that we can actually follow through on it.

Neale Hanvey: That is enormously helpful; thank you very much.

Q118 **Rosie Cooper:** This is slightly off-piste, but I wondered whether any of the panel would like to comment. So far today, we have talked about the many pressures associated with hospital discharges, PPE and testing, but how, for example, are care home staff expected to cope with their consciences and deal with frontline families when "Do not attempt resuscitation" orders are imposed on care homes, or there are restrictions on residents' access to hospital? All those things are completely outside their control. Who is there to defend them, defend the patient and help the staff?

Vic Rayner: It is a very important point in terms of all the pressures that you mention and the many wider pressures that managers and frontline staff experience. I guess I would just respond to that by saying that I do not think the position we are in at the moment is okay at all. A lot of the witnesses have referred very helpfully to the NHS people plan, but I do not think it is okay that we do not have a detailed plan for the 1.6 million people who are working in social care. They have been broadly feted by society, communities and politicians, yet we are in a position where we do not have an outline about what we expect from employers on occupational health support, recruitment, training and indeed pay, which I know this Committee has focused on previously.

We need to get ourselves to a position where we have a fundamental commitment to protect them and make sure that they are supported to do their job, whatever situation they face in the context of their own mental health and wellbeing. We need to protect them and support them so that they do not experience the kinds of things we have heard about today in relation to burnout. We have to have the people plan. We have to resource it properly and make sure that those staff are recognised, not just in claps and commitments but by getting the proper support and resource in order to do the job that they desperately want to do.

Q119 **Rosie Cooper:** Thank you. Do other members of the panel want to comment? It is bad enough being subject to pressure in your day-to-day

work, without things that are completely on the border of being illegal, where you are the frontline and have to implement them but you do not have the control to be able to stop them. Who actually stops that kind of illegal behaviour?

Chair: We have reached 11.30, and we are going to have to draw things to a close. I will ask Clare Gerada to make a brief comment on that, and then I am afraid that we have to wrap up.

Professor Dame Clare Gerada: I think you are referring to moral injury. There are many people who can talk to you about that, including Professor Neil Greenberg and Professor Simon Wessely. I am not sure whether they are giving evidence.

I am not sure that anybody has been involved in illegal behaviour, but I think it might be about behaviour that might go against their moral and ethical code, as you have heard from many of the witnesses here.

Chair: Thank you very much indeed. That is a very important note to end on.

To our witnesses in the second panel, Paul Farmer, Dame Clare Gerada, Vic Rayner and Dr Adrian James, a very big thank you for your excellent evidence. Thank you, Dr Chaand Nagpaul and Denise Crouch, for the evidence in the first panel. You can hear from the bell that we now have to move on to Health questions in the Chamber, so thank you very much for joining us this morning. That concludes this morning's session.