HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Industrial action in the NHS, HC 1341

Tuesday 9 May 2023

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Watch the meeting

Members present: Steve Brine (Chair); Lucy Allan; Paul Bristow; Chris Green; Mrs Paulette Hamilton; Dr Caroline Johnson; Rachael Maskell; Taiwo Owatemi.

Questions 1 - 89

Witnesses

I: Matthew Taylor, Chief Executive, NHS Confederation; Sir Julian Hartley, Chief Executive, NHS Providers; and Danny Mortimer, Chief Executive, NHS Employers.

II: Pat Cullen, General Secretary and Chief Executive, Royal College of Nursing; and Dr Emma Runswick, Deputy Council Chair, British Medical Association.

Examination of witnesses

Witnesses: Matthew Taylor, Sir Julian Hartley and Danny Mortimer.

Q1 **Chair:** Good afternoon. This is the Health and Social Care Select Committee. We are today meeting in one of our one-off topical sessions. We are talking about the industrial action by nurses and junior doctors. We will focus on that ongoing action with our guests, whom I will introduce in a minute. In our second panel we will be talking to the Royal College of Nursing and the British Medical Association.

The purpose of our session this afternoon is to explore the union demands relating to pay and the ongoing negotiations, the ways in which that may be resolved, and the impact, of course, that that is having on the NHS and our constituents, and the pay review body process, which, as I am sure our guests and some of those watching will know, we have looked at before. We have also had the head of the NHS pay review body in before us.

The reason we are doing this is because the NHS is going through a very challenging period of industrial action. The ONS report there was a total of 16 days of strike action affecting the NHS in England between December 2022 and January and February of this year. It seems that the reported number of rescheduled appointments because of strike action was at least 93,000 outpatient appointments, almost 19,000 elective procedures, almost 28,000 community service appointments, and over 9,500 mental health and learning disability appointments. So there was a significant impact on the service that we are charged with scrutinising as this Select Committee.

In our first panel today, we have Sir Julian Hartley, chief executive of NHS Providers, Danny Mortimer, chief executive of NHS Employers, and Matthew Taylor from the NHS Confederation.

Matthew, before you were at the NHS Confed, you were the chief executive of the Royal Society of Arts, and you worked in government as a political strategist to Labour Prime Minister Tony Blair. You also appear on my favourite radio show, "Moral Maze", on Radio 4.

Matthew Taylor: It is not really your favourite radio programme.

Q2 **Chair:** Tragically, it actually is. It is really good. Anyway, I digress.

Sir Julian Hartley, you joined NHS Providers as chief executive in February 2023, so you are relatively new in post. Before that, you had been chief executive at Leeds Teaching Hospitals since 2013.

Mr Mortimer, you have been chief executive of NHS Employers since November 2014. Apparently, you worked as a porter in the healthcare system before you worked in executive roles in hospitals in Hertfordshire and Nottingham before you joined Employers. You are all very welcome. Thank you very much for coming in today and talking to us.

If I might start with you, Mr Taylor, you said in April, "This strike is going on much longer than expected and will have long-term consequences for patients." It begs the question: how long did you expect the strikes to last?

Matthew Taylor: I did not have a particular time in mind. I could see at that point that things were trailing on and there did not seem to be an end in sight. My reflection on that specific issue of the length of how long this has gone is that there was a long period of time when the Government did not seem to be willing to negotiate about last year's pay settlement. We felt that it was both right and inevitable that that negotiation would happen in the end, and, of course, it did happen in the end. Our job as representing leaders is not to take sides in these disputes, but, certainly, some of the impact could have been lessened had the Government come to the negotiating table earlier in relation to the "Agenda for Change" unions. At that point in April, we were continuing to call on the Government to enter into those negotiations.

Q3 **Chair:** It was just last month that you called for ACAS to get involved in the junior doctors' strike. Given the gulf that there is between the starting point and the Government's view on the 35% demand of the BMA, how could they help?

Matthew Taylor: I think that is precisely what they are there for. They are there as a body in relation to situations like this where there does not even seem to be a basis for talking. Now, the Government and the junior doctors have gone down a different route, but I guess the idea behind the proposal—and, of course, ACAS were used the last time we had a junior doctors' dispute—was precisely to try to find a basis for going forward. The point about ACAS is that they cannot get involved unless both sides invite them to get involved. So the very act of inviting ACAS in at least starts to open up something in a dispute that felt, at that point, completely intractable.

Q4 **Chair:** Yes. There have been more positive signs in recent days, have there not, in that dispute? On the hope-ometer, where would you say you feel about the junior doctors' dispute at the moment?

Matthew Taylor: I would be keen to pass that one on to Danny on the detail of it. Certainly, at least there are talks about talks, which is better than where we were a few weeks ago.

Q5 **Chair:** Indeed, which the Academy of Medical Royal Colleges was calling for to help in that, which is quite a rare intervention, I suppose, by them.

Danny Mortimer, the title of your organisation sounds positive—Employers—but not quite. What role do you have to resolve this?

Danny Mortimer: The Government set annual pay and they also set mandates for periods of contract reform. In recent years, the Government have invested in, for example, reforming the contract for our specialist doctors—our non-consultant, career-grade doctors. NHS Employers operates within that mandate on behalf of the NHS and is

responsible also for running the collective mechanisms that oversee the various contracts that we have.

In this recent period, we have had a couple of roles. One has been, in particular, in supporting our members, employers in England, in terms of how they respond to industrial action, how they plan appropriately for that and how they work with their staff and their trade unions in particular to respond to that.

The second is that in the recent "Agenda for Change"-based talks we provided a supportive role. The Government led those negotiations, but we were part of the discussions in the agreement that was reached between the Government and the "Agenda for Change" trade unions, and we were there to represent the interests of the NHS as the employers of the staff.

Q6 **Chair:** It is fair to say you were pretty unimpressed with the recent court case that the Government and the RCN had, and you had to ask the Secretary of State to refer that to the lawyers.

Danny Mortimer: We did. We believed that the day in question, last Tuesday, was outside of the mandate that the RCN had for industrial action, and acting on behalf of our members we were not able to challenge that ourselves. It was not feasible for individual trusts to challenge it. We asked the Secretary of State to get involved, and slightly reluctantly he did.

Q7 **Chair:** Okay. Finally on this opening exchange, Sir Julian Hartley, thanks for being here today. Are your chief executives just bystanders in all of this? On pay, that is a negotiation between them and Government and between the pay review body, so there is a process. My understanding of the first junior doctors' strike when I was at the Department of Health as a parliamentary aide to Jeremy Hunt is that, yes, it was about the contract, but it was about lots of other things as well. This one, so we hear on the media, whether it be the nurses or the junior doctors, seems to be the same. There are lots of other gripes about employment. Are chief executives standing by a little bit when, actually, they could get a bit more involved and get down in the weeds of this with the people whom they employ?

Sir Julian Hartley: That is a really key question, Chair.

Q8 **Chair:** Is it a fair question?

Sir Julian Hartley: Let me answer it. Trust chief execs, and indeed all trust leaders, are absolutely invested in ensuring that we have a resolution to these disputes. Although they are not responsible for setting pay and the pay negotiations, I know, because until recently I was one myself, we absolutely have a huge interest in the wellbeing of and the support for our nurses, doctors, professions allied to medicine, porters and cleaners—the hundreds of different roles that make up the NHS. The

NHS only works effectively when you have all of those colleagues working effectively together with that strong sense of shared purpose.

Trust chief executives are absolutely invested in the importance of good workforce relations, which is why when we speak on their behalf we are urging these issues to be resolved. The danger is that, the longer they go on, some of those tensions that can develop between different groups in hospitals can play out locally, and that is not where we need to be. We need to be bringing people together to drive the priorities that the NHS faces right now.

Q9 **Chair:** Could you give us some examples of the softer-side stuff, if you like, that sits alongside pay that really grates?

Sir Julian Hartley: Absolutely: regular conversations with colleagues about things like some of the hygiene factors, car parking, lockers, hot meals out of hours, flexible travel, flexible working, childcare, leave arrangements, special leave, compassionate leave, and also other benefits—added benefits. Many businesses will support NHS staff with a benefits booklet, health and wellbeing, and offers of support. Given the significant public health crisis we have been through with the shockwaves of covid, many staff need and deserve that additional support, and that comes in many forms. Lots of trusts have done a lot for their health and wellbeing offer as well as health and fitness. So there is quite a lot that comes together.

It is not easy to define, but crucial among all of that is the creation of a positive culture in the organisation that is being led by people like me. It is that sense of the board being absolutely connected to the concerns of frontline staff and having a way of organising your trust so that those issues and concerns are factored into the trust's planning, they are thinking them through, they are engaging staff networks, they are focusing on things like the concerns that our BME networks in many trusts have and the concerns of disabled staff. There are many things that come together to create a positive and proactive environment and culture. That matters to people coming to work, and it matters to staff who work in the NHS, as well as all those other factors that I have gone through.

Q10 **Chair:** But those factors are not in the control of the Secretary of State, are they?

Sir Julian Hartley: No, they are not, but I know that it is important and of interest to national leaders that there are healthy cultures throughout the NHS. We see, don't we, the challenges that some organisations have when the culture is not as I would describe? The importance of that in the context of the work that is being done currently, for example, by NHS England on an improvement-led approach rather than just relying on a traditional performance and management approach is crucial in this regard.

The idea that you engage frontline teams in finding solutions to the challenges and learning the lessons from those organisations that have done this very well, both here and indeed globally, is a key part of the job of leaders at this time. But I return to the point that, when there is a pay dispute, trust leaders need and want to see a resolution so they can continue to attend to all the other factors that make working in the NHS so vital.

Chair: We are going to move to colleagues now. Before I do that, does anybody have any interests they wish to declare? Caroline, first.

Dr Johnson: Thank you. I declare that I am a consultant paediatrician and also a member of the British Medical Association. I worked at Nottingham University Hospitals at the time that Mr Mortimer was the director of HR. Since we are discussing industrial relations, while I was working there and he was a director of HR, I took the trust to tribunal in a case that I won.

Rachael Maskell: I am a former physiotherapist with 20 years in the NHS and a trade union rep at that time, head of health at Unite for a number of years, and a member of the staff council at that time.

Mrs Hamilton: I am a retired nurse now and I worked in the Royal College of Nursing for a number of years.

Chair: Marvellous, thank you. Paul Bristow, you are next.

Q11 **Paul Bristow:** Thank you, Chair. Sir Julian, have any patients died, in your mind, as a result of the disruption caused by industrial action?

Sir Julian Hartley: We have no evidence to support that, and I think it is incredibly difficult in any way to establish cause and effect. My experience and my knowledge of how trusts have gone about this is, no. 1, to prioritise patient safety and quality, particularly during those industrial action disputes. That means an absolute laser-like focus on those key risk areas like emergency department, critical care, ITU, maternity, and paediatric intensive care. The issue for patients—and, Chair, you have outlined a significant number of rescheduled operations—is that it pushes back patients who have already waited a long time given the impact of covid.

Q12 **Paul Bristow:** It would seem reasonable, if you are waiting for a serious cardiology operation, for example, that a lack of surgery may cause a myocardial infarction or heart attack and that patient may die. Surely, that makes logical sense.

Sir Julian Hartley: Indeed, but the process that trusts go through is to make sure that they are prioritising clinically those patients who require those priority interventions. Even in periods of industrial disputes, certainly in my own trust we were able to make sure that we were dealing with the top-priority cases to keep things like major trauma, urgent—

Q13 **Paul Bristow:** You are saying you do not think any patients have died as a result.

Sir Julian Hartley: I do not know the answer to that. There have been commentators and there are anecdotes, but in terms of a clear evidence base we need to wait to judge exactly what that is telling us. Certainly, there has been major disruption and there have been lengthy waits. Of course, when patients are waiting longer for treatment, there are inherent risks in that, but the job of the NHS is to identify and prioritise those patients who are at risk and ensure that their care is dealt with.

Q14 **Paul Bristow:** The eminent cardiologist Dr Richard Grocott-Mason is quoted as saying that "it is only right to warn that some patients will inevitably die due to the cumulative impact of delaying hundreds who are on the waiting list for surgery." Is he right to say that?

Sir Julian Hartley: That is his view and his experience. Certainly, he is highlighting some of the big challenges there. What I can say is that the focus for all trusts is about safeguarding patients' safety, quality and experience wherever possible, albeit that that means that other patients have to wait because staff are being moved into those key, urgent areas in order to keep the hospital safe during those strike periods. That has been challenging. I would not pretend otherwise. Many of our members have said how challenging and difficult that has been. However, they have worked constructively with staff-side colleagues to make sure that, where necessary, interventions are made if they are struggling with staff, and we have seen examples of that as well.

Q15 **Paul Bristow:** Mr Mortimer, Dr Arjan Singh, who is the chair of the BMA's North Thames junior doctors committee, is quoted as saying to his members that there are no legal requirements to tell hospital managers that they are going on strike and that industrial action has thrown payroll departments into such chaos that doctors may not see their salaries docked. Do you think that is ethical advice to give to members?

Danny Mortimer: There are two things there. The first is that Dr Singh is absolutely right that any worker who is taking strike action has no legal obligation to tell their employer that they are planning to take the action. The assumption that most of my members have worked with is that, if they ask the question and they are not given an answer, the person probably is taking strike action and they plan accordingly.

The advice around payroll deductions is mistaken. That would be my principal observation. I am sure my colleagues later will be able to confirm that deductions have been made where people have not attended work because of strike action.

Paul Bristow: Thank you very much.

Chair: Rachael Maskell is going to talk about the pay review body now.

Q16 **Rachael Maskell:** I will start with you, Matthew, to talk about the pay

review body. The pay review body process has had some challenges over time, but it has largely worked when there has been stability in the economy. However, of late, obviously we have seen instability and a high cost of living, and there is now no confidence on behalf of the trade unions in the pay review body. How do we move forward from this point?

Matthew Taylor: First of all, you have to understand that the pay review body has to work, broadly speaking, within the parameters that are set for it. When there is a big gap between the perception of what is affordable and the aspirations of the trade unions, the pay review body's job is particularly difficult.

Having said that, I think that over the years the pay review body process has worked reasonably well. Danny will have a stronger view than me, I suspect, on this, but I would not see any reason not to believe that it cannot still play an important role going forward. But there will be times when there is a sense that, as I say, the gap between what the pay review body believes is realistic in view of the overall situation facing the health service and the aspirations of workers comes apart. That is when the situation occurs, as we have seen now. You are also right that, in a situation where inflation is volatile, the gap between a review body sitting and reaching its recommendations and then what unfolds in inflation is also a factor.

Q17 **Rachael Maskell:** Thank you. Danny, can I turn to you?

Danny Mortimer: We face two things. The first is that the brief that is given to the two pay review bodies that we work with in particular, the PRB and the Doctors' and Dentists' Review Body, is often so narrowly set that the pay review bodies are not asked to go much further than recommend pay awards. We have now had the consultant contract for 20 years and "Agenda For Change" for slightly longer, as you will know. Actually, those contracts need updating and modernisation, and the pay review body needs to be given greater scope to say that Employers, trade unions and the Government should work together to improve these areas of the contract. The limited terms of reference it is often given prevent it from doing that, and we would really welcome that role.

The second thing is that the crisis of confidence that trade unions have has been magnified by the recent cost of living crisis that the country has faced. Trade unions have also had more than a decade of the Government, as Matthew said, giving very limited scope for investment to all pay review bodies. This is not unique to the NHS. It is seen across all nine pay review bodies across the public sector. There is the sense that the trade unions were patient for quite a long period when Mr Osborne was Chancellor in terms of "restricted" settlements or scope for restricted settlements, and that restriction for the pay review bodies again across the public sector, and not just in the NHS, has continued.

While the NHS has been able to agree some additional investment with the pay review bodies for "Agenda for Change", for SAS doctors and for

junior doctors some years ago, trade unions have lost confidence. It is really important that we find a way through the conversations that the Government are having in the various contracts to commit to processes that rebuild that confidence for our trade unions in particular in the role of the pay review bodies, because the whole point is to avoid the kinds of disputes that you are having to spend time this afternoon looking at.

Q18 **Rachael Maskell:** Sir Julian, is the challenge placed on the remit that the pay review bodies are issued with, and should there be more latitude within the pay review body to reflect the real economic situation?

Sir Julian Hartley: I think that is right. I would echo the points that Danny has made, and also the timeliness of it to ensure that they are able to make those decisions and enact them in real time rather than what we are seeing with some of the delays. That is crucial. The points Danny has made are absolutely right.

Q19 **Rachael Maskell:** I would like to extend it a little bit. Disputes are often dressed up in the end as a bit of a tug of war where there are winners and losers, but that is very unhelpful in the current context. What is behind a lot of the dispute is clearly the retention crisis in the NHS and increasing options that are there for people under much stress and with low morale, who are then taking the decision to leave employment. Of course, the cost of living is feeding into that as well.

As a result of that, is there more that Employers could do in order to support that very core which has come from the workforce that the retention issue needs to be addressed first and foremost, and that this year's settlement has not fully addressed that?

Sir Julian Hartley: There are a number of things we talked about earlier in the discussion about what Employers can do: first of all, to create a positive culture for staff where they feel they have a sense of belonging and purpose and that they are well supported; secondly, that, other than the pay issue, which is negotiated at a national level, there is an opportunity for staff to feel that they have career development, that there are good training opportunities, that the organisation they work in supports that training and development pathway so that they see promotion opportunities; and also that we maximise the use of the apprenticeship levy so we are getting a pipeline of new staff into trusts as well as retaining our existing staff.

There is a connection. In every town and city across England, the NHS plays a crucial role as an anchor institution where it has a responsibility to its people but also to its community. Indeed, many of our staff would go into local schools and give talks about working in the NHS and the importance of that, and create a sense of real mission around the difference it can make. I have worked with fabulous colleagues and in your professions represented round the Committee's table as well as many others, and I still believe that there is that unique sense of real purpose, drive and energy that NHS staff have, but the tank is running

empty in terms of discretionary effort because of the challenges that we face.

It is all about making sure that we rebuild that sense of really strong commitment. To do that, we need to get over the pay dispute, and we need to really focus on the needs of our people and our workforce. We are hoping for the long-term workforce plan soon. That should give us some indications of a more strategic approach to workforce development and indeed some of those retention points that you made. Training, retention, different forms of flexibility and recruitment—that sense of being part of the community and creating those opportunities—are all key elements of what Employers locally can do.

Q20 **Rachael Maskell:** Thank you. Danny, retention and pay are not disjointed; they are very much two sides of the same coin. How has the resolution that has been achieved to date in the NHS really resolved that issue of keeping those staff in their jobs in the NHS?

Danny Mortimer: I would also add to Sir Julian's remarks that the workforce plan is really important, as I will come on to talk about, and that is not to minimise what my members have to do around retention. It also speaks to the fact that, increasingly, our staff are telling us, and Pat and Emma's members will be telling them, that they are not always able to do the job that they want to do for their patients. That is not just under the control of the employer or the local health system. That is about a failure of investment in health and social care over quite a long period of time now, and those are important factors.

In terms of the retention piece, absolutely the "Agenda for Change" deal recognises, because the trade unions wanted it to recognise and the Government were very supportive of this, that there are things we need to do around career development, particularly for nurses and midwives. There are things we need to do around maximising the use of apprenticeships, as Sir Julian touched on. There are things we need to do around protecting our staff from violence in particular, and there are a whole series of actions around retention we need to take forward.

While we are waiting for the plan and while we are pushing the Government to commit to having a publicly available, fully funded plan, there is absolutely a sense in which that plan will challenge my members to more consistently address the support they offer new starters in the workplace, the access they give people to career development, and to more consistently apply the agreements we have reached with our trade unions around access to flexible working.

We know, and we accept, that there is far too much variation in staff experience within organisations and between organisations around those things. Depressingly, those things were a factor when you were the head of health at Unison.

Rachael Maskell: Unite.

Danny Mortimer: They are still a factor now. We are better than we were, but we are still not where we need to be in terms of offering the best experience to our people. As I said, the plan will challenge us to do way, way better and to take more consistent action in those places.

Rachael Maskell: Thank you.

Q21 **Chair:** Julian, you touched on the pay review body with Rachael. It seems that if it did not exist it would have to be invented. In repairing it, I just wonder if you would expand on—you touched on it—the timetable of the pay review body process. What used to happen is that the remit would come out late summer/early autumn, this would then report, and it would be presented at a spring budget, whereas that process has got later and later, and then it is backdated, which adds to anxiety. Presumably, for trust chief executives trying to write their budgets for their year ahead, we are now well into this fiscal year, and they do not know what their budget looks like. So everything knocks on from that. Is it fair that repairing the PRB means getting the timetable back?

Sir Julian Hartley: Yes, absolutely right. The point you just made about financial planning is a crucial one. The NHS is under an incredibly challenging financial position right now. Chief execs and finance directors are looking hard at this coming year. Certainty around pay awards and also those pay awards being fully funded is a crucial point. The timeliness point is a key one, because to plan effectively and to do the things that trusts want to do for their workforce you need certainty and you need as few unresolved problems or issues as possible in order to get on the front foot with recruitment, retention and things that we have been discussing. That is an important message.

Q22 **Chair:** You mentioned a good point there about being fully funded, because the 3% rise announced by the previous pay review body report that the Government accepted was fully funded. Are you satisfied that trusts are clear how the 5% for the "Agenda for Change" cohort, which has now been imposed, we understand, through ministerial direction today, is funded?

Sir Julian Hartley: So far, we know that NHS England are funded for 3% of that, so that leaves 2% to be funded. We need the clarity on that. All of us have said that that is required as soon as possible. It is important that the NHS is not expected to deliver more efficiency savings, because the efficiency ask this year is a hugely significant one. Some NHS organisations are having to deliver up to 7%, 8%, 9% cost improvements. ICBs are being asked to take out 30% headcount. The NHS simply does not have the room to bridge that gap, which is why we have been calling for that funding to be made available centrally in order to make sure that it is there to support the pay award.

Q23 **Chair:** The Government said when the NHS Staff Council accepted the "Agenda for Change", "There is already funding available for up to a 3.5% pay increase within DHSC existing budgets. Funding on top of that

will come from a combination of reprioritisation and additional funding, which is new money for DHSC." Are any of you any clearer on that?

Matthew Taylor: No. There is a further ministerial assurance that this will not have an impact on frontline services. Given precisely Julian's point that that implies if the money is not made available it is not going to affect frontline services, there is an assumption that this can somehow be found through the bottomless pit of efficiency savings. As Julian says, we are already stretching credibility in terms of the efficiency targets that we are pursuing.

Q24 **Chair:** Of course, efficiency savings, when they materialise, never happen as quickly as you might hope they would, and they need to happen yesterday for this.

Matthew Taylor: Especially in a service that is woefully underfunded in capital terms. Some of the things you could do to improve efficiency rely on capital investment, and that is even more problematic, arguably, than revenue expenditure.

Q25 **Chair:** At some point we are going to look at the new hospitals programme, which is the big capital promise, as you would imagine.

Danny Mortimer: The financial flows, as always, are complicated. Money flows to trusts and other providers through public health local government contracts as well as NHS contracts, as I am sure you know. We also see, particularly in mental health and community services, a lot of non-statutory organisations like charities and community interest companies that provide services, and they need certainty about how the money will flow to them as well. While they may not be my members, we know that they are always concerned that they get forgotten about in how the money, if it is available, does flow, and the flow through local authority contracts like sexual health, alcohol and substance abuse treatment is really important.

Chair: Thank you. We have a couple of colleagues, and then we are going to change panels because we are trying to wrap up this session by 4 pm because of the statement in the House on the primary care access plan today, which I would love to get your view on if we have time, but we probably will not. Paulette Hamilton, over to you.

Q26 **Mrs Hamilton:** Good afternoon. My question is to Sir Julian Hartley and to Matthew Taylor. Unfortunately, Danny, I do not have a question for you this afternoon.

Chair: He is gutted.

Mrs Hamilton: Basically, I read about the future action, and let me just say what you said. Dr Arjan Singh, a member of the BMA's junior doctors committee, told Sky News that the BMA has very close relationships with the RCN. In response, you said, "A co-ordinated strike would be completely unprecedented, and it would be more challenging to plan for,

manage and mitigate all the enormous challenges it would present with the service that it is with."

With that in mind, my question is this. The RCN has announced its intention to ballot for strike action on a national level rather than a local level. What difference would that make in terms of the impact of any strike action?

Sir Julian Hartley: I guess the first thing to say from my point of view would be that it would be, if there were to be co-ordinated action, but, having listened to Pat, who I think you are seeing next, she is saying there are no plans for a co-ordinated action. From a trust perspective, having both valued colleagues—junior doctors and nurses—out at the same time would create an unprecedented situation. So we will see what the outcome of a national ballot will be for the nurses.

Q27 **Mrs Hamilton:** My question to you is: give me a couple of examples of what it will create, because it is a big statement, and at the end of the day you had to have something in mind when you made the comment.

Sir Julian Hartley: I will give you a sense that even for any of the strikes that we have previously undergone—we have had a number of those, as the Chair said, in terms of industrial action—every time we have been through those, and I was running a trust during January and February, we would have to do a load of detailed planning to understand how we were going to manage those key areas like emergency departments, critical care and so on, and work out which staff we could use to cover those. In the case of junior doctors, it would be consultants acting down. Obviously, with nursing staff, we had to make sure we were covering with a range of other staff, and indeed some nurses who were not part of the industrial action.

We had to plan and then contact patients whose operations, procedures or appointments we would have to cancel and rearrange, because we knew we would need those staff elsewhere. The logistical exercise was absolutely enormous as well as the cost of paying consultants to cover shifts and so on, and paying staff to cover rotas. Then there was the co-ordination of all of that to protect patient safety, and on the day having the whole command structure of bronze, silver and gold commands to manage on an hour-by-hour basis.

It is worth saying at this point though that that co-ordination at a national level between the RCN, BMA and NHSE around critical incidents and responding to those has worked in terms of making sure that that has been given a real priority. If we are doing all of that for junior doctors walking out and then, say, nurses walking out, imagine that the two together is going to give us fewer options to be able to cover the gaps that that would create, which is why I talked about it being unprecedented and really challenging to manage. I know a lot of the colleagues I represent would shudder at the thought of having a co-ordinated action in that way given the challenges that that would present.

Q28 **Mrs Hamilton:** Thank you. Matthew, I am going to ask you the same question, the reason being that I have worked on and off where I have been to conferences and things. Like yourselves, the NHS Confederation is a reasonable body. You really do try to look at ways to prevent this. I support what nurses are trying to achieve because I have been one. I have been on the wards and I have struggled when we have not had enough staff. It is not about money. This is about the fact that many of our nurses out there are burnt out before they get to 50 and they are leaving the profession ill. On the back of that, for a nurse and a doctor to say, "We are going to join together to come out because we do not feel we have been heard," what would the NHS Confederation like to add to that discussion?

Matthew Taylor: I do not think there is anything that I can add to what Julian has said. It is about the level of preparation and planning that leaders have to put in. It is about the added complexity. I was in a hospital in north Bristol on one of the days of the junior doctors' strike. One of the reasons they were coping, albeit coping recognising that they had had to cancel many operations and outpatient appointments, was because of the flexibility of those people who were in work. So you take another tranche of those people out and a situation that you can cope with.

The general experience of industrial action has been that, through a combination of trade unions standing by their mitigations and the preparation and work that leaders have put in, we have coped on the days of industrial action. The public, to be honest, has also played a part by tending to use services less intensively on those days. The problem has been the effect that it has had and the figures that you used, Chair. The figures I have are much higher than that for cancelled operations and outpatient procedures.

What I would say very starkly in relation to what Julian has said with regard to our ability to cope day to day, albeit having knock-on effects, is that all bets would be off if we were in a situation where both the junior doctors and nurses were striking. The situation would not just be, "How do we cope for the day despite the knock-on effects?" It really would be incredibly difficult to maintain patient services to guarantee patient safety.

Q29 **Mrs Hamilton:** I just want a one-word answer. Is this what is being told to Government?

Matthew Taylor: I think we have made it repeatedly clear, first, that we have a great deal of sympathy for the case that the trade unions make. We recognise, exactly as you suggest, that it is not just about pay. It is about working conditions and morale, but, on the other hand, we have also been very clear about the effect this industrial action has on the service, which is why we have called pretty consistently—our two organisations have never disagreed at all—for ways of trying to resolve these disputes and to avoid further industrial action.

Mrs Hamilton: Thank you.

Chair: Thank you, Paulette. That was short and snappy, as always. We have two short and snappy questions from Caroline Johnson first and then Taiwo.

Q30 **Dr Johnson:** You talked just now about the danger to patients, both from delayed appointments and the risk of safety caused by these strikes. You have talked about the RCN sticking to its mitigations.

Unusually, with this most recent strike, they did not have a derogation for intensive care, A&E, neonatal and children's intensive care, as we would routinely have expected them to have. Unfortunately, the mitigations may have been stuck to by the RCN, but they were not necessarily by the staff themselves.

On 1 May Nick Hulme, the chief executive of East Suffolk and North Essex NHS Foundation Trust, was on Times Radio saying that his intensive care unit in his hospital had to reduce the number of patients because, despite the mitigation given by the RCN, the nursing staff who were asked to come in to cover that mitigation chose not to arrive, and chose not to come in to work that day. That was their right because it was a mitigation and not a derogation.

As the Government consider minimum strike legislation in order to preserve patient safety, which particular areas do you think the Government should ensure—regardless of who is striking—always have that minimum level of service cover so that patients are kept safe?

Matthew Taylor: I am sure that Danny and Julian will have their own view on this, but my view would be that, generally speaking, the system has worked as well as could be expected in relation to patient safety in terms of derogations and then most recently in terms of mitigations.

However, as I think leaders have said to me over the months, ultimately, this industrial action makes it more difficult to maintain the kinds of relationships you want with your staff. While in the vast majority of cases leaders were able to agree the arrangements they needed to agree in order to protect patient safety, inevitably, with hundreds of individual employers, there are going to be points at which it breaks down. It is very unfortunate when it does. I do not think any leader wants to be in the situation where relations are not able to address those kinds of issues.

Specifically on the legislation, our view would be that given the derogations and mitigations that the trade unions have put in place—and which, as I say, have overwhelmingly held through the last difficult few months—I am not sure that we see the legislation as being relevant in terms of improving the situation or further industrial action in the health service.

Sir Julian Hartley: I am not sure that we need additional legal frameworks here. At the heart of this, my own experience has been—

notwithstanding the example you gave from Nick Hulme's trust—that those local relationships between trust leaders and local RCN, BMA or other staff side colleagues are the ones where you get sensible decisions made focused on the safety of patients about how you manage those eventualities. Anything that brings in a potential issue between employer and employee in a legal framework around a minimum strikes Bill or their employment rights and so on risks creating unnecessary tensions.

As a general point, there has been incredible progress, despite this industrial action, that the NHS has made, for example, on recovering the backlog. There has been a 90% reduction on people waiting over 78 weeks from the high watermark in September 2020-21. That is a huge effort, despite all of those days of industrial action and all the challenges we have faced.

It is much better to have that local engagement and working between employer and staff side colleagues around industrial action than bringing in a legal framework that could, potentially, make things more difficult rather than easier.

Chair: I am going to jump over to Taiwo, if that is okay. I know you have only asked one question. I know you are going to come back in the second panel. We will find out on Thursday about those figures in the NHS. We have to move to the next panel. I am sorry, Caroline.

Q31 **Taiwo Owatemi:** I am particularly interested in preventing strike action from happening in the first place. Julian, earlier you spoke about the importance of having good workforce planning and good workforce numbers. That is a key factor in staff retention.

Would you say that delays in the Government producing a workforce plan would potentially impact the prospect of future strikes happening, due to staff being burnt out?

Sir Julian Hartley: I think it is a factor. Obviously, we cannot underestimate the impact of the cost of living crisis and the erosion of NHS staff pay, given that environment. That has been a key issue. But you are absolutely right to flag the importance of a clear strategy for workforce development and growth, with the number of vacancies we have across the service and how a lot of staff feel about the pressure under which they are working. There is the importance of having a good 15-year plan with clear annual milestones where we can hopefully see some improvements in staff satisfaction surveys, the level of recruitment and retention, and a reduction in sickness absence. All of those things are about the experience that any NHS employee has in their workplace. It is their experience of their line manager, their sense of belonging and their sense of esprit de corps. All those things matter. Those are the things that the workforce plan will give us. Crucially, it will help us to invest and fund the growth in the NHS workforce that we need for the future.

Q32 **Taiwo Owatemi:** That will definitely help with creating stability within the NHS. I have one last question. The pay review bodies are due to

report in the coming months. What would you like to see in the report?

Danny Mortimer: The "Agenda for Change" pay review body will receive a communication from the staff council to say that an agreement has been reached which has been implemented. There will be a slightly different set of observations from the pay review body in light of that.

With the Doctors' and Dentists' Review Body, it will clearly be more material given the fact that we have not seen meaningful negotiations yet between the consultant committee, the junior doctors committee and the Government.

There is clearly some outstanding business for the Doctors' and Dentists' Review Body from last year. There are some observations that the DDRB made, particularly in relation to pay for junior doctors that the Government chose not to implement. I would expect the pay review body to return to that.

Q33 **Taiwo Owatemi:** Can you give us some examples?

Danny Mortimer: The junior doctors agreed a multi-year pay deal with NHS Employers and with the Government. The Doctors' and Dentists' Review Body last year observed that the final year of that multi-year deal was not fit for purpose and that the Government should, in effect, make an additional payment on top of the agreement that the doctors had reached with us three or four years ago. The Government chose not to do that. Undoubtedly, that is something the DDRB will return to.

The DDRB may well point to some of the things I touched on in my conversation with Ms Maskell, which is that there are other factors at play here, not least the workforce plan. I think everybody has been very clear with the Doctors' and Dentists' Review Body, and with the Pay Review Body as well, that the fact we have not seen the costed plan, or a plan in England with numbers in it for 15 years, has a profound impact on the availability of the workforce. In simple terms, we are not educating and training enough health and social care staff to work in our sector. Clearly, that impacts on how people feel. I would expect the review bodies to comment on that.

Chair: So much rests on the workforce plan. There is general agreement on that, for sure. Sir Julian Hartley from NHS Providers, thank you very much. Danny Mortimer from NHS Employers and Matthew Taylor from NHS Confederation, thank you very much for your time.

Examination of witnesses

Witnesses: Pat Cullen and Dr Emma Runswick.

Q34 **Chair:** This is the Health and Social Care Select Committee. We have a one-off topical session this afternoon looking at industrial dispute in the NHS across the "Agenda for Change", with nurses and junior doctors.

We have two very well-known voices. We have Pat Cullen, who is general

secretary and chief executive of the Royal College of Nursing. Welcome. We have Dr Emma Runswick, the deputy council chair at the British Medical Association. Thank you so much for coming.

We are going to finish by four o'clock as there is a statement in the House on the primary care plan. That is to give you a sense of where the time is.

I will start with you, Pat. Last week the staff council made its decision. The ministerial direction today has implemented the "Agenda for Change" agreement. Are you now quite isolated among health unions? You recommended this to your members, and they have thrown it back at you. Are you quite isolated now at the RCN?

Pat Cullen: No, Chair. I would not agree with that at all.

Q35 **Chair:** Why not?

Pat Cullen: The 300,000 nurses that I represent in the NHS have made it very clear that this offer does not meet the requirements that they have put forward. Let us be clear. The ruling council of the Royal College of Nursing did recommend the offer because there were elements of that offer that we still want to continue to pursue with the Government.

For example, one of the key areas that our nursing staff have constantly raised as part of this dispute is around safe nurse staffing. We have said very clearly that we want to have the safe nurse staffing framework that we were able to negotiate as part of the framework left on the table.

We have also heard from our NHS representatives who have just spoken to say that the "Agenda for Change" framework is not fit for purpose. It is out of date. It is 24 years old. The people who have done least well out of that are our nursing staff. The majority of our nursing staff sit in the lowest band within "Agenda for Change". In fact, it is 62% of them, and they remain there, Chair, for probably most of their career. They do not have any opportunity to move forward.

We put that to our members, because it was not for me to take a gamble with the money that was put on the table for our members. We did have the largest turnout in the ballot. While it was close, the majority of our members rejected the offer. They said that the one-off payment was, in their words, "quite a cruel thing to do". It was to give them money this year as a one-off bonus, and then remove it from their pay packets next year, so they were back to where they started. The 5% is well below inflation. It does not meet the requirements in relation to the long-term issues that we have within the profession around recruitment and retention.

In many ways it was selfless of those people who voted in that ballot. What they were saying was, "This is about the long-term plans within the NHS. It might put money in my pocket, but it is not going to address the recruitment and retention issues as we move forward."

Q36 **Chair:** When it comes to the legal dispute—was that only last week? No, it was probably the week before, was it not?

Pat Cullen: It seems like last week.

Q37 **Chair:** They merge into one. You said that on the legal dispute it was not for you to gamble with that money. If we look at what the judge said in that case, he ordered you to pay £35,000 costs for that hearing. He said that the union had showed "a high degree of unreasonableness". These are quite unusual words from a judge. He said that the outcome was inevitable and, instead of grasping the nettle and conceding, the RCN had forced the case to court.

Who is going to pay £35,000? That is coming out of your members' subs; right?

Pat Cullen: I want to correct that, Chair, because it is not. It will be coming out of other moneys within the college, but it is certainly not coming off our members.

Q38 **Chair:** What money?

Pat Cullen: We have a lot of commercial income. There is a distinction in terms of our income within the college, but that is neither here nor there. I think it was a sorry and sad state of affairs for any Government to take their nurses to court. We did describe it as a dark day, Chair.

Q39 **Chair:** I heard you say that, yes.

Pat Cullen: Yes, it was a dark day, but what I would say is that the Government's own Act and the explanatory notes are at odds with each other. Let us not go into that now, but let me tell you where I am sitting with this.

The dispute was over 20 hours. If you look at what happened in Scotland and Wales, they both granted a three-month extension for our members to continue their action, while this Government disputed the 20 hours. We moved on. We certainly did not take action outside the legal parameters that are set for us. Our members worked within that, and they continue to do that.

We are now about to embark on our second six months of mandated strike. I ballot members on 23 May for the next period of six months if we cannot get a resolution to the current dispute that our members have.

Q40 **Chair:** Yes, "if". We will come on to that ballot in a minute. When was the last time that you were personally in a room with the Secretary of State?

Pat Cullen: I wrote again to the Secretary of State last week, again urging the Secretary—

Q41 **Chair:** You say you wrote to him.

Pat Cullen: Yes, to ask for a meeting. So I am waiting patiently for that meeting to happen.

Q42 **Chair:** Okay; that is still to happen. When was the last time that you were actually in that room together?

Pat Cullen: It was at the end of the negotiations, which I was involved in for the first week.

Q43 **Chair:** Why did Unison, the Royal College of Midwives, the Chartered Society of Physiotherapy and the GMB union accept it, and Unite and the Royal College of Nursing did not?

Pat Cullen: I respect those members, Chair.

Q44 **Chair:** Are they wrong?

Pat Cullen: They will all have their own reasons for doing it. What I am here today to talk about is that it did not meet the requirements of the 300,000 nurses whom I represent. I respect their decisions. Again, you will have to look at the fact that two of the largest of the three unions in the NHS staff council—us and Unite—rejected the pay offer, or our members did. That is the position we are in.

Q45 **Chair:** You wish they had not.

Pat Cullen: No; I trust our members impeccably. As a nurse, alongside my colleagues, I believe they always make the right decision. They believed that that deal was not fair and reasonable. They accept, alongside me, that there were some elements of it that we wished to take forward, but in terms of pay it does not address the issues that I have just talked about.

Q46 **Chair:** Of course, that deal is going to appear in pay packets, is it not? It is being imposed.

Pat Cullen: It is going to be imposed.

Q47 **Chair:** The staff council have voted for it.

Pat Cullen: Yes; that is right. We have said to Government as well—and urged the Government as a royal college—to take nothing off the table but please add to it. That is what we need to do to resolve this dispute.

Q48 **Chair:** On the strike action, the thresholds and the voting, the BMJ said 102 of 215 trusts reached the turnout threshold. That is not even half, is it? Now you are going for a national ballot, I understand. I am not sure why you did not in the first place, but I am sure there were reasons.

Bearing in mind that it was 54 against and 46 for on your members voting for or against the "Agenda for Change" deal, are you hopeful that you are going to get a successful re-ballot vote?

Pat Cullen: What I am hoping for is a resolution to the current dispute. That is really important. If we get a resolution to the current dispute, then we would not see our nursing staff having to take to picket lines again. I have spent a lot of my hours out with our nurses on picket lines, Chair. Their stories are harrowing.

These people are not villains. They are desperate to try to sort out the real problems within the NHS. They want to address the real problems we have within the profession, to do the very things that our NHS reps before us talked about. It is getting people treated in a timely fashion and being able to get back in to their work and look after their patients.

Q49 **Chair:** I do not recall anybody saying that your members were villains. Nobody around this table has ever said that. I have never heard anybody say they are villains. The question I asked you is, are you confident that you will get a successful national ballot for strike action?

Pat Cullen: That will be entirely up to our members. What I am saying, Chair, is that I think if you were to test the temperature of the mood within the nursing staff, they feel in desperation for someone to listen to them. If the only way they can get listened to is through industrial action, then I would suggest that may be the only way.

Q50 **Chair:** But almost half of them voted to accept the deal and move on, so why would they vote for more strike action? It is counterintuitive, is it not?

Pat Cullen: Over half rejected the deal. We had the highest turnout in that ballot in the history of the Royal College of Nursing. We cannot ignore their voice, nor can we ignore the 46% who, for all their own individual reasons, accepted that pay offer. I talked to many of those people who were actually taking industrial action at the end of April and beginning of May. We cannot ignore their voice either. Let us take them all with us and do the right thing for them.

Q51 **Chair:** Finally, before I open this up to colleagues, neither of you—the Royal College of Nursing nor the British Medical Association—is called a union, but both of you are acting very much like a trade union.

Is there a case, Pat Cullen, for some sort of split within the RCN that separates out the professional body side of what you do and the trade union side of what you do? From what I see and hear of you right now it sounds very trade union.

Pat Cullen: May I correct you, if that is okay?

Chair: Please.

Pat Cullen: We are a special trade union. We have special trade union status. We are very proud to be a professional organisation as well. That is why, if you look at the underlying principles of the dispute that our nurses have taken forward, it is around safe nurse staffing and ultimately being able to move to safe nurse staffing legislation.

The two arms of our royal college are what I describe as conjoined twins. Both survive as one. One is as important as the other, and one does not trump the other.

Q52 **Chair:** Fine. You are perfectly entitled to correct me. Many do. Dr

Runswick?

Dr Runswick: I would echo that. In the BMA, we are also a special registered body. We are both a professional association and a trade union. They are not at all in conflict. One of the major issues underlying the pay dispute for junior doctors, but also for consultants and other doctors, is about the workforce. It is about being able to provide timely and high-quality care to patients, which we know that they deserve. It is about burnout. It is about all of the other issues that we know are affecting me and my colleagues in work every day.

Pay is part of that, for which we require the trade union side, but we are also pursuing on our professional association side the workforce plan. That is still unpublished. We are pursuing the covid inquiry. We are substantial contributors to that. There is quite a lot of work going on around public health, health inequalities, gambling and so on. All of that work is a healthy part of our association and as important as the trade union side.

Q53 **Chair:** Finally, there were some positive signals coming out of conversations between the BMA and the Government last week. I thought there were much more conciliatory messages from both of you. Would that be fair? Am I reading that correctly?

Dr Runswick: I am cautiously optimistic. The progress is really very slow. We opened up this dispute back in October. We made our demands, or requests, for pay restoration early last summer. It took all the way until the first round of industrial action, despite multiple warnings that we were planning to ballot and would call substantial industrial action and then take industrial action. We had a half-hour meeting with the Secretary of State, which very rapidly collapsed due to unreasonable preconditions on the Secretary of State's side.

We then had a further round of industrial action. Only now are we in a position where we have had talks about talks. That is definitely positive and I am cautiously optimistic about that, but the pace here is painfully slow.

Q54 **Chair:** You said it was slow, but you did say there was progress.

Dr Runswick: Absolutely.

Q55 **Chair:** I am clinging to that right now, Emma.

Dr Runswick: As am I.

Chair: Excellent news. Paul Bristow.

Q56 **Paul Bristow:** Dr Runswick, it was revealed that the social media feed of Dr Martin Whyte, the deputy chair of the junior doctors committee, promoted videos that claimed the Holocaust was a hoax and he joked about "gassing the Jews". Do you think this is an appropriate individual to have been in a leading role in the BMA and involved in this industrial

dispute?

Dr Runswick: Clearly not, which is why the BMA acted extremely quickly to suspend him from all roles. There is an ongoing investigation through our usual code of conduct and resolution processes.

I do not think that is reflective at all of either the wider BMA positions on this or indeed BMA representatives, in exactly the same way that you would not consider the terrible actions of some Conservative MPs to be a reflection on you. I do not think that is a reflection at all on the BMA or the vast majority of my 70,000 junior doctor colleagues in England.

Q57 **Paul Bristow:** How did an individual like this rise to a leading role in the BMA?

Dr Runswick: We have a democratic election process. It is certainly obvious that he was not open about those opinions or whether he still holds those opinions.

Q58 **Paul Bristow:** It was on his social media feed. It was publicly available.

Dr Runswick: Sure, but I am not sure that thousands of people, when they are voting, are scrolling through the social media feeds of people several years ago to check every single tweet, Facebook post, Reddit post and so on. It is just not possible to do that, particularly for those of us at the younger end of the spectrum whose social media profiles can be very prolific.

Q59 **Paul Bristow:** The Campaign Against Antisemitism have reported this individual to the GMC. Do you think they are right to do so?

Dr Runswick: It is absolutely within their right to do so, absolutely.

Q60 **Paul Bristow:** Do you think it is right for them to do so?

Dr Runswick: I personally think it is right for them to do so. The BMA has its own disciplinary processes, which we will pursue.

Q61 **Paul Bristow:** Putting yourself in the Secretary of State's position, would you sit down and negotiate with a racist?

Dr Runswick: Martin Whyte was never on the negotiations team. The Secretary of State has met with our negotiations team last week and we have made progress.

Q62 **Paul Bristow:** Pat Cullen, to what extent do you think what most people would consider to be an excessive pay demand at 19% would have contributed to the rejection of a very reasonable 5%?

Pat Cullen: Our members do not believe that 5% is reasonable. It is significantly below inflation. With 10 years of pay erosion for our members, they are starting from a very significant deficit.

I have been on record many times saying that I have never asked, and nor did the Royal College of Nursing ask, for 19%. That was not our

policy position. What I did say was that we would get into a room and negotiate. We asked for 5% above inflation. That was our policy position set by our ruling council. We were going to negotiate from there, but I am certainly not on the record as ever asking for 19%.

Q63 **Paul Bristow:** There was clearly a lot of media coverage around 19%, so there was clearly a lot of noise around 19%.

Pat Cullen: There was.

Q64 **Paul Bristow:** I guess the question I am asking is, if your members were led to believe that they may get something nearing 19%, to what extent you think that motivated people to think, "Oh, wait a minute, 5% is nowhere near that."

Pat Cullen: I think our members are entitled to 19% because their pay has been eroded by 20% and the cost of living has significantly increased. Our nurses are really struggling. That is shown, is it not, by the recruitment and retention issues we have?

Q65 **Paul Bristow:** You encouraged them to accept 5%.

Pat Cullen: Well, again, as I answered the Chair's question, it was not for me to decide that I was going to withhold money from nurses who are really struggling to pay their bills. The money that was on offer to them could be the difference between them having a roof over their head next month or not. That is the reality for nursing staff at this point in time. So 19% was not a policy position by the college. Do we believe that they are entitled to 19%? Yes, we do.

Q66 **Paul Bristow:** What worries me—this is the last question—is that, very reasonably, if individual members hear the figures 19% and in the junior doctors committee 35%, if they hear these two figures, and then suddenly both trade unions settle for something which is much more reasonable, I do not think it is any surprise that they turn around and reject it. That is my concern.

Do you not think it would be more appropriate to come in at a more realistic number and to have ended this dispute much earlier than we did?

Pat Cullen: Look, I am very hopeful that we will get back into a negotiating room with the Secretary of State. I am waiting on a response to my letter last week. With all due respect to the Committee, I respectfully will negotiate in that room and not publicly, or not in the Committee, if you don't mind.

Q67 **Paul Bristow:** Will you be asking for 19%?

Pat Cullen: Again, as I have said, I will not negotiate with yourselves, if you don't mind.

Paul Bristow: Thank you.

Dr Runswick: Might I come in on the assertion on pay restoration? Pay restoration for junior doctors would cost approximately £1 billion. That is a drop in the money of Government expenditure overall. We have seen far more spent on many other items in the health budget, let alone in the wider Government budget. We do not think that is unrealistic or unreasonable at all.

Q68 **Paul Bristow:** It is taxpayers' money.

Dr Runswick: Absolutely.

Q69 **Paul Bristow:** It is not insubstantial at all. It is £1 billion. It is a lot of money.

Dr Runswick: For Government spending, that is completely reasonable. It is an excellent investment in the 70,000 junior doctors who are the workhorses of our health service and provide care.

Q70 **Chair:** Just following on from that 35%, in the same way as the £14.09 campaign for the BMA has been very heavily disputed by Full Fact, the 35% has been heavily disputed by the IFS—who I presume you respect—who say, "A more accurate figure for the fall in junior doctors would be 11% to 16% in the last 13 years."

Dr Runswick: I am happy to share with the Committee payslips of junior doctors that say, quite clearly, it is £14.09 an hour. We are happy to share those with you. We are also happy to share with you the calculations that we have made. We have had quite public methodology about how we have come to the pay erosion figures for junior doctors in England. It is 26.1%. We are using RPI because it includes lots of costs that are very prominent for junior doctors—for example, housing—in a way that CPI does not.

We are starting at the beginning of our pay erosion process in 2008, in the way that the IFS has not. We are using RPI because it is used for our student loans; it is used for Government gilts; and it is used for the uprating of many Government taxes. I would very heavily defend our methodology that has got to 26.1%. If you take 25% away from something, approximately, then to return it to full value—the pay that we had in 2008—you have to give back a third. It is completely realistic and reasonable to ask for that.

Q71 **Chair:** Full Fact said, just going back to the £14.09 campaign, that it was potentially misleading, if it is taken to mean the typical pay for the average junior doctor. When challenged by that campaign and what Full Fact said, the BMA said, "Of course, our campaign is not suggesting £14.09 is the hourly basic rate for all junior doctors, as this title covers everyone from newly graduated medics to people who have been working for eight to 10 years or more as doctors."

You are happy to correct the record that the £14.09 was for a specific cohort.

Dr Runswick: It is accurate for over 10% of junior doctors who work at that grade. Some junior doctors have been practising for 15 years or more, and they might be paid £28 an hour.

Q72 **Chair:** All I am saying is that 10% is not all junior doctors.

Dr Runswick: Absolutely, but Full Fact also did a number of interesting things, in my opinion. They included, for example, holiday pay. It is illegal to roll up holiday pay, for obvious reasons. I would dispute their figures as well and very robustly defend ours. We are happy to share the methodology. It is publicly available on our website.

Chair: We can access that. Over to Rachael Maskell.

Q73 **Rachael Maskell:** First of all, I convey my appreciation for what your members do every single day, but I am also concerned that they are working in a very unsafe environment every day. We have the minimum service levels Bill before the House of Lords this week. That is obviously seeking to achieve, during periods of industrial dispute, minimum service levels. However, that is often not achieved on other days.

What impact do you think that Bill will have on your relationship with Employers and being able to achieve minimum service levels, if I can start with the BMA?

Dr Runswick: Absolutely. Just like you heard from Employers, Providers and the Confederation, we do not think that legislation is at all necessary. Patient safety is a really high priority for the BMA. It is a crucial priority for the BMA and for all of our members, including me. I am a working junior doctor. I am not just representing others. We are all working doctors as representatives of the BMA.

We have and have used, both in 2016 and in the recent industrial action, an arrangement for major and critical incidents with NHS England. We have received only one request for a derogation through that process, which we granted. When our junior doctors went in for that derogation, we found that consultants and SAS doctors—specialists and others—had already appropriately staffed. We were able to revoke the derogation so that those people could come out on strike again.

We do not think it is at all necessary. There is already life and limb cover in legislation. We have existing protections. However, it does put us in a very difficult position with Employers. It might be the case that a service level is set entirely without consultation with our members and is imposed on Employers. Employers are then in a position where they are being forced to take disciplinary action against staff—medical, nursing and other staff such as dental staff—in a service which is already dramatically understaffed. I think that would be unconscionable, even before you get to all of the other problems about this legislation.

Q74 **Rachael Maskell:** Pat Cullen, I put the same question to you.

Pat Cullen: I was particularly pleased to hear the NHS reps before saying that this legislation will go as far as driving a wedge between Employers and the people that they employ. I think that is right. Our nursing staff would dearly love to see the emphasis and the conversations that we have now about safe nurse staffing on days of strike happening every day of the year. It is our nursing staff who carry that burden, and it is really a burden when you go on to a ward and find that half of your nursing workforce is missing every day and every night, and you are doing your utmost to try to carry that responsibility. You are trying to keep your patients safe, reduce the risk as much as possible and make sure that you get through all of the current treatment that you are trying to provide that day.

Then when they go off—and our surveys from the RCN are evidence of this—80% of our nursing staff tell us that they leave their shift knowing that they have left care undone. Who suffers as a consequence of that? Our patients suffer, as our nursing staff do, because they cannot have time off without thinking about what is happening to their patients. Will this minimum legislation sort that out? Absolutely not. It is actually sending a very negative message out to our nursing staff.

Chair, I was not suggesting for one minute that you are painting nursing as villains, but there is certainly a rhetoric out in the wider public that suggests that nurses have somehow turned their backs on patients. That is not the case. This legislation will not do anything to bridge the gap between Employers and the people that they employ.

Q75 **Rachael Maskell:** My concern at the end of this dispute, or where we have got to, is that the big issue—as both of you have referred to—is staff retention. Of course, pay is a major factor within retaining staff and stopping staff from going to agency or indeed leaving employment altogether.

In your dealings with the Secretary of State, although I understand they have been limited, how has he engaged with the issue of relating pay to retention and maintaining safe staffing levels for the longer term?

Pat Cullen: Clearly, there is a gap, because we arrived at a position of 5% with the Secretary of State for 2023-24. We know from what our members tell us, which is right, that that will certainly not address the recruitment and retention issues we have within the profession.

We have 47,000 vacant posts in England. With every one of those nurses absent on every shift, the impact is felt. The one way we will address that is through giving nurses a decent pay award so that we can recruit nurses into the profession.

When we look at what is happening within the profession at the minute, we are losing really experienced nurses, who are opting for early retirement. Equally, at the other end, we are losing significant numbers of newly qualified nurses within the first two years. We have a much

more mobile workforce now. Those younger nursing staff are now moving elsewhere. They are sought after throughout the world because their training is so fantastic in the UK. So we really need to get to grips with that. We have an over-reliance, of course, on internationally educated nurses.

When you put that all together, we have a picture that can only be addressed through addressing pay so that we can attract the best people into the profession, hold on to the best that we have and also reduce the over-reliance on internationally educated nursing staff, particularly from red list countries.

Q76 **Rachael Maskell:** Thank you. That is really helpful. Certainly, when I have been talking to junior doctors in the BMA, they have talked about those other pull factors, particularly around international recruitment. Again, how is the issue of retention being addressed with regard to pay?

Dr Runswick: In our dealings with the Secretary of State, there has not really been any acceptance that pay erosion is a contributory factor in loss of staff. We regularly see the shift of blame on to the factors that you were discussing before with NHS Providers around culture. They are obviously clearly contributory, but when you can earn 50% or 70% more in Australia and New Zealand, it is no wonder that we are literally losing thousands of doctors to those countries abroad every year.

We, too, have the problem of retention at the end of people's careers. We have an increasing cohort of people who are doing their first two years of postgraduate training in the NHS and then leaving. It used to be that people would go and do something adventurous. They might go somewhere where they might have tropical diseases experience, for example, and then return. Increasingly, we are not seeing those people come back. Larger and larger numbers are going without entering higher speciality training. So we have a serious problem.

I am not sure that the Secretary of State has yet accepted that, but I hope that that will change in the course of negotiations and that we can achieve a deal that both restores the value of doctors' pay and enables us to retain the workforce that we need as colleagues who remain here, but more importantly that patients need.

Q77 **Chair:** Emma, do we have any figures? You said there were literally thousands going. Do you have any figures to back that up? We hear it anecdotally, but do you have any figures that you could write to us with on that?

Dr Runswick: Absolutely. We can share the GMC figures on requests for certificates of good standing, which is probably our best—

Q78 **Chair:** Yes, requesting a certificate is one thing—I remember that from a junior doctor's speech in 2016—but applying for it is another. I do not want to know the people who have requested the certificate. I want to know the people who have actually left.

Dr Runswick: I will do that for you.

Q79 **Mrs Hamilton:** Mine is a real quickie because we are nearly out of time. Dr Emma Runswick, I do not like the term "junior doctor". Let me just put it out there.

Dr Runswick: Neither do we.

Q80 **Mrs Hamilton:** We have a wide variety of professionals. It could be someone who has just qualified or someone who has been there 10 years, who is not a registrar yet and who remains a junior doctor.

My question is this. It is really misleading, so what term would you like to see? Doctors have my sympathy, but there would be less aggression if that was made clear re the levels of pay with doctors, who are, literally, saving people's lives.

Dr Runswick: Absolutely. There is nothing "junior" about the work of an ST8 obstetric junior doctor trainee doing a category 1 C-section at night. There is absolutely nothing "junior" about that work. There is nothing "junior" about leading an arrest, to literally bring somebody back to life when their heart has stopped. There is nothing "junior" about running complex rheumatology clinics. There is nothing "junior" about bringing somebody into hospital in my specialty in psychiatry under the Mental Health Act. There is nothing "junior" about any of those things.

We would quite like to move to just "doctor", and then clarify "senior doctors", "specialists" and "consultants", but there has been substantial work done on this topic. For a whole variety of reasons, we remain either junior doctors or postgraduate doctors in training. There are no perfect solutions that we have worked out with any other group. Internally, we would prefer "doctors".

Q81 **Mrs Hamilton:** My last question is to both of you, and it really is. I was given figures that last year 40,000 nurses left the profession and 20,000 doctors, but only 7,000 actually retired. Just last year 53,000 health professionals were missing or out of action.

I know; I was one of those. Years ago, I just left the profession before it ever got to where it is now. The question I want to ask you is this. If the Government and Steve Barclay were listening this afternoon, what is it that you would both like to say to him to get him to come back round the table? You have made all the right noises, but at the moment he clearly is not listening. What would you like to get across—I am giving you a minute each—to Steve Barclay to get him back round the table? Pat, can we start with you?

Pat Cullen: I would really urge the Secretary of State to get into a room this week with the Royal College of Nursing. Let us start to negotiate again about pay and all of the other terms and conditions that we had the opportunity to speak about in the first week with the Secretary of State. Let us get to a resolution and not push our members to be balloted on 23 May to take a further six months of industrial action.

Q82 **Mrs Hamilton:** You have talked about nurses leaving the profession. I have a young lady in my ward who lasted three weeks. She did not even last a year. It is bad out there. They are just walking and going into other professions.

Pat Cullen: Yes.

Q83 **Mrs Hamilton:** And you?

Dr Runswick: At the BMA the position that we would like Steve Barclay to hear is that he does not have to keep making slow progress. He could end the dispute tomorrow. The dispute could be over tomorrow, with no further strike action. We do not have to keep going on at this very trudging pace. We could have solutions tomorrow or next week, just like we could have had last year before there was even a ballot. We would like to see that pace picked up so that we can get back to solving all the other problems that we have in our health service, which we have talked about.

Q84 **Mrs Hamilton:** What one thing would make doctors stop talking about striking and want to continue with the negotiations—one thing?

Dr Runswick: We are in negotiations at the moment. We would like those to continue. We need there to be much more rapid progress. We have asked for a credible offer or some acceptance of pay erosion and the need for pay restoration. Either of those would help us make much more rapid progress than we are currently doing.

Mrs Hamilton: Chair, over to you. Was that quick enough?

Chair: Very good, Nurse Hamilton. Finally, we have Dr Caroline Johnson.

Q85 **Dr Johnson:** I have some sympathy for the junior doctors' struggles, particularly because the rota gaps sometimes leave particularly the most flexible member of any team working a number of shifts that are constantly disrupting their life and their ability to plan. I also have some sympathy for the concept of junior doctors. I can remember being somewhat aggrieved, as an almost consultant, being referred to as a junior doctor.

I am concerned about doctors striking. As a doctor myself, it absolutely feels like the wrong thing to be doing, to be honest with you. I would be interested to know why you chose to strike from 11 to 15 April, on those days in particular.

Dr Runswick: It was those days because they were two weeks following the collapse of talks, and two weeks is the time that we have to give notice for strike action in the UK under trade union legislation. There is no planning of particular times here. The first action was taken after we had our mandate delivered. There was an overwhelming mandate of 98% "yes" on a 77.5% turnout. We entered negotiations in good faith. They collapsed very rapidly and, unfortunately, we had to call further action.

Q86 **Dr Johnson:** Some people might say that you chose to strike

immediately after a long Easter weekend bank holiday, from the Tuesday morning to the Saturday morning, knowing, as you do as a doctor, that hospitals are most under pressure just after a bank holiday weekend when there are low levels of staffing; knowing that school holidays and childcare will be difficult for people who might otherwise come in and help; and knowing that more consultants and senior nursing staff will be on holiday so that the pool of staff who might cover those shifts will be depleted by that annual leave. You said that patient safety is your high priority. Some might say you have taken those days specifically to make things more difficult for trusts and for patients. I hope that is not the case because I would not like to think it was.

My other question is, how do you square doctors walking away from patients for more money? We know that those first-year junior doctors—the 10%—do get paid a relatively low amount for the hours that they work as a basic, but also the out-of-hours work is much higher paid. The average overall take-home salary in the first year, post medical school, is reported as £38,000, which is more than median average earnings. It is a significant amount of money.

I will go to the story of Oscar. Oscar is a three-year-old boy who has a rhabdomyosarcoma, which, for non-medical people listening, is a cancerous tumour of the soft tissue. He had been declared free of cancer, but he then had an MRI scan which showed he may have got his cancer back. That was obviously something very distressing and worrying for him and his family. He was described by his mum as being in a lot of pain.

The operation to explore whether his cancer had come back was due for 11 April. It was postponed solely because of the junior doctors' strike until 27 April, a delay of more than two weeks. We know as medical professionals, and the general public know, that if you delay treatment of cancer it can lead to death.

Do you really think it is reasonable to potentially lead to the death of a three-year-old boy in order to get more money for junior doctors? What do you say to Oscar's family?

Dr Runswick: I am really sorry to Oscar's family and to all patients who had their appointments and operations postponed and rescheduled. No doctor really wants to be on strike. We are not striking for no reason.

We are balancing the difficulty of knowing that pay erosion is affecting our attention, and knowing that pay erosion is affecting doctors' ability to live and work in this country, and the effect that that has on many patients over a long period of time for the next several decades, with the possibility of difficulties and disruption now. I would really emphasise that there was no need for this strike action to take place. We told the Government all the way back last summer that we were looking to open negotiations. There were no negotiations. When we finally got into negotiations after the first round of strike action, they were almost immediately collapsed by completely unreasonable preconditions.

Doctors are struggling with the costs of living and the costs of training, several of which you will know: GMC fees; the cost of exams; the cost of portfolios; the cost of moving house, often rotating every six months or a year; and the cost of student loan debt and the cost of other debt, because student finance will not fund you through five or six years of medical school.

When you have people who are really struggling to afford the childcare that they require to work unsociable rotas at nights and weekends, then we have to take action both to support the ability of our colleagues to live, work and train in this country and to prevent them leaving in the future.

Before we had any strike action at all from any health professionals we had 7.2 million people on the waiting list, all of whom are in the position of suffering and struggling. I do not think that is acceptable. It is very heavily contributed to by the loss of staff over the past decade or so and the erosion of conditions of work in the NHS. I think it is possible to reverse it. It is reasonable to want to reverse it. It is a real shame that it has taken strike action to get Government to the table on this issue, but I do not think it is unreasonable that we have taken that action, having been pushed there.

Dr Johnson: It is interesting that the NHS team in the panel just before you talked about the 90% reduction in the number of people waiting more than 78 weeks, I think he said, which seems a long time, and the fact that the covid backlogs are being brought down. I do not see how cancelling hundreds of thousands of episodes of care over a four-day period is going to help anyone wait any less time.

I am afraid that I cannot understand junior doctors, or any doctor, who must know that they are on a salary higher than the median average of the UK—I do not know Oscar's parents, but the likelihood is that the junior doctors striking earn more than either of those parents, and certainly more than the average person who has been asked to suffer for longer as a result of strikes. As a doctor, I just physically cannot understand how someone could walk away from a three-year-old with cancer to try to obtain themselves more money. I just cannot; I am sorry.

Q87 **Chair:** Very briefly and finally, because we are going to go to the statement in the House, on a nought to 10 scale, Pat, how hopeful are you that this will be resolved—and not by Christmas—by the time Parliament rises for summer recess in July?

Pat Cullen: I live in absolute hope, Chair.

Q88 **Chair:** On a scale of nought to 10, where are you?

Pat Cullen: I am not going to put a number on it.

Q89 **Chair:** All right. Dr Runswick, how hopeful are you?

Dr Runswick: I am also not inclined to put a number on it. I think the mandate of our members is very strong. I am hopeful that the Government will listen to that, so that we do not have to take further strike action and that we can resolve this dispute for the betterment of doctors and for patients.

Chair: Hope is a good place to end. If there is a Springer's "Final Thought", it is that the Coronation weekend has given us positivity, looking at the glass half full. Hope is a good place to start and end this session.

Thank you very much, Pat Cullen from the RCN, and Dr Emma Runswick from the BMA. Thank you very much for your time.