HOUSE OF COMMONS

Health and Social Care Committee

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

Tuesday 12 January 2021

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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; Dean Russell; Laura Trott.

Questions 120-178

Witnesses

I: Professor Jeremy Dawson, Professor of Health Management, Sheffield University; Chris Hopson, Chief Executive, NHS Providers; Helené Donnelly OBE, Ambassador for Cultural Change/Lead Freedom to Speak Up Guardian, Midlands Partnership NHS Foundation Trust; and Dr Henrietta Hughes OBE, National Guardian for the NHS.

II: Lord Victor Adebowale, Chair, NHS Confederation; Shilpa Ross, Fellow, The King's Fund; and Tricia Pereira, Head of Operations Adults Social Care & Adult Safeguarding, London Borough of Merton.

Examination of witnesses

Witnesses: Professor Dawson, Chris Hopson, Helené Donnelly and Dr Hughes.

Q120 **Chair:** Good morning and welcome to this morning's session of the House of Commons Health and Social Care Select Committee, where we are continuing our inquiry into workforce burnout in the NHS in a period when the issue has never been more important for frontline staff. Today, we are going to focus on two issues in particular: first, the importance of leadership and the role of leaders and, secondly, the particular pressures facing people from minority ethnic backgrounds.

We are going to start by looking at the pressures that staff in the NHS, and indeed the care system, have been facing, even before the pandemic. I am delighted to welcome to our first panel Professor Jeremy Dawson from Sheffield University, who is an expert on the NHS staff survey. We also have a regular to this Committee, Chris Hopson, Chief Executive of NHS Providers.

With them, we have two people who have done an enormous amount of campaigning to make it easier for people on the frontline to speak out when they have concerns. Helené Donnelly is a nurse and was one of the whistleblowers from Mid Staffs, who came to a lot of prominence during the Francis inquiry. Henrietta Hughes is a doctor. She is now the national guardian for the Freedom to Speak Up network, which is a network of people that has been set up by every trust in the country so that frontline staff have someone who is not their line manager that they can talk to if they have concerns. Thank you very much for joining us.

I will start, if I may, with Chris Hopson. This is not directly related to workforce burnout, but it is, of course, indirectly very closely related to workforce burnout. It concerns the pressures on the frontline as we speak. Could you start by giving us an update as to how things feel right now on the frontline?

Chris Hopson: It is incredibly serious. The latest information over the last few days shows three quite worrying trends. The first is that it seems pretty clear now that the infection rate is not going to go down as quickly as it did in the first phase; it is going to go down more slowly because of the increased transmissibility of the new strain.

The second thing relates to infection rates. We have talked a lot over the last few days about London, the south-east and the east of England, but what is very clear is that infection rates are now rising very rapidly beyond those areas, in the midlands, the north-west and the south-west. That is a particular worry because trusts in the midlands and the north have significant numbers of patients still in hospital from the second surge. The south-west, because of its smaller bed base, is less able to absorb pressure than the other regions.

We were hoping for a sharper peak that came sooner and shorter—for example, something where we saw the peak and started to crest it in mid

to late January. It now looks like the peak for NHS demand may be in February. If that is right, it is basically going to mean a higher level and a more extended period of pressure on the NHS than we were expecting even just a week ago.

It is important to explain what is now happening. We are now considering in the NHS a series of emergency contingency arrangements that would maximise the NHS capacity available in the areas under greatest pressure. There is rightly a huge focus on compliance—we have really seen that in the last 48 hours—with the restrictions on social compliance and social contact, and that could not be more important.

There is the obvious bit, which is that we are clearly in a slight limbo period at the moment where we do not quite know whether the tight restrictions and the impact of the Christmas effect are having the desired effect because it is still too early. We need to answer the question as quickly as we can about whether we need tighter restrictions or not. We need the evidence to come through as quickly as it can about whether we need tighter restrictions. Clearly, if they are needed, the sooner we get them in place the better. This is an incredibly serious position.

Q121 **Chair:** Tell me about the impact on morale. How are people feeling? If people had been expecting things to peak in January and they are not now going to peak perhaps for another month after that, it must be a pretty depressing prospect for people you represent.

Chris Hopson: I would not necessarily say a month—two to three weeks perhaps; say, early to mid-February. The answer is that when I talk to our trust chief executives they say they are unbelievably grateful for the commitment, dedication and professionalism of frontline staff, who have to do extraordinarily difficult things in near impossible circumstances. They cannot believe how incredibly well staff are behaving in terms of things like delaying leave, extending shifts and doing extra shifts.

The fundamental problem, and the real issue that I think underpins all of this, is that the reality of the NHS has been that for the last 10 years we have had a mismatch between rapidly rising demand and capacity. Capacity simply has not risen in the same way. The way we tried to close that demand/capacity mismatch was by asking our staff to work harder and harder. The reality is that the demand/capacity mismatch was already showing up before we went into Covid.

As you well know, we had some of the lowest performance against the key metrics in the NHS for a generation before we went into Covid. We are now asking staff to go again and again, and do some extraordinary things. We cannot keep trying to run the NHS and close that capacity/demand mismatch by asking our staff to work harder and harder. It was already pretty unsustainable before we got into Covid. It seems to us that this is just reinforcing it.

The message we are getting very clearly is that people will do everything they need to do in this immediate period because they do not want to let their colleagues down and they do not want to let patients down. What all of our chief execs are saying is that they are worried that when we get through this immediate phase we will start to see people leave the NHS—for example, those near retirement, junior doctors or people who have come over here from overseas who wanted to train. We will get core workers leaving the NHS because, effectively, the whole concept of trying to close that gap by asking our staff to work harder and harder is creating an impossible and unsustainable workload for our frontline staff.

Q122 **Chair:** Thinking about a long-term solution, Chris, we have never been good in the NHS at properly planning for the number of doctors, nurses, midwives and so on that we will need in five, 10 or 15 years' time, and making sure that we properly train them so that we can avoid the kind of ratcheting up of pressure you are talking about. Is there any argument that, as a long-term reform, we should have an independent OBR-type body that projects what the NHS workforce need is going to be over 10, 15 or 20 years, and makes sure that we are actually training the numbers we should have?

Chris Hopson: This gives me a perfect opportunity to say one thing, which is some very warm words of encouragement to you and your Committee to continue the excellent work you have been doing, calling for a fully costed, long-term, properly funded plan on workforce numbers. That feels to us to be absolutely central. As you were coming towards the end of your term as Secretary of State, you and I spoke about that a lot.

You have quite rightly been pushing various parts of the system quite hard, including our colleagues at NHS England and NHS Improvement. As you and I both know from our time when you were working as Secretary of State, to be frank, the issue is as much with the Treasury and with No. 10 as with the Department and NHS England and NHS Improvement. We have to get all of Government to recognise that, if we cannot get a long-term plan in place, we have an unsustainable approach to workforce.

We absolutely do not have enough people working in the NHS. We need a very clear long-term plan about how we are going to grow the workforce for precisely the reasons that you have been saying, which is that it takes a considerable period of time to train a nurse or a doctor. If we want to develop some of the really important intermediate posts like nurse associates and physician associates, we need to do that in the context of a long-term plan.

There are lots of things I would like to come out of Covid, but in this context one of the really important things that must come out of Covid is a categoric commitment right the way across Government that we are going to do long-term workforce planning. It is vital.

Q123 **Chair:** We are going to listen to Professor Jeremy Dawson talk about the NHS staff survey. One of the things that is very striking about that is the

very large proportion of NHS staff who say they have experienced bullying and harassment, often by a line manager.

Your organisation represents all the people running the show across the different parts of the NHS. Do you think there is an argument that one of the reasons why we do not have as good workforce relations as we should is that we put managers themselves under too much pressure? They have so many targets, so much regulation, so many inspections and so much on their plate that they have to spend too much time managing up, rather than looking after the teams underneath them.

Chris Hopson: Clearly, there is a significant problem in the NHS with bullying and harassment. All of us in the NHS need to say that openly and recognise that we need to address it. It is a complex issue. I am very pleased that you slightly qualified your question by saying that one element of it is line managers. If you look at the data, it says that there are issues around patient harassment and bullying of staff, staff harassment and bullying of staff and line management harassment and bullying of staff. I think that makes it quite complex.

My basic point is this. Effectively, the capacity/demand mismatch produces a degree of operational pressure on the NHS that I think is unmatched in virtually any other public service or, indeed, in any other part of our national life. Part of the issue is that some people react to that huge degree of pressure in an inappropriate way. I think you are right to identify that there has been a culture in the NHS where the excessive focus on operational delivery of targets, which are incredibly important—for £130 billion of public money we should be accountable for delivery against it—created a culture in the past where there was a real, excessive focus on the delivery of those targets and nothing else.

One observation, if I may say so, is that I think you were quite important in starting to drive this. There is a much richer and deeper conversation in the NHS now about the importance of compassionate leadership, and a recognition that the leadership task is not just about delivery of targets. It is about supporting our staff and giving them the ability to speak up if they see things that are wrong. That is what improves patient safety. It is a greater focus on patient safety. Certainly, some of the newer generation of leaders that are coming forward, and nearly all the leaders I see in the NHS, now recognise that the old way—if I can caricature it as just focusing on the operational delivery of targets—is not the right way of doing things.

There is one final point. You and I had these discussions when you were Secretary of State. We need to get the balance right between what the centre does and what our leaders do. They are an incredibly talented group of people. One of their frustrations is that they are micromanaged from above, when what we should be doing is enabling and empowering them to lead to the best of their skills and ability. These are brilliant people. We are on occasions disempowering them by tying them up in too many knots and telling them how to do their job, when actually each

one of those jobs leading the 217 trusts is different, given the nature of the trust.

Chair: Fascinating. Thank you very much indeed. Luke Evans is going to ask some questions of Professor Dawson about the staff survey.

Q124 **Dr Evans:** Building on what we have heard from Chris Hopson, Professor Dawson, with your experience, would you be able to comment on how much the NHS runs on good will?

Professor Dawson: To a very large extent, that has been especially true recently and has been true for a long time. One of the major challenges for the NHS is obviously how to get the best out of its staff. It has done a very good job on that in many ways. In some ways, it has done too good a job. The problem I see at the moment is that we are relying on the good will of the staff, and their going the extra mile and a half, in a way that is simply unsustainable.

Over the history of the staff survey, which is about 17 years old, a lot of things have remained remarkably constant, or with very little variation, over that time. It is quite remarkable in some ways how static some of the indicators are. That is why, in that context, I think one of the most worrying things in recent years is that the proportion of staff who are suffering illness as a result of work-related stress has increased so much over the last two years. Between 2003 and 2015, it remained fairly solidly in the 30% to 35% region. Over the last five years, there has been a trend for it to increase, so that in 2019 it reached the 40% mark for the first time.

Q125 **Dr Evans:** What do you think is driving that?

Professor Dawson: It is partly what Chris was referring to—the capacity not being able to meet the demand, and the requirement, or the perceived requirement, to put in extra work to cope with that demand. It is also partly the sheer range of issues that have to be dealt with. Again, this is something Chris mentioned a few minutes ago in terms of the range of priorities. When we have fewer staff to deal with that, as you would expect, they get stretched more and more. The worry is that it is coming closer to breaking point.

Q126 **Dr Evans:** Are you able to differentiate, through either your research or the questionnaire, or a combination of both, whether nurses or doctors are more proportionately affected? Is it managers? Is it allied professions? How does that 30% to 40% you talked about break down?

Professor Dawson: It has been increasing across the board. It has been increasing particularly among nursing staff. I would need to check the numbers, but I think nursing staff are the highest proportion of all the staff groups.

We also see some differential in terms of demographic groups. I know that ethnic minority groups will be a focus of this discussion later. They

do not show up so much in terms of stress; the group that does in particular is disabled staff, whose experiences are far worse than those of non-disabled staff. I do not want to suggest that those are the reasons for the change. It has been increasing across the board.

Q127 **Dr Evans:** It may be difficult for you to answer, or it may be outside your scope, but I would be interested to draw comparisons from health services across the world, or indeed from non-health services. I feel I can say this as someone who trained as a GP. Is it the fact that some of the people going into it are a type A personality, so they feel stress in a different way, and that is what the professions bring in? Is it the fact that it is the system and the institution they are working within? Is it a combination of both? Is there a comparison with the private sector—for example, in private healthcare delivery or across the world—where there is a difference? Is this a unique problem in the NHS or is there something else going on?

Professor Dawson: It is something that is certainly more prominent in the NHS, from the research that I and my colleagues have done over the years. We have not done it very recently, but a few years ago we did a study comparing evaluations of mental health of NHS staff and non-NHS staff. Whereas in the population at large about 18% of participants would have benefited from some health intervention for their mental health, in the NHS generally it was about 26% or 27%. That was using a much stronger criterion than we see in the staff survey.

Q128 **Dr Evans:** Could I ask Chris Hopson to pick up where he left off? What percentage of the NHS runs on good will, and what would happen if everyone worked to contract?

Chris Hopson: Well, the NHS simply could not cope. That is the reality. Helené and Henrietta are better people to ask because they are on the frontline, unlike me. I have always used the phrase that discretionary effort is the rocket fuel that powers the NHS, effectively. If staff worked to contract and worked to rule, we simply would not be able to provide anything like the quality of care that we need to. Part of the problem is that we are relying relentlessly on the good will of our staff.

Everybody understands that once in a while, if the workload goes completely through the roof, we all need to adapt our working patterns if we can, to do that extra work. The issue is—

Q129 **Dr Evans:** In that position, would you advocate—a bit like a pilot has timed flights—that nurses should have a legal framework around protecting the number of patients they look after, or doctors having a certain number of clinic appointments? Would you argue for a framework around that to be built on?

Chris Hopson: We have had a discussion in the NHS, which you and Jeremy will remember, about, for example, patient/staff ratios in hospitals; in effect, nurse/staff ratios. The argument that our chief executives have always used is that each individual care setting, almost

each day, is in a different position because of the acuity of the patients in that setting and the experience and the number of staff that they have.

I think the guidelines, which is what we have, are sensible, but if they are unbreachable and completely inflexible, staff ratios must, come what may or whatever, feel more difficult, particularly if they are based on one category of staff, as some people have been arguing for. The basic point you are making, which is that we need to find ways that we can stop asking our staff to go the extra mile every single shift, every single day, every single week, has to be a massive priority.

Q130 **Dr Evans:** Chris and Professor Dawson, one of the things we heard in previous panels was about control, basically accountability for individual members of staff being able to make a difference—to be able to spot a change and enact that change. The pressure of the NHS does not allow people to do that.

Chris, could you comment from the operational side on how good managers in the NHS are at allowing staff to be accountable for what they are in control of? Professor Dawson, perhaps you could then comment on how that plays into the wellbeing of staff in the NHS.

Chris Hopson: What I would point you towards are trusts like the Western Sussex with chief executive Marianne Griffiths and Northumbria with chief executive Jim Mackey, where the whole organisation is based around the principle of enabling staff to take responsibility for making changes in their area that benefit patient care. There is a whole concept of a systematic trust-wide approach to quality improvement based on implementing a system for doing that.

Without wishing to get into terms of art, that is something that was pioneered in other industries, such as the Japanese car manufacturing industry. Systematic quality improvement makes a real difference and, hey, guess what, there are not very many trusts that are "Outstanding", but two of them are—Western Sussex and Northumbria. When you look at their staff survey ratings, you find that the staff absolutely love working in that environment because they feel empowered to make the changes that are needed.

Again, that is picking up. We have a long, long way to go. One of the things that really encourages me, if I may say so, is that we are having these debates in a way that we simply did not three or four years ago. The NHS is beginning to change, but there is an awful long way to go.

Q131 **Dr Evans:** Professor Dawson, could you answer the same question from the survey point of view and what your understanding is of the NHS and their ability to take account of an individual?

Professor Dawson: Certainly. To supplement what Chris just said, we have evidence that shows that organisations where there is more ability for staff to take part in making decisions and influencing how things are

decided are the trusts that have lower mortality rates. They have better outcomes generally for patients and better outcomes generally for staff.

Time and again in research, we see that there are three things that help to drive staff's wellbeing as well as driving high-quality performance outcomes. One is having autonomy and control, which is what you were just talking about, and the kind of thing that Chris was mentioning. One is a sense of belonging, which we have already discussed. We know that it is a key part of working in the NHS. The other is having competence, which is obviously about having the right skills and abilities to do the job. I think the autonomy and control bit is the most likely to go, and it is really important that we address that.

Q132 **Barbara Keeley:** Professor Dawson, from what we have seen, the staff survey results are very helpful in understanding the workforce and burnout issues that we are currently seeing. We lack an equivalent of the NHS staff survey for social care, where there is a particularly fragmented workforce. Do you think it would be a worthwhile thing to carry out, and do you have an expectation of what the findings would be? Would there have to be a very different approach to deal with that very fragmented sector?

Professor Dawson: I should acknowledge that I am not an expert in social care. I expect that that would be the case; it would be much more difficult to get that. I have seen the benefit that the staff survey for the NHS has had over the last 17 years, and I am confident that, if it could be carried out in social care, similar improvements could be driven by the same route.

Q133 **Chair:** Lots of other people want to ask questions, but I want to bring in our other two panellists. First of all, I introduce Helené Donnelly, who I should say is on the advisory board of a charity called Patient Safety Watch that I set up.

Helené, thank you very much for joining us this morning. You experienced terrible bullying at Mid Staffs and showed incredible courage in being perhaps the very first person to speak out about it. Could you tell us a little bit about what you went through, to give people a context of what can go badly wrong?

Helené Donnelly: We know that there were many preventable deaths at Mid Staffs. Many patients suffered without any care, compassion or dignity, and that was really the driving factor in why I spoke out, and so did many other colleagues in support.

We were seeing patients lying in their own excrement. We were seeing patients discharged without proper treatment or examination who later died. We saw patients being left in pain and distress, falling out of bed, and we were not able or allowed to go to assist them because we were pulled off that to go to other patients who were seen as a priority, not because of clinical need but because they were in the timeline next to breach the four-hour target. That was the pressure, which echoes what

Chris was saying earlier about managers feeling very much under pressure. I think you were saying that as well, Jeremy. That was a big factor at Mid Staffs in terms of the pressure to hit targets and so on, and the fact that we were so under-resourced both in staffing and in wider resourcing across the whole hospital infrastructure.

Sitting behind that were real negative behaviours. There was a real bullying culture of fear and intimidation. There was not a culture that encouraged and enabled staff to speak up. If we did, as I did, we were bullied and threatened, both physical threats and threats of a professional nature. There were threats around making it look as if we had made a drug error or something like that. That caused a lot of staff to feel very apathetic and to be silenced.

Q134 **Chair:** Could you tell us one or two of the things that actually happened to you as examples of that bullying?

Helené Donnelly: I was threatened about walking to my car at night and told that I needed to watch my back. Colleagues were warning me, I suppose, and trying to be helpful. They had heard other colleagues making threats that I was going to be attacked or, effectively, lynched walking to my car. I was locked in a changing room cubicle by a fellow nurse, who threatened me and wanted to know if I was going to raise concerns about her behaviour because she knew that there was a degree of misconduct. There were also threats around making it look as if I had a made a drug error. I was warned not to check certain drugs, particularly controlled drugs, which, as I am sure you can appreciate in a busy A&E department, is not always a luxury you have.

Those were real threats that on a daily basis intimidate people and impede people from speaking up. Accompanying that was a real failure from management. Managers knew. We were speaking up. We were telling them about it. They wilfully and knowingly allowed it to continue. In some cases, they actually promoted, praised, recognised and celebrated the perpetrators of such behaviour and misconduct. Alongside that, we were failed by regulators and union representatives who should have been there to support us. We were not listened to and not supported.

Sadly, I still see that over 10 years on, in the national work I do now as a Freedom to Speak Up guardian and as an ambassador for cultural change across the country. I see echoes of what I experienced at Mid Staffs still happening. It is important to acknowledge that it is in the minority. Absolutely. The vast majority of staff throughout health and social care work exceptionally hard, not least at the moment, and in normal times as well, but there is a real problem with bullying, and I think it has to be acknowledged and addressed. Although it is in the minority, as we saw at Mid Staffs, the results can be absolutely catastrophic.

Q135 **Chair:** That is probably a good moment to bring in Henrietta Hughes. You are responsible for the Freedom to Speak Up programme, which Helené is

now part of. That was set up following the second investigation by Robert Francis into whistleblowing to try to make sure that someone like Helené has someone she can turn to in precisely those kinds of situations. How well do you think the programme is going?

Dr Hughes: Thank you very much, Jeremy. When we think about the work that we do with Freedom to Speak Up guardians, we always say, "Is there a Helené in your organisation? What would make the difference to somebody in Helené's situation when she was trying to speak up to support patient care, and know that she would be able to do that safely and without fear of victimisation?"

We now have over 600 Freedom to Speak Up guardians across England in more than 400 organisations. That includes all the NHS trusts. It is also in some primary care organisations and in many of the national bodies. They have handled over 45,000 cases in the last three and a half years. I commend the work that guardians have been doing. Not only do they thank everyone who speaks up to them, but they listen and ensure that the right actions are taken as a result.

The focus of your Committee is on leadership. Speaking up is a relational exercise. It is only effective if leaders listen and act. I am a GP, and I have to say that the work NHS staff and other staff across the health sector are doing at the moment is truly phenomenal. For them to be able to be resilient, they need to know that they will be valued, and that their views are of genuine interest to their leaders and can lead to positive changes.

As Helené said, and as Chris said earlier, the situation is variable. We need all leaders to see as a core part of their role that being a leader in the NHS is being genuinely interested in and valuing the views of your workforce. The vast majority of leaders are taking that on board and see it as absolutely core to their leadership, but there are still some organisations that do not take it as seriously and, for whatever reason, are less interested in the views of their staff. Unfortunately, they are not seeing the improvements in their staff wellbeing, staff safety and patient safety and experience that we would like to see.

Q136 **Chair:** Chris Hopson was talking earlier about leaders like Marianne Griffiths and Jim Mackey, who run organisations that have a very good internal culture of listening to staff. They also tend to be some of the few places that get CQC "Outstanding" ratings. In your experience, is there a link between people's CQC rating and the quality and culture inside organisations?

Dr Hughes: We have looked at this in various different ways. It is one of the great advantages of the national NHS staff survey that we can look at trends over time and correlations with CQC ratings. Also, we have the views of guardians in the annual Freedom to Speak Up guardians survey.

What we have seen year on year is that in the organisations rated outstanding by the CQC their guardians tend to have a much more positive perception of the speak-up culture compared with organisations rated "Good", "Requires improvement" or "Inadequate". When we have looked at the NHS staff survey we have created a metric called the freedom to speak up index, which is drawn from four questions about whether staff felt knowledgeable, secure and treated fairly if they were involved in an incident.

When we look at those questions, we can actually look at organisations that are improving over time. When leaders make changes to support the workforce, we see it immediately in the staff survey results, so it is possible to change the culture. If you get the leadership right and the leaders are focusing on that, the workforce feel it immediately. We have great examples where we have not only looked at the numbers around it; we have it as part of Model Hospital now, so that people can draw inspiration from others' great work, from the qualitative side—the stories and examples when people have spoken up and it has led to meaningful change. We are keen that the excellent work that is seen by organisations across the country is picked up and spread, so that others are able to make the same improvements.

Q137 **Chair:** Do national organisations like NHS England and NHS Improvement, the Department of Health and CQC also have Freedom to Speak Up guardians? Is there somewhere that whistleblowers in those organisations can turn if they feel they are not able to speak out?

Dr Hughes: When we got our first survey results and they showed the apparent correlation between the speaking-up culture and the CQC ratings, I met the chief execs of the funding bodies of my organisation, NHS England and Improvement, and the CQC, and asked them where they would be on that graph. They all appointed Freedom to Speak Up guardians, as did many other national bodies, including professional regulators and arm's length bodies. Collectively, we have shown year on year that the cultures in those organisations, as perceived by their guardians, is on a par with organisations rated as "Requires improvement" or "Inadequate" by the CQC.

It is really important that the cultures of the national bodies are improved, so that that gives support and encouragement to leaders across the NHS, and they can then support and empower their workforce to be able to drive the improvements that we were hearing about earlier.

Q138 **Neale Hanvey:** I am enormously grateful for the tremendous work that both of you are doing in ensuring that people are able to speak up. It is important, certainly for me personally, to say to Helené that your bravery and fortitude in such a dreadful situation is really commendable. I can only imagine how difficult it was, not just to live through but actually to make such an important difference. It is very impressive. Well done.

I want to touch on getting leadership right. I would be interested in your

thoughts on some of the issues I have picked up in my career in the NHS and some of the concerns I have had. I think the work you are both doing is tremendously important, but, as the staff survey shows, significant challenges still exist, particularly around cultures of bullying and how staff are supported in addressing that.

Helené, could you talk a little bit more about the management team and your attempt to engage with them? What was your sense from them about their priorities? One of the findings of the report was that they were more focused on NHS foundation trust status than on delivery of patient care. Can you tell me a little bit about those interactions?

Helené Donnelly: Yes. Across the board, management did not want to hear. They did not want to listen, and they did not want to act, with the exception of a few. There was one particular matron who was incredibly supportive and encouraged us in what we were trying to do, but she was in the minority and she herself was threatened for supporting us in what we were trying to raise. There was a culture from the top of wanting to turn a blind eye, wanting to sweep it under the carpet and for staff just to get the job done; the target was the driving factor, and, as you say, it was achieving foundation status.

Of course, we still see that now, as Chris and Jeremy both alluded to earlier. Managers, particularly middle managers—I hate that term, but you know what I mean—are in a really difficult position. They are absolutely sandwiched between their teams and trying to support them, but also trying constantly to meet targets with ever-increasing pressure. Covid has put another unprecedented layer on top of that, but it was going on way before then. If we do not do something about it, it will continue into the future.

Compassionate leadership is needed, but it needs to be sustained. I recognise what Chris was saying earlier; there is a real appetite for this. I think we are now seeing a real will and understanding across the service that it is required, but, of course, when the pressure is on and the blinkers are on, that goes out the window and some of the negative behaviour continues. Indeed, it is encouraged; what we saw at Mid Staffs—I see it happening now—is that certain behaviours, certain managers, certain leaders or senior clinicians even, because they are very good at getting the job done, delivering and hitting targets, almost have a free pass to behave in any way they want. That is not acceptable, and we have to stamp it out.

Q139 **Neale Hanvey:** That is a really interesting point. I want to ask you specifically about that in terms of people who are perceived to be strong leaders. Certainly, in my experience, some of those strong leaders are actually very fickle and ruthless. They are nowhere near compassionate leaders, whereas some of the compassionate leaders who get the job done but by very different means are not as highly regarded. I think you have just very clearly stated that that is the case. Is that something you recognise?

Helené Donnelly: Yes, I do. We are talking in broad and general terms, but I think that is still an issue. Those who deliver real compassion and care are seen as not robust and a bit lightweight. A lot of it is around role modelling as well. If you get it right at executive level, as Henrietta says, and across the other departments, regulators and so on, it is all role-modelled and comes right down to the frontline. If you get it right at that level, other more junior leaders will see that that is the right way to behave, but it is not always the case. As we know, for particular leaders, hitting the target outweighs that.

It is not just around the leadership. It is around compassionate leadership, absolutely, but it is also around having the right policies and procedures in place and making sure that they are implemented in the right way. I am particularly thinking of HR. We know that a lot of people who try to speak up do so through HR. It goes through grievance routes, which might be entirely acceptable, but I would argue that some of those policies and processes are entirely outdated now and they are not keeping pace with the cultural change and the compassionate leadership we are trying to drive.

Q140 **Neale Hanvey:** Henrietta, can I ask you a bit about that kind of culture and how it could be addressed? I am reminded of a situation where a member of staff was advised by their union rep that they could not make a complaint about an executive member of the corporate team because they were "untouchable". That tacks on to Helené's point that people get a free pass.

One of the arguments in that situation was that they would be protected because of the reputational damage to the organisation if they were to be identified as a perpetrator of unprofessional behaviour and misconduct in a senior position. Often, staff who raise concerns like that, when there is a perception of reputational damage, will be silenced with a non-disclosure agreement. One of the Mid Staffs recommendations was the banning of non-disclosure agreements in the NHS. That was something that the Chair of this Committee sought to move forward.

The current Secretary of State raised it again at the beginning of last year. I am very interested to know what your thoughts are on outlawing that practice, when it is not really the reputation of the organisation that is at stake but the protection of a senior member of staff and their reputation. Do you consider that to be a misappropriation or a misuse of the trust's corporate body? It is quite a complex situation. How can that kind of misbehaviour be challenged and addressed?

Dr Hughes: I am pleased to say that I think the world has moved on from perceiving that protecting people in senior positions is the right thing to do. We have seen that in many other industries, with the #MeToo movement and other social movements, when protecting people in senior positions was seen to be more important than the ethical and the appropriate activities of an organisation.

Where people put the culture first, safety and all of those other positive things follow. We have worked with NHS Employers, with a group of law firms and with others to demystify and debunk some of the myths that surrounded settlement agreements. In my experience, we were seeing settlement agreements being written that gave the impression that people could not speak up and stopped people even from being able to see their GP about it because they put so much secrecy around it. All organisations need to follow the guidance, which is in the contract, so that for anyone who, for whatever reason, leaves the employment with some kind of agreement, it means there is nothing to stop them from speaking up about anything that gets in the way of delivering great care.

All organisations need to know about that. It is in their contract. The risk departments need to know about it; the legal departments need to know about it; and in my view it is something that the regulators should be checking. I have had conversations saying, "Are you checking it?" I am still waiting for an answer. I am pleased that you have brought this up, because there are a lot of barriers that get in the way of people speaking up. We have to identify and then tackle those barriers. That is what I and my team and Freedom to Speak Up guardians have been doing systematically over the last four years.

People need to get with the programme. The world is changing and leadership behaviours that are not compassionate and do not value and support the workforce need to be consigned to history.

Q141 **Neale Hanvey:** If there are people listening to this meeting today who have been in that position, and feel that they have been silenced or can no longer speak about the traumatic events that they lived through, what advice would you give them about how to move that forward? That is a really important healing message for many.

Dr Hughes: It is about the advice that people have had from their lawyers. People will have been given advice, but the fact of the matter is that a settlement agreement should not prohibit someone from speaking up in the public interest.

Neale Hanvey: That's brilliant. Thank you.

Q142 **Dr Davies:** Professor Dawson, I am keen to return to the issue of the NHS staff survey. Clearly, it throws up some pretty alarming statistics. We have seen some of that reflected in what we have heard today. I see it in my own MP postbag. Nevertheless, I am keen to understand how representative it is.

Do you have an idea as to the proportion of the NHS workforce that takes part and the workplace settings that perhaps form the majority of respondents? I ask that as someone who has worked in the NHS for 16 years. I do not think I have completed it or particularly remember having been asked to complete it. When I speak to colleagues, they either do not know anything about it or did not see the point.

Professor Dawson: It is a sample that is done in many organisations. Actually, in recent years a lot of organisations have moved to a census, so in a lot of trusts everyone should have the opportunity to participate in it. Even when the sample was at its smallest, the number of staff participating each year was around 200,000, representing well over 10%, getting up towards 20%, of the workforce. More recently, that has been getting up closer towards 40% to 50% who are at least invited to take part. The response rate has been around about the 50% mark.

It is impossible to say that it is completely representative. As with any survey, it will always have its flaws in terms of the methodology. The work that we have done, and others have done, on seeing who responds shows that there is a slight bias to staff groups who are more likely to be working at a desk. That is not surprising, but it is only slight. The difference between the highest-responding staff group—the admin and clerical staff—and nurses, for example, is only a few percentage points.

Q143 **Dr Davies:** So it is targeted; it is not a free-for-all. It is not something that every member of staff can participate in every year.

Professor Dawson: It depends on the individual trust as to what their preference is. In some trusts it is targeted, and in some trusts they ask everyone.

Q144 **Dr Davies:** In terms of increasing participation, do you think there is a possibility that perhaps there could be more feedback to those taking part in it? Is there a case whereby perhaps concerning revelations could be addressed as a consequence, where currently they are not, or is it completely anonymised?

Professor Dawson: It is anonymised in the sense that who says what will not be reported. In fact, no one within an organisation or within the NHS will be able to identify any particular responses, but there is certainly information about which department people work in, for example, or which staff group, so that there can be a targeted response.

More can be done on feeding back. This has been something the NHS has been working on constantly since the survey started. The survey cycle is quite a long thing, as you would expect with a large organisation, which makes it hard to do that. The gap between the survey results being reported and the next cycle starting is actually quite short, but I think there could be more done that feeds that back, yes.

Q145 **Dr Davies:** On addressing concerns raised it is a bit of a postcode lottery perhaps, depending on which trust receives the data and who acts on it.

Professor Dawson: That is right. All trusts receive a good amount of feedback. The way in which they act on that is up to the individual leadership of those trusts. A lot of them do it very well, but the cycle is quite slow.

Q146 **Dr Davies:** Finally, in other disciplines and other workplaces, such as the

teaching profession, is there anything similar that you can compare? I know this has been raised earlier in the session to a degree, but are there surveys of this magnitude elsewhere that provide an interesting comparison?

Professor Dawson: The short answer to that is no, at least not regular annual surveys. Occasionally, a large workforce will do a one-off survey, but as far as I am aware this is the only survey of its kind, not only in the country but in the world.

Q147 **Dean Russell:** Chris, you mentioned earlier knots in the system. I am particularly interested around the challenges of red tape and how that impacts leadership. It feels to me that when you have staff who know what they are doing on the frontline, adding additional red tape to stop them doing that can be a challenge. I was interested in whether you agree with that view and what we could potentially do about it.

Chris Hopson: There is a really important balance to strike. This is an industry—sorry, that's a terrible phrase. This is a sector of our national life where, if you get things wrong, people die. Quite rightly, there should be an appropriate degree of regulation to ensure that, for example, health professionals are registered and their practice is appropriately defined.

We have chosen in the health service to say that the 216 trusts, which are responsible for about £90 billion of the £130 billion and employ 800,000 of the 1.3 million staff in the NHS, are responsible for overseeing the delivery of secondary care services. That is 1 million patients every 36 hours. The real question is the degree to which we say we are going to trust those NHS trust boards, and the leadership and middle management teams within them, to get on with doing what they need to do, and the degree to which we are going to micromanage them and tell them, "This job needs to be done in this particular way."

The frustration in the past has been that people have felt that NHS England and NHS Improvement and the Department of Health and Social Care have basically got the balance wrong. They have been too prescriptive. Again, it is very important that our politicians who are responsible for the NHS should be accountable to Parliament, but quite often what we hear is the CQC, NHS England and other bodies asking for the same information, and asking for it very quickly. Huge amounts of information returns need to be produced to enable that accountability to be exercised. Those are the kinds of things that frustrate people.

Q148 **Dean Russell:** Would you say that there is too much paperwork?

Chris Hopson: Yes, I think people would definitely say that. I think we are changing. As Jeremy will know, we have a new structure in the NHS where we have, for example, a chief operating officer in NHS England and NHS Improvement who is a former trust chief executive. We have a regional structure now where two of the seven regional directors are people who come from a trust background. We are trying to cut the

amount of paperwork. We are trying to let people get on with it, but, in a centralised structure, you can see why those at the centre feel themselves accountable and therefore want to get huge amounts of detail, and specify in lots of detail, about what the frontline should be doing. We need to get that balance right.

Q149 **Dean Russell:** The reason why I ask is in part that I recently produced a report to colleagues looking at community, and volunteering in particular. I spent the day with St John Ambulance, who told me that prior to the start of lockdown last year they were never able to help on wards, even though they had the capacity and skills to do that. Once lockdown happened, some of the red tape at the bottom level, as it were, was able to be released. Agreements were put in place and they were able to help and make a big difference. I also volunteer myself at my local hospital. I have seen the impact of volunteering. Do you think that is something we should encourage, moving forward? I have proposed the scheme of an NHS cadet system, for example. Is that something that you would say would be beneficial?

Chris Hopson: I certainly believe that there is a real opportunity to harness people's commitment to the NHS, and the skills that many volunteers have. I could point you to some very specific examples. King's College Hospital is a very good one, where they have 1,000 volunteers who work on a very regular basis. My wife volunteers for the Royal Free Hospital, just up the road, and with a bunch of hardy volunteers has done a fantastic job to transform the garden. There is a really good opportunity to do that.

I would be the first to say that this is not something that is universally taken up by all of our members. I think we could definitely do better. The whole thing about the relationship between the NHS and the third sector is something that feels to me, and always felt, underexploited. Yes, I completely agree. Quite how formalised it is and quite how much we would leave it up to local individual organisations is an interesting debate.

Chair: I am sure that the Committee would like to put on record our thanks to Charlotte for her volunteering.

Q150 **Dean Russell:** Absolutely, and to all volunteers. I have worked alongside some incredible volunteers.

I have a question for Dr Hughes regarding the impact specifically on mental health wards. I imagine that, not just during Covid but generally, they are very high-stress environments. I wondered whether, from your work, you found that the level of stress in mental health wards for staff is something that is looked at. I imagine they must deal with really difficult situations. Are they getting the support, the counselling and the follow-up as staff to enable them to sustain that level of work?

Dr Hughes: What we have found from our surveys is that the cultures in the community and mental health trusts tend to be the better cultures across the NHS. One of the things that is significant about that is that the

leaders in those organisations are familiar with dealing with people in distress. That knowledge and skill is taken forward in how they support their workforce as well. Clinical supervision also forms a really important part of that. Consistently, year on year, we have seen that the cultures in the community and mental health trusts and those who manage patients with learning disabilities are consistently better than in other types of provider.

There is a great deal of learning that can come from those organisations to share their experience and expertise in how they take their skills and use them to support their workforce. I agree with you that they are dealing with very difficult and stressful situations, particularly during the pandemic.

Q151 **Barbara Keeley:** I have a follow-up question to Dr Hughes and Helené, and possibly Chris Hopson. As well as staff working for NHS trusts and the community mental health trusts that you have talked about, there are obviously a large number of staff working for outsourced NHS services such as private mental health units, which frequently give a lot of cause for concern. There have been some terrible scandals about what goes on in those units because they also tend to use restraint, and other issues arise in the way they manage patients.

Do you think we have the structures in place to support and encourage whistleblowing from those staff in the same way that we do for NHS-employed staff? When we get to a scandal or a very bad CQC report, it often comes out that there is a really poor culture in those places.

Dr Hughes: In fact, a third of guardians are not in NHS trusts. We have guardians in many independent sector providers. It is part of their contract, and many independent sector providers are either specialised commissioned or subcontracted, and have NHS contracts. It is something that should absolutely be a core part of their provision.

There is something about visible leadership and normalisation. What is important is that the workforce are able to speak up about things that they feel are not right and have an alternative channel, so that if their line manager is somebody they are not able to approach, or the line manager is actually the problem, they have another safe channel where they can go and where they will be listened to and can speak confidentially, or even anonymously if they want to, and that the leadership will take the necessary actions to put things right. I am really keen that in contract management, whether it is through specialised commissioning or through other types of commissioning, commissioners attend to that as something that is a really important part of their contract management. This is now part of the standard NHS contract.

It is also part of the CQC inspection. I am actually training CQC inspectors so that they have the skills and knowledge, and so that they can learn from each other's experience when it comes to doing inspections, and ask searching questions about the culture, asking the

leaders about how they are fostering a speaking-up culture in their organisation and ensuring that patients are kept safe.

Q152 **Barbara Keeley:** The point you made about commissioners is a good one and worth while. There have been lots of cases where people have been in mental health units for long periods of time, including people with learning disabilities, where it seems that commissioners just forget about them altogether and they are not having reviews. You were painting a picture of community mental health trusts doing a good job there, but it seems to me that we have to accept that we have a corner of provision that has a problem and that needs to be dealt with.

Dr Hughes: There is something about the will. It is not for lack of information about doing the right thing. It is about leaders seeing it as their role. A core function of their role is to be genuinely interested in the views of their workforce, to be visible and to be approachable. We have excellent leaders across the NHS and in the independent sector. There is something about being able to have fresh eyes and ensure that all service users and patients are getting the care that they need. There is something about the whole system working together to achieve that aim and seeing the freedom to speak up as an absolutely core element of whether an organisation is well led.

I completely agree with you that, where that falls down, patients can be put at risk. Staff can be put at risk. It is absolutely key that people all prioritise this as part of the work they are doing as leaders, as commissioners and as inspectors as well.

Q153 **Barbara Keeley:** Do we need Freedom to Speak Up guardians for social care?

Dr Hughes: I think that is a yawning gap. I know that when it was started it was very much seen as something for secondary care. In the last two years, we have been looking at models in primary care. We have an increasing number of Freedom to Speak Up guardians in primary care.

As we move to more integrated care systems, the role of adult social care, particularly in the pandemic, has come to the fore as an absolutely key element of looking after patients. I strongly believe that we should have Freedom to Speak Up, or equivalent alternative channels, for workers looking after patients in whatever setting to be able to speak up about their concerns, knowing that the leaders will be listening, and the right actions will be taken as a result. Certainly, when it comes to the CQC, they have found that people raising concerns directly to them has been the key decision-making factor to cross the threshold during the pandemic.

Barbara Keeley: Thank you. Helené is nodding.

Q154 **Laura Trott:** We have heard a lot today about how in many ways workforce culture has improved, but there are still some significant challenges. As we are thinking about the Committee putting forward

some recommendations in the future, as we write up our report, I want to give Chris, Helené and Dr Hughes the opportunity to set out clearly what are the two top recommendations you think we should include.

Obviously, as we have heard, social care Freedom to Speak Up guardians seems an obvious one. I want to give you the opportunity to set out clearly what you think we should be putting in our report.

Chris Hopson: I go right back to where I started, which is reinforcing the need to close that demand/capacity mismatch. I do not see how we can get to a sustainable workforce and an appropriate culture in which we can show compassionate leadership until we have the right-sized workforce with the right skills to deal with the demand that the NHS is facing. I would encourage you, if I may, to reinforce and strengthen your call for that long-term, fully costed and fully funded workforce plan.

The second thing is that I think quite strongly that what matters, as a Government but also as the NHS, is what we value. What we have said in the past, as has come across really effectively—Helené was very powerful on this—is that we have tended to over-emphasise the delivery of operational targets and the money at the expense of quality of care, staff experience and patient experience. I think what it would be really helpful for you to do is to reinforce the importance of Governments, NHS leaders and everybody taking a balanced view of what needs to be delivered.

Clearly, targets matter and clearly money matters, but they absolutely do not matter to the exclusion of staff and patient experience and quality of care. We need to get that balance right in a way that we simply were not doing. I think we are moving rapidly towards it. If I may be so bold, I think your Chair did a really good job when he was Secretary of State to start that journey. We have pushed it on, but there is still an awfully long way to go.

Q155 **Laura Trott:** Chris, in tangible terms, if we were setting out a recommendation, what would it look like? Are there specifics that you want to see less of? When you have the recommendation, do you say there are mitigating factors, which mean that you do not have to meet it? What does that look like?

Chris Hopson: What I think it looks like is, effectively, that we absolutely insist that when performance of the NHS is judged—you may know that we are in the process of looking at recalibrating how we measure performance on the accident and emergency care pathway—we are clear that measurement of NHS performance is a balanced basket of measures in which quality of care and patient experience and staff experience are just as important as finance and operational targets.

The reason we put targets in place in terms of the four-hour wait and 18-week elective surgery is that back in the late 1990s we had huge problems in those areas. I think that all of us in the NHS would agree that we have made massive strides forward in the 2000s to deliver against those. The problem was that it got taken to excess, and there

was a real focus on the money and on the targets. What we need to bed in now really clearly is the sense of a much broader range of things, in which patient safety, staff experience, and so on, are really important.

Q156 **Laura Trott:** Thank you. Helené, two thoughts from you.

Helené Donnelly: I think we need much greater scrutiny and data collection on specifically staff safety and wellbeing. The point was made earlier around staff surveys that you cannot drill down necessarily into that and feed back to individuals, but we can via Freedom to Speak Up guardians. We have a huge resource there that we need to tap into more to get real meaningful data on who is speaking up, and what that looks like in terms of patient safety and patient care, but crucially the step before that is around staff safety and wellbeing.

Q157 **Laura Trott:** We are doing an inquiry into maternity safety. Part of the problem there is that there were early warning signs. We have data and there are early warning signs, but they are not necessarily being picked up. How do you think they should be linked together?

Helené Donnelly: The early warning signs are absolutely around staff wellbeing. You can look at staff sickness. You can look at retention. Obviously, that is picked up in the staff survey as well, but again guardians are a huge and to a large extent still untapped resource that trusts and organisations are not necessarily utilising in the best way. Some are, and Henrietta's team absolutely promotes and encourages that, but there are some that are still not getting it. For those who are still not getting it, we need to do some significant deep dive drills into where the problems are and where the barriers are. Then we need greater accountability and sanctions for those who refuse to reflect and those who persistently and consistently display bullying and intimidating behaviours, even when support has been offered.

The other thing we could do is to create a national body or a steering group with all the relevant stakeholders around the table. That would offer some tangible traction on improving cultures, compassionate leadership and stamping out bullying once and for all. We need to offer peer support and expert support to organisations that are struggling in this area. We do not want to be punitive. It needs to be a supportive and positive approach, but for the individuals and/or organisations who fail to address this there needs to be greater accountability.

Alongside that, we need to address the issue of just moving the problem, both internally within individual organisations and across the whole NHS. We have particular individuals and characters who are known to display persistently negative bullying and intimidating behaviours, but they are too difficult to handle so they just get moved along. Again, that can be internally or externally. It just passes the problem and does not really address it. That, in turn, leads more and more staff to feel apathetic and disillusioned. It creates a culture of staff not speaking up rather than

speaking up. We need much better focus on that. We need the data as well, to drill down and see where the issues are, as an early warning sign.

As you say, Laura, by the time staff are leaving and by the time staff are suffering significant sickness, both mental and physical, it is too late. Obviously, patients then suffer as well. There are significant warning signs, and Freedom to Speak Up guardians are well placed to offer that. I still think they are not utilised in the best way.

Q158 **Laura Trott:** Thank you for all that you have done. Lastly, Dr Hughes.

Dr Hughes: I agree with Chris that this is absolutely about the culture and prioritising the culture. When we get the culture right, the safety follows, and then the money follows. That has to be the order. Ensuring that all regulators are aligned in that, so that they can support the right cultures in the providers, is absolutely key.

I completely agree with Helené about triangulating the data and bringing together within organisations a steering group where you have full support of the Freedom to Speak Up guardians by the leadership, so that you can identify hotspots and see the early warning signals, and act on them. In the best organisations, they have regular steering groups or summits bringing together all the different parts of the organisation that have an impact on the culture, including the staff side and the junior doctors committee, the workforce race equality standard—I know you will be talking about the impact of race later—and many other parts of the organisation, so that they can actually say, "Where are the areas that we are concerned about? Where are the gaps?" Then the guardian can deploy their proactive role to support workers. By bringing the information up from the frontline, the leaders are able to use it for learning and improvement.

In summary, it is triangulation of data locally and a change in focus nationally, putting culture absolutely on a par with finances and performance.

Laura Trott: Thank you very much.

Q159 **Rosie Cooper:** I would like to address a couple of questions to each of you, if I may. While things may have improved in the NHS, a lot of NHS staff will be reading the transcript afterwards and thinking, "Well, the NHS talks a really good game, but on the ground our experience is very different." I would make a comment to Dr Hughes that we cannot rely on commissioners; for example, the chair of a CCG actually told me that a £2.8 million underspend on frontline district nurses was "swings and roundabouts". That has come out and will come out further in Kirkup reports.

My first question is to Chris Hopson. Coming out of the first Kirkup report, Health Minister Steve Barclay commissioned Tom Kark QC to look at the bullying culture and how to implement a fit and proper person test that actually worked to protect staff and, therefore, increased patient safety.

Chris, are NHS Providers, NHS boards, a stumbling block, a blocking mechanism, to a real fit and proper person test? Where do you see the situation now, and what have you done to make this work? What help have you given?

Chris Hopson: There are a number of questions there. The answer is that, in terms of the final ones, I sat with a group of people, including a group of first-line whistleblowers and NHS England and NHS Improvement, at the invitation of Baroness Harding, who was commissioned by the Secretary of State to work out some formal implementation recommendations for Kark. I put quite a lot of work in, with those other people, as to what the best way of implementing the Kark recommendations would be. As I understand it formally, because I was asking the other day, those recommendations are with Ministers and we are waiting for them to come back.

I do not think that NHS trust boards are the stumbling block. I think there are some highly complex and difficult issues that need to be worked through. For example, if you want to create the database of managers that Tom Kark wanted to create, one way of doing it would be formally and statutorily to commission it, which would require primary legislation. Another way of doing it would be on a voluntary basis. If we are going to do it on a voluntary basis, we need to work out exactly how we would encourage people to sign up to the database and what it would contain.

There are some quite important detailed conversations that need to go around how those recommendations would be adopted. If I may say so, this is where I get slightly frustrated. I think everybody in the NHS recognises that it is incredibly important that any senior leader on a trust board should be a fit and proper person, and we need a robust system to ensure that that occurs.

Q160 **Rosie Cooper:** Tom Kark made his recommendations on 20 March 2019. That is two whole years ago. People will draw their own conclusions. If the system wanted to actually fix this, it would have fixed it. The truth is that the system in different parts wants different things; therefore, this is in a cul-de-sac. I will leave that, but people will draw their own conclusions. After two years, there has been absolutely no movement whatsoever. Is that really the NHS looking after its—

Chris Hopson: I don't think it is fair to say that there has been no movement, Rosie.

Rosie Cooper: It doesn't exist.

Chris Hopson: I think a huge amount of work has been done. If I may say, this is an issue between Baroness Harding, NHS England and NHS Improvement, and the Department and Ministers. All I can say is that a group of us put in a significant amount of work to try to get to a sensible and workable way of implementing the Kark report. Quite a lot of things have happened since March 2019, including a global pandemic, in which the NHS has been somewhat busy and focused on doing other things.

Yes, I agree, Rosie. I am in the same place as you are, which is that we need a robust and effective system to ensure that every single trust director is a fit and proper person.

Rosie Cooper: Absolutely. What I will say is that we are two years on, we have a pandemic and the people we are relying on are the frontline staff who depend on being led by fit and proper people. I am sure Baroness Harding and the Department will hear that. Thank you very much for that.

Chair: Rosie, can we make this the last question? Sorry.

Q161 **Rosie Cooper:** Dr Hughes, how do you get the poor parts of the system to really respond, do the work and listen to the staff survey—and not rely on the good parts of the system? For example, in LCH those staff surveys were either not reported to the board or were meddled with. How do you know that everybody is aware of the real situation? I can only speak of Helené's comments, which I totally agree with. The staff survey and greater accountability is at the core. Dr Hughes, how do you know that is really happening?

Dr Hughes: I completely agree with you that it is the organisations that are really struggling with this that need the support to do better, but also the accountability. In terms of support, where guardians feel that they are not getting support from their leadership, or that they are not being asked, for example, to present in person to the board, they are able to come to my office. We have surgeries where they are able to discuss difficult situations.

It also forms part of the well-led inspection by the CQC. It is absolutely vital that, when the CQC inspect, they are able to ask the right questions to draw the right conclusions and then, if necessary, use their regulations. We have seen breaches being issued by the CQC in terms of Freedom to Speak Up.

Ideally, we want leaders seeing this as absolutely fundamental, but in some organisations there is a vacuum in the leadership. They do not seem to understand it. They do not want to know, and they do not see the value of listening to the information that is coming through their Freedom to Speak Up guardian. The main thing about it is that we can provide the information. The will has to be there. The boards have to be fully bought in and engaged. If they are not, that forms part of their inspection by the CQC.

Chair: Thank you very much indeed. I am so sorry; we have so many questions we wanted to ask you. It has been an absolutely fascinating session, and I thank everyone for coming in.

Thank you, Professor Dawson for your expertise on the staff survey. Chris Hopson, all of us would like you to pass on to your members our thanks for the incredible hard work that is going on right at the moment. I also thank Helené Donnelly and Henrietta Hughes for your campaigning to

make it easier for NHS staff to speak out under such extraordinary pressure. We are really grateful to you for joining us. Thank you very much.

Examination of witnesses

Witnesses: Lord Adebowale, Shilpa Ross and Tricia Pereira.

Q162 **Chair:** In the second and final panel this morning, we are focusing more specifically on the challenges facing those from black, Asian and minority ethnic backgrounds. I welcome our panellists. Lord Victor Adebowale is chair of the NHS Confederation, and I am sure he will have a lot of views on the things we have just been discussing. He also hosts the NHS Race and Health Observatory.

Shilpa Ross is a fellow from the King's Fund, who has led research on workforce race inequalities in NHS Providers. Trisha Pereira is head of operations for adult social care and is co-chair of the BAME Communities Advisory Group to the Social Care Sector Covid-19 Support Taskforce.

We have a big range of people. I want to ask all three of you the same question, but I will start with you, Lord Adebowale. When we had Simon Stevens in front of us and we were talking about this issue, he said that he thought there were systemic features to discrimination and racism, and the NHS was both part of the problem and part of the solution. How supportive overall do you think the NHS is to its employees from black, Asian and minority ethnic backgrounds?

Lord Adebowale: Thank you, Chair, for inviting me to this panel. Simon is right; it is a systemic issue, but it is and/and. What I have noted is that leaders in the NHS, who are mainly white, generally are not held accountable for leading all the people all the time. That is a systemic issue. What you end up with is a situation where you have leaders who, indeed, come before your Committee and are asked all sorts of questions about the NHS, but actually they are not asked about 20% of the workforce. In business, if 20% of your workforce were receiving more bullying, were not being promoted, were refusing to work in the NHS and were working for agencies, costing the NHS money, were dying disproportionately and where repeated staff surveys showed that they were unhappy—that is an understatement—you would make it part of the generality of what you held leaders accountable for.

While things have improved, largely as a result of things like the workforce race equality standard—which, by the way, was one of the most difficult things I have ever set up in the NHS—we have a long way to go. At the moment, the NHS is on the brink, and we cannot afford to have 20% of our staff feeling disengaged or under-led. We have to make the people we put in leadership positions lead all the people all the time.

Q163 **Chair:** Let me ask Shilpa for a response to the same question.

Shilpa Ross: My thanks also for being invited. In terms of how supportive the NHS is of its ethnic minority staff, the research that my colleagues at the King's Fund and I carried out, and data such as the workforce race equality standard and the staff survey, show that staff experience in the NHS is not the same for everyone.

Our research shed some light on some of the issues where the NHS as an employer is not felt to be supportive. This includes offering equal opportunities to progress in one's career, and transparency about career progression opportunities, such as access to training and development or job vacancies. It is also lacking in creating work environments that are inclusive and value every member of staff.

Q164 **Chair:** Thank you. That is a very helpful answer. Tricia, can I ask for your perspective on that same issue, with respect not to the NHS but to the social care system?

Tricia Pereira: Good morning. Thank you for inviting me to take part in this Select Committee.

All the discussions and responses that have taken place this morning around the NHS are echoed in social care. The experiences that people have been talking about are exactly the same for social care, but we do not have parity with our colleagues in the NHS. The visibility is not there. The conversations roll around the NHS, and social care is often felt as being an afterthought.

There is a 1.5 million-strong workforce in social care, but only around 5% of board execs of the biggest care providers are filled by leaders from BAME backgrounds. As you know, social care is a very different set-up from the NHS. It is quite fragmented. It is across the country nationally, so you are looking at larger organisations and smaller organisations. The information and the data that you have spoken about already for the NHS and its workforce is harder to capture in social care.

You touched on the WRES—the workforce race equality standard. I can appreciate that it must have been quite a task to get that on board and a big challenge, but it is there. We are now developing something very similar for social care, but it is largely within our statutory social care settings. It is not so easy to replicate things that have taken place in the NHS and just move them across into social care. We need to think of ways that it can be comparable.

First of all, is leadership supportive? There needs to be some research to gather that information. There needs to be some engagement. There need to be opportunities for the workforce to be able to speak their truths and talk about their experiences in the same way that you have been able to capture for the NHS.

Chair: Thank you very much indeed.

Q165 **Taiwo Owatemi:** My initial questions are about the impact of workplace

bullying on staff from black, Asian and ethnic minority backgrounds and what can be done to address it. My first question is for all members of the panel, starting with Lord Adebowale.

You have already spoken a bit about some of the impacts, such as NHS staff choosing to become locums or just choosing not to completely engage with the workplace due to some of the bullying and harassment they face. What impact do you think workplace bullying and harassment is having additionally on colleagues in the NHS and social care from black, Asian and minority ethnic backgrounds?

Lord Adebowale: There are a few things. First of all, the issue is not divorced from the quality of patient care. We know, because of work done by Coghill et al, that there is a direct impact on patient care if you treat your BAME staff poorly. Those staff suffer when they see patients treated badly or when there is poor care and moral harm. That is the first thing.

Second is the lack of promotion. There is a direct financial cost: we know that. There was a report done by the King's Fund some time ago that showed millions in additional cost to the NHS of having to recruit agency staff.

The mental and physical health of black staff is deeply damaged, as would be the same for anyone. There is no difference between being bullied or disengaged if you are black or if you are white, basically. It has an impact on your self-esteem, your mental health and your physical health. Of course, what the NHS is then doing is denying itself the advice and knowledge of those staff. For example, in the first days of the crisis it was noted that most of the leaders of the response to the Covid crisis were white. Indeed, anecdotally, when people asked, "Why aren't black leaders involved in this?", they were told, "Well, we needed to get the best people possible." That says something.

The fact of the matter is that if we are to respond to this crisis we are going to need BAME communities in places like London, Leeds and Bristol to work with us. If we do not have black leaders at the top of the tree, how are we going to understand the experiences of communities at the bottom of the tree? This is not a case of either/or: we either look at race or we look at the rest of the system. It is and/and. The impact on black staff is tremendous. They are 20% of the staff.

By the way, when I talk about this, in relation to the response given by Tricia, whom I really respect—she was spot on—it is a health and social care challenge. When we look at it across the NHS Confederation, we refer to it in that way. Indeed, 90% of my members consider that the inequalities in health and social care, which incorporate race, are a No. 1 one issue on their agenda. Before I close on this point, 74% of BAME leaders believe that BAME communities continue to have poorer services than their white counterparts. That is a significant challenge for the whole of the NHS, not just black people. All leaders should be measured by whether or not they meet that challenge.

Q166 **Taiwo Owatemi:** That is very concerning, especially the impact it is having on patient care. Shilpa, do you have anything to add?

Shilpa Ross: In terms of the impact of bullying, harassment and abuse on ethnic minority staff, it is important to keep in mind that in our research a number of people prefaced what they said in interviews by talking about their passion for their job in the NHS. It is important not to think of them as a wholly disengaged group. They love their job and want to do their job well.

However, when they talked about their negative experiences, it definitely left them feeling frustrated, angry, sad, unsupported and exhausted. It may be helpful to think about what can characterise the NHS working environment for someone from an ethnic minority background. Not everyone from an ethnic minority background will say this, but there were patterns in what people said in interview.

On a frequent basis, you can experience things like microaggression from colleagues and patients. You can feel more at risk of a patient or a colleague complaining about you, and that turning into a full-on disciplinary process. You can feel that you are being blocked from progressing in your career, while seeing quite different career trajectories for your white counterparts. That was repeatedly mentioned by several participants. You can feel excluded and marginalised from decision-making groups and so on.

Q167 **Taiwo Owatemi:** Microaggression is definitely something that many NHS staff that I know personally express that they feel in the workplace.

Tricia, with regard to the social care sector, what are the challenges that colleagues from black, Asian and minority ethnic backgrounds are facing?

Tricia Pereira: Exactly the same. They talk to me about experiences around racism, bullying, lack of career progression and opportunities to progress in their careers as well. They talk of being overlooked for more senior positions. The daily microaggressions that we have already spoken of and touched on in the workplace, and also from families and from people they are supporting, seem to have increased during the pandemic. That has a real impact and effect on an individual's wellbeing.

I myself have been going out into the community. I am still working. Our social workers are visiting, and our social care staff are visiting homes. Just the other day, when I was visiting somebody, they said, "Oh, I am pleasantly surprised." I said, "What are you surprised about?" They said, "You speak really good English." I stopped for a moment and said, "Thanks. I should because I was born in the midlands." You make light of these things, but they are the daily things that staff go through. They are working on their own individually in the community, and I don't think that people understand and appreciate just how hard we are working in social care. We are supporting people with vast complex needs who are being discharged from hospitals by our health colleagues. We are supporting

them, and all of that takes its toll, especially when staff are asking about risk assessments.

At the beginning of the pandemic, there was concern when it started to be heard and known that certain members of communities were perhaps more at risk of Covid. Staff were asking about individual and organisational risk assessments, to enable them to do their work safely. They were made to feel that they were being over-anxious: "This is part of the job. You go out into the community. You support." They don't want to let their colleagues down. They want to keep going on, and they will still keep going on.

There was the introduction of the risk reduction framework, but it would be interesting to know how it has been adopted across social care. Larger organisations have their own templates to do risk assessments, but how is it being done in a meaningful way? We know that in the NHS 95% of BAME staff have had a risk assessment. We don't have the same data for social care. That is something we need to have.

Q168 **Taiwo Owatemi:** I agree. It is one of the key issues that we are looking at in other investigations that we are currently doing in the Committee in terms of what improvements can be made in the social care sector.

Following up on that, what barriers do you think prevent colleagues from black, Asian and minority ethnic backgrounds from raising their concerns in the workplace?

Tricia Pereira: They don't want to be labelled as challenging and difficult. They feel that they are misunderstood. We have spoken about parity, and it is very clear that it is not there; it is not the same. They feel that their career progression opportunities may be limited. Also, a large proportion of the workforce are in lower-paid roles. They are not low-skilled roles, just lower paid, especially in comparison with our colleagues in the NHS. They are doing almost identical work but are paid much less. They perhaps have to work across organisations to be able to make up their pay, and they do not want to lose their shifts. They do not want to be penalised in that way, so there is a fear of speaking out.

Q169 **Taiwo Owatemi:** Precisely. They do not feel safe enough to be able to raise their concerns, and they think their job might be at risk if they do.

Tricia Pereira: Yes. That is some of the anecdotal evidence that people are talking to us about. Large-sector organisations, like the British Association of Social Workers and Skills for Care, have set up peer support sessions and opportunities, so that people have a safe space in which to talk honestly and openly but anonymously about their experiences. That is one of the ways that they are able to capture some of the data, but there is fear of speaking out.

Taiwo Owatemi: It would be good to be able to look at that data and see what information has been collected. Thank you.

Chair: Yes, that would be helpful. If you are able to supply that to us, Tricia, it would be really helpful.

Q170 **Taiwo Owatemi:** What can managers and leaders do to support colleagues from black, Asian and minority ethnic backgrounds? I also want to ask a bit more about the Covid-19 experiences. I know that has been raised a lot.

Chair: Shall we direct that question to Victor?

Taiwo Owatemi: Yes.

Lord Adebowale: I noted the response from the conversation about standards of leadership in the NHS, the Clark report and the need to build it in. I take the view that it is about competency. As I say, they are paid, and indeed asked, to lead all the people all the time. Certainly, my members, when I talk to them, want professional support and guidance to operate at their best and to lead all the people all the time.

I think the following things need to occur. I am not convinced that it requires legislation. What it requires is professional support. It requires almost a code of practice for managers that most would sign up to, but then what you need are the interventions that help them to carry out that practice day to day, as you do in other professions where there are leaders. From surveyors to doctors, there is a sort of professional cadre, such as the British Institute of Management. It is that kind of thing that could be done.

Secondly, they need to be held accountable, as I have said, for the whole system. If we know that 20% of staff receive a poor leadership service, that is an issue for you as a Committee to be asking all leaders, as Jeremy pointed out in his conversation with Simon Stevens, who, by the way, was exceptional in dealing with the issue of race on his way in, as opposed to the way out. It should be a core measure of system performance and individual performance. I have a lot of time for the CQC, but I find it astonishing that a trust—many of my colleagues lead trusts—can be rated "Outstanding" while 30% of its BAME staff are basically saying that they are performing below standard because of bullying and harassment.

The same applies to social care. It is about holding leadership accountable for the whole system, because we cannot afford to have any section of that system performing below par, particularly as we go into the next challenge of population health and system leadership. I know that the leaders of ICSs—integrated care systems—that I talk to on a daily basis are really concerned to ensure that they have the data from trusts, primary care, community trusts, mental health trusts and the voluntary sector in their system, so that they know where the leadership gaps are and how that relates to performance in population health.

If we can do all that, we can start to turn the ship faster and bring on board the 20% of staff who, at the moment, feel that they are not part of

the leadership debate, not part of the patient debate and not part of the forward view of the NHS and social care system. That is critically important in relation to the vaccine because already, anecdotally, we know that significant numbers of black staff are refusing to take the vaccine. This is a critical issue, and we cannot afford to get it wrong. There isn't a plan B, so we have to make it part of the mainstream debate on leadership, in which case it is a debate for everyone. We cannot have it as a side issue, and we cannot expect black staff to solve their problems. That is not reasonable.

Chair: Thank you very much indeed.

Q171 **Dean Russell:** I would like to ask the whole panel this, but I am conscious of the time so I will start with Victor, if I may. Continuing the Covid discussion, last year there were really worrying numbers shared around the percentage of the BAME population, especially staff, who sadly died through Covid. I wondered whether there have been any studies yet into the long Covid impact across the whole of the NHS and social care staff but looking in particular at the BAME population. Has that been done yet, or is it under way?

Lord Adebowale: Thank you for that question, Dean. The first 10 people to die in the NHS were black, and that rate of disproportion has continued, so it is terrifying for frontline black staff. As far as I am aware, there has not been a study of the impact of long Covid in minority ethnic groups.

One of the things that the Observatory on Race and Health is doing at the moment, in partnership with the College of Hygiene and Tropical Medicine, is looking at both the impact of Covid and the issue of the vaccine and how we relate that to BAME communities, and what leaders need to do to reverse that needle. It is a very good point; we need to look at the impact across the piece. There are very few studies of people with long Covid. We have just started to look at the impact of long Covid as a piece, but we should look at the disproportionate impact on BAME communities because it is having a disproportionate impact.

Q172 **Dean Russell:** Absolutely. One of the challenges there is on workforce numbers. If long Covid becomes something that is a large factor for all of the NHS and social care, but in particular, in the instance of this Select Committee, on the BAME population, my worry is what that means in terms of absence issues for individuals, long-term health concerns and so on.

Looking at it from your perspective, if that sort of work starts, to look at that, how would you see it rolling out? Are there mechanisms at the moment to be able to measure it, to get feedback and those sorts of statistics, or do new mechanisms need to be set up?

Lord Adebowale: My view is that new mechanisms need to be set up to look at it. We can build on the mechanisms—the staff surveys—and talk to the clinical frontline, which I think is vitally important. It should be

remembered that we went into this crisis with reported staff shortages across the NHS and we were already challenged. This has not made it any better. All staff, black and white, are working under tremendous pressure, as you know.

We need to deal with the challenges they face on the frontline first and start removing some of those challenges. For black staff, it is the continued sense that they are on the frontline. They are literally facing the Covid virus. The anecdotal evidence, which is evidence in and of itself—in the absence of quantitative data, you only have qualitative data and there is a lot of it—is that black staff continue to feel pushed into the frontline, unable to get the protection and support that is necessary, and are still being affected in disproportionate numbers.

The way to reverse that is to start listening more carefully to those staff about supportive structures and how much control we can give them over their day-to-day work environment and the way in which they design and manage their work. The same principle applies to white staff, which is why I say it is about leaders leading all the people all the time. What we know from research about dealing with stress is that the more control you give people, the less stress they feel. The more support you give them to remove the barriers—bureaucracy and so on—the more likely it is that they will feel in control.

Those are the things that we need to do, but we need particularly to do them in relation to BAME staff because they are the people absolutely facing this on the frontline in the poorest communities, who we already know are disproportionately affected.

Q173 **Dean Russell:** I agree wholeheartedly on the red tape issue. There was a question in the earlier session as well around the impact of that. I will not explore it further now because we covered it earlier.

We talk about frontline workers, who many people think of as doctors and nurses, but if you are a porter or a cleaner working in a hospital you are just as much in the thick of it as everyone else. In my local hospital, we have a large Filipino community. When we are talking about frontline workers and BAME, are we reaching out to all members of staff across the board, from porters through to clinicians, and all ethnicities, which may include the need for support with languages as well?

Lord Adebowale: To be absolutely clear, when I refer to black and minority ethnic workers, I include Filipino workers. When I talk about frontline workers, and certainly at the confederation, it is not just about the 44% of GPs from minority ethnic groups, or indeed just GPs; we refer to nurses, cleaners and porters, all of whom are disproportionately represented in the BAME community. I think your point is well made.

I think we should commission the research on long Covid now. Let's not muck about—let's do it. The question of understanding the conditions in which those people work, and the communities they come from, is

critically important. There is evidence that they are the people who are least likely to be able to cope with being shielded and having to stay at home, because they are on low wages. They are more likely to live in overcrowded conditions, so there is a greater risk of spread, and they have the least flexibility over their job roles. That is not to say that they do not know. When I talk to porters, frontline workers and nurses, the amount of knowledge they have about how things could be done better is remarkable—it really is—but they are not listened to. Where there are good examples, and there are many good examples, and when they are listened to, you see the improvements immediately across the piece.

If you look at the Social Partnership Forum work that has been done by NHS Employers, frontline workers are empowered to share their experience in such a way that it leads to change. If you look at North Bristol trust's Red Card for Racism approach, and at Rob Webster's strategic approach in the West Yorkshire partnership around ICSs, you start to see the seeds of a shift in leadership, and leaders taking responsibility for the culture they create. The only test for a progressive culture that works is not at the top. They are the people who usually feel rock and roll. It is the people at the bottom. That is the key test. Do the people at the bottom feel that they are empowered to do the best and be experts in the work that they do? I am afraid that we have a way to go there, but the confederation is working with our members across trusts, primary care and ICSs to move the needle in that direction. That is what our reset report was all about.

Chair: Thank you very much.

Q174 **Barbara Keeley:** This is a question for Tricia Pereira about social care organisations and how supportive they are to their employees from black, Asian and minority ethnic backgrounds.

You touched on people being in low-paid roles, not low-skilled roles. We know that social care lacks many defined career progression pathways. Thinking about senior staff in the sector, such as registered managers, does that lack of a career pathway have a particular impact on diversity and representation for people from black, Asian and minority ethnic backgrounds?

Tricia Pereira: Yes. There are fewer registered managers from black or minority ethnic backgrounds. The majority of the staff are in the caring roles, so they are at the entry-level roles. Across the whole sector, progression is an issue. Just having the opportunities, the right modelling, the right coaching and the right training is lacking. It could be vastly improved.

Q175 **Paul Bristow:** My questions are to Lord Adebowale and Tricia. To what extent do you believe that the particular experiences of black and ethnic minority staff that you have identified are a specific thing for our NHS and social care system, or do you believe that they are represented more broadly across society and in other institutions?

Lord Adebowale: Obviously, the NHS and social care system, with 2.5 million people, is a significant chunk of society itself, so it is bound to reflect the pressures on society. Recently, Black Lives Matter and the issues of Covid, and what is happening, are bound to have an impact on black staff because they are segments of society.

What I think is different is that it is only recently, in the last two and a half years, that the workforce race equality standard was developed, so we only started getting real data on this in the last couple of years. The Observatory on Race and Health is literally having its first meeting next week. I edited, along with Professor Mala Rao, an edition of the *BMJ* that looked at race across the NHS and the social care system for the first time.

It could be argued that the NHS and the social care system is somewhat behind other industries. Certainly, if you look at the representation of BAME staff at the senior levels, you will see that there is a real challenge. It is improving, but the flow of leaders into the top positions in the NHS is somewhat depressing, to be honest. What we are doing is removing talent.

There are specific issues that affect black and minority ethnic staff, which have been referred to by other witnesses but are particularly significant. They are well researched. If you look at the research done by David Williams at Harvard University on weathering the impact on black staff of the stress of discrimination, lack of recognition, poor inter-professional relationships and the lack of being listened to, you see that there is an impact on health, with increased blood pressure, cancer and heightened quantities of damaging hormones. Those are all measured, so there is a disproportionate impact on black staff.

Of course, the whole of the NHS workforce reflects in some way the impact of what is happening in society. The difference is that the NHS is on the frontline of care. There is an element whereby we are putting people in a position where their job is stressful by definition. There is a limitless need out there, so it behoves us as leaders to put in place the structures and support necessary to alleviate those stresses, regardless of what colour you are. Where we see a disproportionate impact on 20% of our workforce, we should hold leaders responsible for putting those structures in place, and for the cultures they create that mitigate against fairness and good practice. It is not an accident that these things happen in the NHS. That is what I am saying. Does that help?

Q176 **Paul Bristow:** It does. I will come back on that, but I wonder whether Tricia wants to comment.

Tricia Pereira: I am still quite disappointed that we are having conversations separating the NHS and social care. The experiences of black and minority ethnic staff are the same, no matter what part of the sector they work in. The systemic racism and inequalities are exactly the same. The difference, as I have said previously, is that the visibility, the

value and the parity is not there for social care as it is in the NHS. When you talk about leadership and aspiration, there are very few visible senior leaders in social care, even less so perhaps than in the NHS. For people who are aspiring, if the visibility is not there, they feel that perhaps they would not belong in those particular roles. If the systems are not there, but there are barriers or challenges for you to progress into certain roles, that is what we need to address and tackle.

What people say to us is that there is a whole lack of understanding; there is lack of support and recognition of their role and the work that they are doing within organisations. There is the fact that, even if they are progressing and undertake specific training to become an aspirational leader or a future leader, they might need to leave the organisation and work elsewhere because they are not recognised in the organisation they are in. I can imagine that that is exactly the same in the NHS, whatever health trust they work in.

I would like the conversation to be broader. If you are focusing on the NHS, expand it to us in social care. We want to be included, and we want parity. We want to be the same.

Q177 **Paul Bristow:** Reflecting on that, what I specifically heard there was that the NHS and the social care system itself is not more discriminatory than the rest of society, but the very nature of the health and care elements perhaps exemplify some of the problems. *[Inaudible]*

Lord Adebowale: I am sorry, I didn't hear that.

Q178 **Chair:** Could we have a final comment from you on that, Victor? The argument is that it is not a special issue in the NHS, but because the NHS is such a large chunk of society, it exemplifies broader societal problems. Is that broadly something you would agree with?

Lord Adebowale: Not really. I would agree with the first part—that it reflects broader societal problems. The fact of the matter is that, if two-thirds of the disproportionate deaths have been BAME as a direct result of Covid, that is not the same as in any other industry in society. If you are statistically less likely to get a senior role in the healthcare profession in the NHS than you would in other professions, that is something about the NHS. In London, 50% of nurses are BAME. There are very few industries where 20% of the workforce are black and minority ethnic. We actually rely on them. The discrimination mitigates against the effective use of 20% and an effective partnership with 20% of the workforce.

As we move into the new challenges of population health and system leadership, we have to test every piece of strategy, legislation and structure against this. Are we leading all the people all the time? Are we reversing the inverse care law? That is specific to the NHS and social care system. If we do not, it costs everybody. It is not just black people or poor communities. We all pay the price. That places the NHS in a very special position, even though because it is 1.5 million, and 1 million in the

social care system, by definition it reflects some of the challenges in society at large. It is a systemic challenge, but I do not wish to get into the systemic causes of societal challenges at this stage. It is critical that we hold NHS and social care leaders to account for the cultures they create.

Chair: Thank you. That is a very powerful point to end on. We could obviously talk about this a lot more. Indeed, we have been talking about it in a number of different sessions that we have had on the pandemic and on other issues.

This has been a very thoughtful session. Both our sessions today in different ways have focused on the issue of leadership and the importance of leadership. I particularly thank our second set of panellists, Lord Adebowale, Shilpa Ross and Tricia Pereira. We are incredibly grateful to you for all the time you have given us this morning, when everyone is so busy. We wish you every success in your continuing roles. That concludes this morning's session.