HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Workforce: recruitment, training and retention in health and social care, HC 893

Tuesday 22 March 2022

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Watch the meeting

Members present: Jeremy Hunt (Chair); Lucy Allan; Martyn Day; Dr Luke Evans; Taiwo Owatemi; Dean Russell.

Questions 67 - 128

Witnesses

I: Professor Dame Clare Gerada, Medical Director, NHS Practitioner Health, and Chair, Doctors in Distress; Wayne Jaffe, Consultant Plastic and Reconstructive Surgeon, University Hospital of North Midlands NHS Trust; and Dr Vishal Sharma, Consultant Cardiologist, Royal Liverpool and Broadgreen University Hospital NHS Trust; Chair, BMA Consultants Committee; and Chair, BMA Pension Committee.

II: Professor Carol Atkinson, Professor of Human Resource Management, Manchester Metropolitan University; Jacqui McBurnie, Chair, NHS England and NHS Improvement Menopause Group; and Professor Carol Woodhams, Professor of Human Resource Management, University of Surrey.

III: Prema Fairburn-Dorai, Director, Primary Homecare, Suffolk; Nina Hemmings, Researcher in Health Policy, Nuffield Trust; Shilpa Ross, Policy Fellow, The King's Fund; and Dr Wen Wang, Associate Professor in Human Resource Management, Data Analytics and Interpretation, University of Leicester.

Examination of witnesses

Witnesses: Professor Gerada, Wayne Jaffe and Dr Sharma.

Q67 **Chair:** Good morning and welcome to the second evidence session of the Health and Social Care Committee's inquiry into issues faced by the NHS and social care workforces. In this week's session we are going to focus on the important issue of retention, why people are leaving early, why they are going part time and what we can do about it. The reason this is particularly important is that we often talk about whether we are training enough doctors and nurses for the future, which is obviously a long-term solution, but in the short term the one thing that we can do that has an immediate impact is to stop the drain of people leaving for whatever reason. That is the purpose of this morning's session.

In our first panel, we have some stellar witnesses, who will talk to us about the issue of mental health in particular, and why burnout is causing pressure. It is something we have looked at before, but it is obviously very relevant to the broader issue of workforce pressures.

I welcome Professor Dame Clare Gerada, who is former medical director of NHS Practitioner Health, and well known to this Committee. Since November 2021, she has been chair of the charity Doctors in Distress, which has the goal of zero suicides among doctors by 2025. It is a very specific aim, but it will be amazing if we can get there.

Wayne Jaffe is joining us virtually. He is a consultant plastic and reconstructive surgeon at University Hospital of North Midlands NHS Trust. He is currently on pre-retirement leave, partly caused by pension taxation issues. This is an issue that comes up time and time again. We are very grateful to him for joining us.

With us in the House of Commons we have Dr Vishal Sharma, who has been a consultant cardiologist at the Royal Liverpool and Broadgreen University Hospital NHS Trust since November 2011. He is chair of the BMA consultants committee and chair of the BMA pensions committee.

Clare, let's start with your general assessment of the mental health of the NHS workforce. Last week Martin Marshall, who succeeded you as chair of the RCGP, told us that 60% of GPs said that their mental health had suffered and that about a third of GPs were planning to leave the profession in the next five years. Is that kind of picture reflected across the NHS as a whole?

Professor Gerada: Yes, it is. I have been caring for about 17,000 doctors over the last 12 or 13 years. What we saw during the pandemic specifically was as many doctors present to my confidential service as we saw in the first 10 years of the service. There were 5,000 in the pandemic year—March 2020 to April 2021—versus the first 10 years, so there clearly is a problem exaggerated by the pandemic, but we had it before the pandemic, and you know that well, Jeremy.

We had the Wounded Healer international conference last week and heard story after story of doctors who are leaving. In particular there was an FY2, a very junior paediatrician, who was found on the railway tracks—he openly talked about this—trying to kill himself because of the workload, the intensity, the bullying he experienced and the lack of compassion and caring he found in the workplace. We have stories like that, and I care for those bereaved following the suicide of health professionals. That is the closest you can get to the person who has killed themselves. Story after story, it is around the workplace.

I think we should abandon the word "burnout". Burnout is too gentle a term for the mental distress that is going on among our workforce. Burnout is an occupational illness. For many years, I have said that if you had an occupational illness such as pneumoconiosis, as we had in miners, you would not ask the miners just to go and have an x-ray every year and wear a flak jacket. You would actually reduce the toxic agent and start to make it safer for them. I know that you are trying to do that. We have to make it safer. We should stop photographing the problem and stop collecting data, and actually start addressing the solutions.

There are solutions. They need to be brave solutions if we are to do it. In particular, the distress that is caused right across the board is around the intensity of the workload. It is a spiralling problem because the more staff who leave, the more the intensity of the workload increases and the staff are less compassionate and have less time to care for each other and to have reflective spaces, so we spiral further down. I have sent you evidence of the pandemic year. I can send you endless evidence. You collected it last year in your Health Committee report on wellbeing.

Q68 **Chair:** Let me ask you about a couple of things you said there. First, on the pandemic, one very specific issue that I am hearing about is doctors with long Covid being fired by their trust. Have you come across that? Do you have concerns about the support that doctors and nurses—we should not just talk about doctors; it is anyone working in the NHS and care system—are getting to deal with long Covid?

Professor Gerada: My charity, Doctors in Distress, has run groups for doctors and nurses with long Covid. Throughout the pandemic we have run support groups and reflective spaces. We have heard tale after tale of doctors, nurses and other health professionals being sacked because they have long Covid.

Long Covid is just one issue that is going on. It is one very specific issue due to the pandemic. The symptoms we have underneath all of this are symptoms of an organisation that is unable to care for its workforce in the way that it should be caring. We have seen it in all the professional groups. GPs are worse. GPs represent about 60% to 70% of that 5,000 and the other specialties represent about 30% to 40%. Long Covid is an issue, but I do not think we should get fixed on long Covid because then we go down a rabbit hole and start providing support for long Covid. You cannot get burnt if you are not on a burning platform. Working in the

NHS is almost entirely working on a burning platform. We have to put the fire out and not just patch up the people who are burnt.

Q69 **Chair:** My second question on what you said is this, and perhaps you could unpack it for us. I think people who are not doctors, who do not work on the NHS frontline and do not have a medical background, are very perplexed when they hear talk about bullying in the NHS. We associate people in the NHS with being some of the most caring people you could imagine. When the NHS staff survey says that 28% of staff report bullying and harassment, it feels very perplexing and even counterintuitive. Could you unpack what is happening on that bullying and harassment issue?

Professor Gerada: It is exactly as you say. Bullying is anything from shouting at staff, not allowing staff time off when they are meant to be having time off and not allowing them rota changes. As we know from our own families, for example, you do not have an argument unless you are particularly stressed. I think bullying is a symptom of what is going on. Most of the time, as you have said, members of staff—although the NHS has a few psychopaths floating around—or people who work in the NHS do it because they want to care.

The problem is that when you have to give more to others, which you do as a doctor, you do not have much left to either care for yourself or for your colleagues. It is a symptom of the underlying problem.

Q70 **Chair:** Thank you. Dr Sharma, does what you heard from Clare ring true to you?

Dr Sharma: Absolutely. I agree 100% with what Clare is saying. You mentioned what Martin Marshall said last week. The BMA figures back that up. The BMA survey from last November shows that 60% of doctors were saying they have stress and workplace anxiety. One in five are planning to leave the NHS altogether, and two out of five are planning to retire early. It is almost exactly the same figures, and that absolutely is the case.

It is not one thing. The whole system is under incredible pressure. Not one bit of the work you do is easy or straightforward. The acute side is under incredible pressure. It is now a common occurrence to go to work and be told that a critical incident or a full capacity protocol has been declared. The A&Es are full; the corridors are full; you are being asked all the time to go and help out in ED, which of course you need to do, but also to discharge patients even if they are not quite ready for discharge. All this pressure is just building up.

You know, throughout all of it, that you are not providing the quality of care that you want to provide. You are not actually providing patients with the quality of care that they deserve, because everything is under pressure. Then you go away from the acute setting to your out-patient work, and that is no better. The waiting lists are so long. For every bit—

out-patient clinics, procedures and surgeries—it is all incredibly stressed, and you are contacted on a daily basis by patients and GPs saying, "I'm not well. I need to be seen," and you have nowhere to bring them. It is incredibly stressful, and it all builds up and up, as Clare says.

You mentioned the bullying. I am sure there is, of course, true bullying, but most of it is just transference. You have all this pressure on you. You are under so much stress yourself and, sometimes, as Clare mentioned, you transfer that on to other people. Of course, that is not acceptable, but it is a symptom of all the pressure that you are under. Adding to all of it is the moral injury of not being able to provide the care that you want to provide to your patients. It is really intense. You are terrified all the time of making a mistake because the system is not supporting you.

Q71 **Chair:** Can you explain what you mean by moral injury?

Dr Sharma: Moral injury is the guilt when you see people suffering and you cannot do what you need to do to provide the care they need. You may have patients at home who are suffering, and you cannot bring them in for treatments. You have patients on the wards, in corridors on trolleys, not getting the care they need. You are sending people home when they are not quite ready. You are being asked to do all of these things that you know are not right, but you have no choice because you have to try to look at the whole picture and provide the best possible care for the whole population. You know that actual individuals are suffering as a result.

Q72 **Chair:** The BMA supported our Select Committee recommendation for a total overhaul of long-term workforce planning. In the short term—because it obviously takes a long time to get more doctors and nurses trained up—what are the things that would make the biggest difference to stop people deciding to leave, and thereby inadvertently of course increasing the pressure for their colleagues when they leave?

Dr Sharma: Absolutely. It is incredibly difficult. A lot of it will take time, but the one thing that could be done now, which you alluded to at the start, is fixing pensions. You need to keep that workforce in, so to have rules whereby people are forced to either retire early or reduce the amount that they do is completely counterintuitive. We have such a shortage of doctors already in this country. We have 25% fewer doctors than the European average, and nearly half as many fewer than Germany. Germany has three times more hospital beds than we have. All of these things are a problem.

Q73 **Chair:** Could you explain to us how the pension issue has happened?

Dr Sharma: The first thing to be clear about is that doctors do not want any special tax treatment. We are not after anything more generous than anybody else. The problem is the interaction between the pension rules and the tax rules, and the two combine. Essentially, the annual allowance and the lifetime allowance are designed to claw back tax relief that you get on pensions, but the way the NHS pension is set up means that you

do not actually get tax relief in the first place because it is built into the scheme. Higher earners pay more per pound of pension in the scheme, so it already adjusts for tax relief. That is one of the problems.

The other issue is that, because it is a claw-back tax, when you are affected by it you have very high marginal rates of tax. They have designed these taxes to reduce the amount of money you pay towards your pension, but in the NHS and other public sector schemes the only way you can reduce the amount you pay into your pension is by working or earning less. That is the problem. If you were in the private sector, you would say, "Okay, these are my limits. I will just pay this much into my pension." But in the public sector, particularly the NHS, the only way you can change that is by working less and earning less.

Q74 **Chair:** If you do not do that and carry on working, what does your marginal tax rate increase to?

Dr Sharma: In some cases it can be up to 100%. If you are affected by the annual allowance and the lifetime allowance on the same pension growth, when you throw in your contribution rates and your income tax it can be close to 100%. If you go over certain thresholds, it can be many times that; you can actually end up worse off by going above the thresholds. Generally, the combination of the taxes plus your contributions means that you earn less, or all your money will disappear if you carry on paying into the scheme.

Q75 **Chair:** If you have not already done this, could you write to the Committee and explain that particular issue? It is obviously a big issue. Let me bring in Mr Jaffe to explain his situation. Thank you very much for joining us. You are on pre-retirement leave, and I think the pensions issue is one of the reasons.

Wayne Jaffe: Good morning. Thank you for allowing me to appear before you today. I am a senior NHS consultant plastic and reconstructive surgeon based at the Royal Stoke University Hospital, where I lead the largest cancer MDT in the trust. I am chair of the expert advisory committee for skin cancer for the West Midlands Cancer Alliance.

Yes, I am going to retire from the NHS next week, almost against my will. I feel that it is like a constructive dismissal. I have also seen many fellow senior colleagues just leave. I am the last man standing. This is completely unprecedented, in my experience, and is at such a bad time for the NHS. I see more and more patients with skin cancer presenting late with advanced disease, and am having more and more difficulty treating those patients because of issues in the NHS itself with lack of staff and lack of beds.

We seem to be haemorrhaging senior staff. I feel it is like a cull of senior doctors. The only reason I am going is what I feel are unfair and punitive additional taxes which I have to pay each year because of my seniority. I cannot avoid them and go to work at the same time so, like many other

consultants, I had to take expert financial advice. It is always the same: "You need to leave; it is a no-brainer."

Why has such a straightforward and previously highly regarded pension scheme become so toxic and complex? This was meant to be my deferred pay from my days of ADHs and UMTs back in the day. Now, every year in October, I fear the brown envelope arriving on my mat from my tax office.

Q76 **Chair:** I do not want to ask you to divulge anything personal, but can you give us a sense as to what your marginal tax rate would be if you were to carry on working, or what your advice is, so that we, on the Committee, can understand the impact on an individual consultant?

Wayne Jaffe: I really do not understand any of the moneys at all. All I know is that I am paying tens of thousands of pounds additional tax each January due to pension growth, which I cannot do anything about, as you have heard. I now cannot afford the additional tax that I have to pay, so it has to come out of my pension. I may not even live long enough to see the benefits. I am paying a whole load of tax—literally tens and tens of thousands of pounds—and I may not live to see the benefit. The financial advice that I have taken, and, as you know, financial advice is not cheap, has always been, "You need to be very careful when you leave," and now that time has come, which is next Thursday.

Q77 **Chair:** Can I ask you to move away from pensions for a moment? Then I am going to bring in my colleagues, to reflect on what we heard from Clare Gerada about mental health issues, stress and doctor suicide. We understand the long-term solution. I think most people would agree that we need more doctors, and indeed more in every specialty and every bit of the NHS, not just doctors. What are the short-term things that could make a difference for your colleagues at the Royal Stoke?

Wayne Jaffe: You have heard the solution already. We need to tackle pensions. Basically, I am seeing an exodus of my senior colleagues and I think we need a policy change led by the Secretary of State. We see civil servants advising, but it is the Secretary of State who actually decides. We feel that we are being targeted—both myself and other senior doctors—at a really vulnerable time for our patients and the NHS with these perverse disincentives that you have heard about. They cause financial penalties simply by going to work.

We have heard from the Department of Health that there are going to be proposed pension seminars. Fine words are not a real solution. Yes, there is a solution that will stop the exodus of disillusioned and disappointed doctors at a difficult time for our staff and our patients. It is the judges' solution. What is sauce for the judiciary is good for the NHS.

Chair: Thank you.

Q78 **Dr Evans:** I will start by asking the two panellists here a yes or no question. Do you know any colleagues who are actively looking to take

extra work on?

Dr Sharma: No.

Professor Gerada: No.

Q79 **Dr Evans:** Wayne, yes or no to that question? Do you know any colleagues who are actively looking to take extra work on?

Wayne Jaffe: I know colleagues who are refusing to take extra work on.

Q80 **Dr Evans:** Thank you. Professor Gerada, you pointed out the intensity of the workload and what is going on there. Do you think the way to solve it is for every doctor and nurse to work to contract?

Professor Gerada: No, I don't. I think that is too simplistic a solution. Doctors and nurses can work to contract—of course they can—but, as you have heard from the evidence, people work harder because they care about patients, and the system allows them to work harder because they care about patients.

In response to Jeremy, other than pensions I do not think there is a quick solution. This now needs a much longer, thought-through solution. We can talk about those, but I do not think it is just working to contract. You would get more disillusioned staff because they would be even more miserable as they would be leaving patients on trolleys.

Q81 **Dr Evans:** I was being slightly facetious in my question because I always thought, when I was practising, that a lot of the NHS runs on good will. For the policymakers, if the NHS suddenly stopped and said, "No, enough is enough and we will work to contract," it would leave gaping holes for the politicians to try to fill. The downside is that the patients and the care that they would get are the consequence of that. Dr Sharma, would you like to come in on that?

Dr Sharma: Yes, I would. I think that is part of the problem, and that is what is leading people to breaking-point, effectively. People would not choose to do extra work, but they feel that they have no choice. They feel that, if they do not carry on doing it, the patients will suffer. That is why they keep on doing it, keep on going that extra mile and doing the extra bit of work. Then they break. That is what happens.

Q82 **Dr Evans:** I appreciate you picking that point up because that is the bit I am most concerned about. You are absolutely right. You have already talked about the moral injury. I want to pick you up about something else you said, which is that they are terrified of making a mistake. Can you explain what that means in reality when you are practising?

Dr Sharma: Unfortunately, when you are working under such pressure and when you do not have the facilities you would like and you cannot organise the tests as quickly as you would like to do, or you have to send people out sooner than you would normally do, you are terrified of missing something and the consequence of that, both for the patient and

how you feel because of that, and about what happens with the regulator and the GMC. People are terrified of GMC investigations. They are very difficult things to go through, and increasingly it does not stop there.

There was a case recently in London where the coroner came up with a conclusion of unlawful killing of a patient. If you look through what happened, a lot of that was system failure and system pressures. All of these things are in the back of your mind the whole way through: "What if I make a mistake? What if I miss this? What is going to happen to my patient? What is going to happen to me?"

Professor Gerada: I have had more complaints in the last two years than in 40 years. Even at my seniority, complaints cause such grief and such mental distress. For the doctors who have killed themselves, if you dig around, complaints are there 40% or 50% of the time. We are encouraging people to complain as well. There is a sense that the NHS traditionally encourages complaints rather than encouraging people to find solutions. Yes, I have had more complaints in the last two years than in the last 40 years put together.

Q83 **Dr Evans:** If I can summarise and put this all together, we have an ageing population with more demands post Covid; a workforce that is being stretched further with higher intensity and no way of dropping that intensity; the fear of making a mistake, which is getting worse with the moral injury of not being able to do what you can; plus, now, the financial burden of the fact that pensions are an issue as well. That hits all the spectrum. What gets you out of bed to go to work?

Dr Sharma: A sense of duty, really. I am of an age where I cannot retire. If people of my age group could retire, they probably would in higher numbers. That is the thing we need to be very mindful of. At least a third of the total NHS workforce are over 50. In some specialties like anaesthetics, 39% are over 50. We have an ageing workforce. One of the things that really worries me is that we need clear action around some of the issues we have talked about, like pensions.

It is one of the things we speak to the Secretary of State or the Treasury about. They say that numbers are going up and people are not leaving in their droves. The problem is that, if you wait until they leave in their droves, they are gone and you cannot replace them. That is a real worry for us. Without some very firm and decisive action, we are going to have a workforce crisis like we have never seen, and it will be too late at that point to change the rules.

Q84 **Dr Evans:** We often look at the airline industry which had these issues to start with. They had very rigid rules and regulations about what pilots can and cannot do. If they do not feel they are able to fly, they do not go out and do so. Should we be doing something in the same vein? You are a physician in hospital. Should we be doing something like that in secondary care?

Dr Sharma: There is a lot of merit in that. In a sense, doctors have always been, as Clare said, very bad at looking after themselves. The last person to be looked after is always yourself. Having rules that have those protections is really helpful.

The problem is that at the moment, as you said, the NHS is relying on good will. It is relying on overtime. If that were just to stop, there would be a massive problem.

Professor Gerada: I talk about this very often. Everybody reaches their limit. There is a limit when we have to say, "No, we cannot go on." You asked about secondary care. I am a GP. It is very difficult to be engaged with 50 or 60 people a day, even 50 to 60 a week. It is important that we can say no, but then we have to say that there is even further moral injury. If we are closing our doors, there is more than guilt; there is anger.

Q85 **Taiwo Owatemi:** Professor Gerada, you spoke about barriers such as a lack of compassion and staff not being able to take time off when they desperately need it—for example, to attend an appointment. What practical steps do you think can be taken to address those issues?

Professor Gerada: That is a very good question, but to unpack it is very difficult. I think it needs to start right from the top. Every single NHS trust and every single NHS organisation has to take the health and wellbeing of the staff as importantly as it takes finance. Right at board level you need a non-executive director whose sole responsibility is looking at the proxy issues around wellbeing, which include complaints, sanctions, grievance responses and sick leave.

The organisation that leads the NHS also needs to take the issue very seriously. I have given evidence before, as I have said. I think we need an independent arm's length body that holds the NHS staff in their mind. In other words, it is as important as the CQC and the regulator.

It is very difficult to say one solution. As I said before, this is not about Zumba classes, mindfulness or something with dolphins. It is much more endemic. You have to treat it now like a public health problem, with primary, secondary and tertiary prevention. It is getting people who are sick and treating them. This is something that requires full-scale, systematic change in how we address the wellbeing of the people who are doing all the caring.

Q86 **Taiwo Owatemi:** You spoke about an independent arm's length body. How would you envision that being set up?

Professor Gerada: I envisage it having the same authority, the same power and the same resource as, for example, the Care Quality Commission and the national speaking out guardians that hold the NHS to account on its wellbeing. It would set the metrics and the standards, and look at research and development to support health organisations to embed good practice in their organisation. That is one solution. In a way,

if we had had that, I think we would be in a better place than we are now. It would have seen some of the early warning signs.

The second thing we need is the equivalent of a staff college. It could be virtual or real, but with a programme of lifelong support for NHS staff, with mentoring, careers advice and leadership training that is inbuilt throughout one's career, and not just for doctors but for everybody, and at pinch points in one's career. These are big ticket issues, but unless we do big ticket issues, as I said, we have a burning platform for the NHS. If we do not address it, I am afraid that five years from now we will be in an even worse position.

Q87 **Taiwo Owatemi:** Dr Sharma, are you able to explain to us the retire and return policies that currently exist in trusts, and the discrepancies across all trusts?

Dr Sharma: Yes. As was said before, the key is to stop people retiring in the first place. We need to start thinking about that before people actually retire. Pensions are a massive issue and there is a solution available for that, as Wayne mentioned. For people coming up to the retirement period, the other thing that makes them retire early is the intensity and the fact that there is no ability to change how you work as you get older.

People in their late 50s, for example, are often still on on-call rotas. They are doing incredibly complex work late at night. It becomes much more difficult for some people when they get older. The NHS is not good at recognising that and saying, "You have so much that you can offer, why don't we change your role a little bit so that you can be involved in more teaching, training or things like that?", and allow people to work a bit longer without the intensity. There are things that the NHS could do but is very bad at doing.

Professor Gerada: Very bad. Sorry to interrupt. I deal with all NHS staff. To have a neonatologist having to do an on-call role in their mid-50s is very difficult. I am in my early 60s and I have just done my last on-call. It was unbelievably difficult.

Dr Sharma: If you are able to change that, they might not retire quite as early, so retirement becomes less of an issue. Obviously, you need to remove the barrier of pensions that are forcing them to retire. Once people choose to retire, and I think that will still happen regardless, at the moment there is no consistency about what terms you come back on. Often, when people retire and return, they are offered inferior terms compared with what they left on. They are on worse terms than their colleagues of a similar age. They are often on lower pay scales. They are often on short-term contracts, 12 months at a time. It is not a way to treat people when they still want to come back and give more to the NHS and their patients. Work around that would be really helpful.

Part retirement—in some pension schemes you have the ability to flexibly access your pension but without actually retiring fully. Again, that would be very helpful. There are a lot of things we can do around that period of time. The BMA has written a briefing document around this which I can share with you. It highlights good practice on retire and return.

Q88 **Chair:** Thank you. I think Wayne wants to come in on that point.

Wayne Jaffe: As I said, I retire very shortly. I have expressed an interest in returning to work, but the rules state that I cannot be offered a contract until after two weeks, so I do not actually know whether I am going back to work or not. As Vishal says, when I do go back I will be on a lower rate of pay. I lose my CEA award and all the benefits that I got from the NHS pension scheme. I cannot rejoin it, so I do not get any death-in-service benefits or sickness benefits. It is not easy even to go back and do a similar role without feeling that you are being taken advantage of.

Q89 **Lucy Allan:** Dr Sharma and Mr Jaffe have both been very articulate on the issue of pensions and the tax penalty. At what age is this kicking in? Mr Jaffe, could I ask how old you are?

Wayne Jaffe: Yes. I am 59.

Chair: You don't look a day over 40. Don't mind what the others say.

Wayne Jaffe: Never ask a gentleman his age; I am not a gentleman. I turn 60 in two days' time.

Q90 **Lucy Allan:** Thank you. That would apply to everybody in your position aged 60. They would be suffering the same pension tax penalty, potentially, as you.

Wayne Jaffe: Yes.

Q91 **Lucy Allan:** It is something that has clearly been known about for a very long time. Dr Sharma, what hint do you get that Ministers or Government are actually listening or whether there is work in progress to tackle it?

Dr Sharma: Very little, unfortunately. Wayne mentioned the 60-year-olds, but it starts earlier than that. We have a lot of people retiring aged 55, which is the normal age. We suspect that around 10% of the senior medical workforce will retire in the next 18 months, with the biggest reason being pensions. That is backed up by both the BMA survey and a survey from the Royal College of Physicians. It starts earlier than that, but even before that, consultants in their 40s will get hit by the annual allowance. It starts very early. That is a real issue.

We have been pushing the Government on this for a long time. To be honest, we are not really making much progress, and we do not understand why. As I said at the outset, we are not asking for any special rules. We are just trying to correct an anomaly in the interaction between pension rules and the tax rules.

We mentioned the judges' scheme. Essentially, the Government have made an arrangement for the judges, where you do not get tax relief on your pension contributions, and because you are paying income tax on all your earnings there is no requirement to pay an annual allowance tax charge or lifetime allowance tax charge. You break the link between earnings and pension tax. It is fundamentally fair.

We have done some modelling at the BMA. Rather than costing the Treasury money, it would actually generate money. Once you factor in the lost capacity that you have to replace with agency spends, locum spends and pensions that you are now not paying, it is revenue generating for the Treasury. It is fair for the taxpayer and fair for doctors because you can just get on and do the work and not worry about it.

Q92 **Lucy Allan:** Professor Gerada, are there barriers to staff seeking mental health treatment and support? If so, how can they be removed?

Professor Gerada: There are many barriers. The barriers can be structural, such as taking time out to make appointments. They can be around the stigma of mental illness or fear of being referred to your regulator if you admit that you have mental illness.

The service that I ran for the last 15 years up until last Friday has reduced many of those barriers. We hope now that it is much easier for NHS staff to present for care, knowing that they can have a confidential consultation. It is by no means perfect, but at least it has improved slightly from what it was a decade and a half ago.

Q93 **Dr Evans:** Can I pick up on that point, and go wider? How much, historically, is it medical bravado and a sense of duty, driving on? You are not going to be the colleague that drops the ball. How much is that at play, and how damaging and positive is it? There are pros and cons to it.

Professor Gerada: Again, it is quite difficult to unpick that. The first line of the Hippocratic oath is that you make the patient your first concern. That is why we are picked; we have a sense of altruism and we are perfectionists. You pick somebody who wants to do well and who goes the extra mile. Then you put them in an environment that slightly exploits that. That is the problem. We have exploitation.

It has always been thus. When I qualified 40 years ago there was a compact that you worked very hard, but in return you got accommodation, hot meals at night and a firm to look after you. Now the compact has been broken. Except during Covid you never get a hot meal at night. You do not even get a place to hang your coat, let alone a place where you could sit down. That compact has been broken, and because of that the bit where you will work as hard as you can has now become slightly disingenuous: "I am working very hard but I am getting nothing in return."

I want to pick up one other thing that could make a difference, which is Doctors in Distress. We have been lobbying for all NHS staff to have an

hour a month of paid reflective space. In your contract, you should have the space and the time to go for an hour a month with your team colleagues, or not if you do not want to be with your team, and that is inbuilt in the contract, rather as I have to do compulsory CPR training every year. You get that built in. I think that would have addressed many of the problems of the doctors who have killed themselves and whose relatives I have been caring for.

Q94 **Dr Evans:** Dr Sharma, hospital-based medicine in particular is doing night shifts and acute shifts. Can you talk to me about how bravado plays a role there?

Dr Sharma: It is an interesting question. I think there has been a real sea change. There was definitely a little bit of that bravado in medicine years ago. By definition, most doctors are very ambitious people. They are very driven people, and that filtered into the workforce. Certainly, in the last few years, I have noticed that that is less evident. Even the most ambitious people around—the ones who were always guilty of that bravado—are more subdued and a little bit more broken, even now.

I see it less. I think the general pressure has got to everybody. It is affecting people across the board. I think that is less of an issue now, and in some ways the bravado is probably not a healthy thing. We saw quite a bit with people coming in when they were sick and not fit to work. That has definitely changed during the pandemic. It is a sign that across the spectrum every type of personality is feeling this and really struggling.

Professor Gerada: I think that is absolutely right.

Q95 **Chair:** We have to draw this panel to a close. I have one last question for Clare, if I may. There is something particularly troubling about the evidence we have. Presumably, all doctors do some training in mental health as part of their training and have some understanding. Perhaps we would expect, as members of the public, that they would have a better understanding than we do of some of the complexities around mental health, but I see from the figures that doctors are more likely to kill themselves than the general population as a whole, and female doctors are even more likely to do so. Could you explain what is going on?

Professor Gerada: To get the figures right, female doctors are between two and five times at risk of suicide compared with their age-matched peers. Male doctors are either the same or 0.8, slightly less. Doctors should be far, far lower. We tend to have high IQs and good social networks. We tend not to be brought up in care or have all the other loading factors that give a high risk. Female doctors in particular are significantly higher.

If the question is why we don’t recognise it in ourselves, it is very difficult to recognise mental illness in yourself. One of the things that goes with mental illness is insight. The last thing to go is your work. Doctors work right to the bitter end before they realise that something might be wrong

in themselves. It is not about themselves recognising the mental illness; in a sense, it is their peers recognising that they are struggling or suffering.

The other important factor is that 50% of people who kill themselves have no previous mental illness, so it is not a mental illness killing them but other factors. We should look at suicide among doctors and nurses—nurses also have very high rates of suicide—as a public health problem. It is an indicator of the distress that the workforce is currently under.

Chair: Thank you. It has been extremely helpful and very sobering, but it was very important that we heard it. Thank you very much for joining us, Clare, Wayne and Vishal. We appreciate your time this morning.

Examination of witnesses

Witnesses: Professor Atkinson, Jacqui McBurnie and Professor Woodhams.

Q96 **Chair:** We now move to our second panel where we will have a particular focus on the issues facing female members of the NHS and the care workforce. Joining us virtually is Professor Carol Atkinson, who is professor of human resource management at Manchester Metropolitan University. She has done extensive research on the adult social care workforce. A very warm welcome to you, Carol.

We also have virtually Jacqui McBurnie. Thank you for joining us. I can see that you are on mute, so you might want to unmute yourself before you say something. She is chair of the NHS England/NHS Improvement menopause group and a member of the cross-government menopause steering group. Thank you very much for joining us.

Here in person is Professor Carol Woodhams. She is professor of human resource management and head of the department of people and organisations at the University of Surrey. She was the lead researcher on "Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England." Thank you all very much for joining us.

Jacqui, what do you think the impact of menopause is on the retention of senior healthcare staff?

Jacqui McBurnie: Thank you, Chair and panel, for inviting me today. As introduced, my name is Jacqui McBurnie and I chair the NHS England Menopause Network, which has several hundred network members. I am very pleased to be able to represent the membership today. The membership is not exclusive to NHS England; it includes NHS employees across England. I invited colleagues to share with me some of their experiences of menopause, particularly around the difficulties in sustaining their posts in 2019. It was critical to pick those points up and then reflect on where we are in preparation for today's meeting.

Around 2019, I received just short of 500 responses. The essential points were about exhaustion, not being seen, not being recognised and not being able to maximise your wellbeing, even if you wanted to retain your

position at work, let alone extend that position to a coaching or a mentoring role, or in fact explore more senior leadership roles. Interestingly, having had that question repeated, the same issues around autonomy and being able to maximise your wellbeing were persistent in the responses that came back. Obviously, NHS England—my employer—has taken significant steps in relation to the points fed back, but there is a varied position across the NHS. We see that in the responses.

Q97 **Chair:** Thank you. There is an issue around exhaustion. Apart from the obvious, which is more doctors and nurses—everyone on the Committee feels that we need to overhaul our long-term workforce planning—what can we do in the short term that would make a difference?

Jacqui McBurnie: That goes to the heart of some of the specific comments we received. We looked at whether there was a gap between generalist support in primary care or occupational health services that we all have access to, and we received feedback to the effect that there was a varied level of confidence from primary care. The occupational health offer was largely around the focus back into work. The specialist aspect was the bit that was missing. In relation to menopause, it allowed them to reach into the space and maximise the opportunities, the tools and the resources that could change that individual so as to overcome some of the symptoms, exhaustion being one of them.

We have shift work. We know that and we accept that. I am still a registered nurse. Having discussed that with colleagues, that is part of the role and, indeed, part of the flexibility too. It is not just a negative, but there are specific gaps that we have now been able to look into that would increase the tools for an individual in their own symptom management to be able to be well.

Chair: Thank you so much. We want to come back to you, but my colleague Taiwo wants to ask some questions. She has to disappear shortly.

Q98 **Taiwo Owatemi:** I want to ask about the social care workforce and the retention of social care workers. What can be done to address that? Over the weekend, I was speaking to one of my constituents, who said that as somebody who had worked in the social care sector for 30 years, she is still not entitled to sick pay due to the kind of contract she is on. I want to hear about some of your experiences from the research that has been carried out. What do you think can be done to address that, especially as regards retention?

Chair: That is for Professor Atkinson. We will come back to you, Jacqui McBurnie, because I want to go more into those issues. Can we hear from you, Professor Atkinson?

Professor Atkinson: Certainly. Thank you for that question. The point you make is about terms and conditions more widely, not just sick pay. If we look at terms and conditions across the adult social care workforce we see low pay; lack of entitlement to the kinds of benefits that you

mentioned; lack of travel time; zero-hours contracts; and poor career pathways and limited training. The whole package together is problematic.

We often see high labour turnover in the sector. Sometimes, there is the view that care workers go and work in the retail sector, and some do, but despite what I have just said about terms and conditions, care workers tend to report quite high levels of job satisfaction. They like the intrinsic nature of what they do. It is the extrinsic factors that are problematic for them, alongside some of the burnout and work intensification that we have heard about in the healthcare sector.

In terms of what can be done about that, we need to take a step back and think about how we fund and support our adult social care sector. Many care providers would say that they are almost forced into those terms and conditions, particularly in the domiciliary care sector, because of the way that care is commissioned and procured. They themselves tend to have low and insecure funding streams. They then pass that risk on to their workforces.

If we want to think about how we might address some of those problems, it would be a better funded and more secure system for commissioning adult social care that then enables better terms and conditions, whether that is still through local government or, as we saw in the pandemic, through a bolder move to a more integrated health and social care employment system.

Taiwo Owatemi: Thank you.

Q99 **Chair:** Before I bring in my colleagues, let me bring in Professor Woodhams. Thank you for joining us. In your "Mend the Gap" report, you said that women in medicine are paid 80% to 85% of what men get for working the same hours. Why is this still happening?

Professor Woodhams: That is a very broad question. There are a number of factors. Some of the most important factors are that the gender pay gap in medicine can be explained by lack of equality in promotion. There are different rates of the two genders progressing to consultant. There is inequality in career path choice. Women tend to find that the training routes do not suit the way that they like to engage with their career. They move into different career paths—for example, SAS doctors and locally employed doctors.

It is to do with different hours and different patterns of work which set them back. It is to do with retention. Until we get the mean age of male doctors and female doctors equalised, there will always be a gender pay gap. Finally, it is down to the design and structure of medical pay itself. The pay system and how it is structured tends to solidify and illustrate the gender pay gap.

Q100 **Lucy Allan:** Professor Woodhams, would you say that there is an ageist and sexist culture within the NHS workforce?

Professor Woodhams: I am not medically trained. I report from evidence and from data. It is certainly sexist and certainly in some specialities. We have produced research that evidences that. In the high intensity specialities it can be exacerbated—for example, in surgery. It is especially in the high-pressured specialities.

Is it ageist? I think the issue is really around what the previous panel indicated. Doctors are leaving early because of the pension issue, but also because they find, as they age, that the work becomes more intense and more difficult to cope with. I would say yes, but it is not really down to those sorts of issues. It is a structural issue around how the workforce are trained and paid that is at the heart of this rather than an individualistic, cultural issue.

Q101 **Lucy Allan:** Jacqui, do you have a view on whether it is a cultural issue at play?

Jacqui McBurnie: I do. I hear from colleagues in provider areas, hospital trusts, that they do not always feel as visible, despite the fact that over three quarters of our workforce are female. We know that around a third of our nursing population—my royal college—are over 55. There must be an ageist leaning in that regard that does not see this as a real issue around a cohort of staff that hold all that experience, intelligence and organisational memory, and in fact will take that with them. I hear that quite a lot.

Q102 **Lucy Allan:** Presumably, your work around the menopause has sometimes identified that women do not want to talk about that or refer to the issue in the workplace because they will be stigmatised as incapable, incompetent or irrational, or all of those things. Is that your experience?

Jacqui McBurnie: I absolutely hear that, even to the extent that a colleague shared with me that it was perhaps career limiting to be visible in a middle to senior role and to be sharing personal experience or offering a platform or senior champion role to others to support networking in their own organisation. I absolutely do hear that, yes.

Q103 **Dr Evans:** Professor Woodhams, would you tell us what the trend has been like in male to female medical students and doctors over the last 40 years?

Professor Woodhams: The removal of barriers to women becoming doctors is quite historic. Women have come through as medical students for quite some time. In 1975, following the Sex Discrimination Act, the barriers were removed in terms of the intake to medical school. They had to equalise the cohorts. Well, they didn't have to equalise them, but barriers were removed.

In the last 20 years, women have outnumbered men. Female students have outnumbered male students graduating from medical school, but that has not been reflected in their progression through the workforce.

You would think that after 20 years of equal or greater numbers of female students you would see them moving through the medical workforce into consultant levels, but it is still the case that 63% of consultants in trusts are men.

Q104 **Dr Evans:** How much is it choice in your medical career? For example, we know that female GPs outnumber male GPs. I think it is about 35,000 to 27,000, female to male. There is a choice there, partly to do with the lifestyle and the kind of care that you provide. How does that factor in when we talk about people who choose to go down the surgery route? Is there an innate difference in the fact that people choose to be in different caring routes versus the role that is actually entailed in doing that job?

Professor Woodhams: That is a very difficult question to address because it is an interactive consideration. What we do know is that many women are actually discouraged from undertaking the sorts of roles that they set off to undertake in medical school. If you speak to medical students, you find that a lot of them want to go into surgery. Gradually, through the course of medical training they realise that a career in surgery is difficult to achieve. That is not because they have made those choices, but they do not see the role models and they suffer micro aggression during training. They gradually come to an understanding that this is not the way that they will undertake a medical career. It is an interactive and two-way conversation between the choice issue and how those choices land.

Q105 **Dr Evans:** Looking forward, with feminisation of the workforce coming through and with women coming through, how should the system change to try to retain? Should there be more flexible working? Should we move away from the partnership model to more salaried GPs? Given your expertise looking at the gender side, and given that we know that the reality is that more women are coming through, how should that NHS structure allow us to provide for our workforce?

Professor Woodhams: That is a very big question. In the review, we have 75 recommendations based on structures. In primary care, the gender pay gap is even larger than it is in trusts. The model of partnership and salaried GPs does women no favours there. What we would like to see, and what we recommend in the review, is far more transparency in how people are paid and much more consistency across general practice in allocating a wage. At the moment, we get the impression that it is very unstable. There is not enough data to inform how that is undertaken.

How can we change trusts and general practice? There are many different ways that we could change to retain, promote and pay differently in order to try to reduce the gender pay gap and hold on to more women staff.

Q106 **Dean Russell:** Thank you for coming today. The main question I have is this. There are lots of priorities and lots of things that could be done to improve things. If you had to choose one that the Government should

take forward in terms of ensuring that women get better pay within the NHS, smash the glass ceiling and make sure that they are in more senior roles, what would that be?

Professor Woodhams: Promotion is very important. We need more women in senior roles. I think that promotion committees have an important part in making sure that there is best practice in those sorts of decisions.

If I had to make one choice, I would modernise the pay structure. The pay structure is so long and has so many salary points that any particular point of departure from that pay structure, for example if you go part time or on to maternity leave and then rejoin, you find that your cohort has advanced ahead of you by a couple of years, and because the pay structures for doctors, particularly consultants, are so long, you never catch up. The pay gap grows for doctors until age 65. The pay gap is still growing at age 65. It is only after age 65 that women actually start to narrow the gap. They do not catch up, but they start to narrow it. That is because male consultants, or those who do not take a break—not just male—or work part time have advanced for a decade or so ahead of them. Until there are some structures put in place that capture that advancement, they will not catch up.

Dean Russell: Thank you.

Q107 **Dr Evans:** If you are out for two years and you are getting more experience as a surgeon, maybe doing an extra couple of hundred operations during that time, isn't that a reasonable difference to expect? You will have a more experienced surgeon doing your surgery versus the person who has taken time out for maternity or paternity leave. Could you address that? It seems really key. Experience counts a lot in medicine. Could you address that point?

Professor Woodhams: Yes, absolutely. Experience should and does count across all professions. However, in other professions the role of experience is capped at, say, six to eight years. The recognition of that experience and the value that it brings in salary structure is capped at around six to eight years. One has to consider, and the Equality and Human Rights Commission stands by this point, how much additional value is added after eight years, for example. The consultant pay scale is 19 years' long. Are we saying that 19 years' worth of experience is worth that much more than 10 years' worth of experience? Doctors have not undergone any sort of job evaluation or assessment. We do not really know if a consultant with 19 years' experience provides much more additional value than a consultant with 10 years' experience, but they are certainly paid differently.

Q108 **Chair:** Thank you. I am sorry to interrupt. We have to move to our final panel, but before I do that I want to bring in Carol Atkinson and Jacqui McBurnie one more time.

Carol, could we have your views in a bit more detail as to why turnover in

the domiciliary care sector is as high as 40%? That is a shockingly high turnover rate. It must be impossible to imagine how you can give good, sustained care to someone if you are losing four in 10 of your workforce every single year. Could you talk to us about that?

Professor Atkinson: Yes, it is a shockingly high rate. You are right. A lot of it goes back to the points I made in brief last time. Pay is very low. Many are not paid for travel time. Sometimes they are, effectively, earning less than the minimum wage. Many of them move around within the sector for only a few pence more an hour. As you just alluded to, that is very problematic for continuity and quality of care. Many are on zero-hours contracts. They are paid episodically. They are paid when they are busy at breakfast, when they are busy at lunch and when they are busy at tea and in the evening, but not in between. They often work full-time hours, because they are not paid for their waiting time, in part-time work.

Zero-hours contracts are a double-edged sword. They give employers flexibility, but they give staff flexibility as well. Guaranteed hours contracts often do not provide the kind of shift patterns that staff need, so they sometimes stay on zero-hours contracts. There are often periods of acute turnover as well. In the summer holidays, we often see a mass exodus of zero-hours contract care workers so that they can care for children, because they do not get the salary levels or the other forms of support in terms of guaranteed hours contracts to facilitate childcare. That is a really acute period of turnover. It is not always spread across the year in a logical fashion, and it is particularly for gender and childcare reasons.

We see intensification of burnout. We see people taking time out between contracts. Time out is not supported. We heard earlier about a lack of sick pay in a typical zero-hours contract. There is a whole host of different factors that come together to mean that turnover is very common.

It is also very problematic. We seek to do induction training. We seek to do qualifications, but often people do not stay long enough to complete them. Again, it is a merry-go-round of moving around and getting a few more pence an hour but starting your training again, so never getting to the point where we have a more adequately trained workforce. Reliability and continuity of care really suffer as a result.

Q109 **Chair:** Thank you; that is very helpful. Finally, I want to ask Jacqui McBurnie this. We were talking initially about the problems of menopause, and I know you have done a lot of thinking about that. I think you might have testimonies from some of the people you have been supporting, which would put into sharp relief for us what it is like and what is happening to date. Do you want to spend a couple of minutes telling us some of the examples of people you have been hearing about?

Jacqui McBurnie: Yes. A lot of the reports come from an individual who finds themselves to be an experienced member of staff having various clinical and perhaps by this stage non-clinical roles. They have a wealth of experience but are struggling between lack of support from their primary care provider, and then the gap in terms of their workplace. Since Covid we are not really in a position to disaggregate the two as much as we did. Wellbeing now has to be a factor right across the different silos that we used to see for an individual's work life.

We found that people have struggled with awareness in the workplace. It has been reported to me that line managers who have not received training in awareness of menopause could effectively gatekeep their access to, for instance, occupational health which might offer some menopause discussion. Somebody who did not recognise as female in the workplace would find that particularly tricky and sensitive.

One of my colleagues who was Muslim did not want to share the detail of her sensitive symptoms, but had to do that in order to access support in the workplace, both for flexible working and onward occupational health. There is a wealth of aspects in work that we could do without making significant changes; they would not cost, but would really benefit the quality of life and wellbeing for those individuals.

Chair: Thank you. That has been very helpful. We are looking in this inquiry for some of the small, practical things that we can do right away. There is a long-term issue of the capacity of the system and the intensity of work for everyone on the care and health frontlines, but we also want to see what we can do in the short term. Those are some very helpful suggestions.

Thank you, Carol Atkinson, for your insights into the care sector, and, Carol Woodhams, for your insights into the gender pay gap. It has been very helpful and much appreciated.

Examination of witnesses

Witnesses: Prema Fairburn-Dorai, Nina Hemmings, Shilpa Ross and Dr Wang.

Q110 **Chair:** We now move to our final panel this morning. We are going to particularly focus on the social care sector. We will be hearing also about issues relating to people from minority ethnic backgrounds. Our theme is about retention and how we can hold people in the health and care workforce, where we desperately need their support in this time of broader workforce crisis.

We will hear shortly from Prema Fairburn-Dorai, who has not arrived yet but we will bring her in as soon as she arrives. She is the director of Primary Homecare in Suffolk, a registered nurse and chair of the Suffolk Association of Independent Care Providers. Shilpa Ross, who has joined us virtually, is a policy fellow at the King's Fund, where she led their research on "Workforce race inequalities and inclusion in NHS providers."

Prema has just joined us. You are very welcome, Prema. That is perfect timing. Dr Wen Wang is with us in person, and has been here right from the start of the session. She is associate professor in human resource management data analytics and interpretation at the University of Leicester. She has looked at the principal factors driving black and minority ethnic staff, and staff aged 50 to 65-plus and why they choose to leave health and social care.

Let's start with you, Prema. A very warm welcome and thank you for joining us this morning. The service that you run is rated "Outstanding" by the CQC, but you are finding it harder and harder to hold on to good staff. Can you tell us why that is?

Prema Fairburn-Dorai: There are so many reasons for that. The pandemic has not helped. Things have changed with staff. I find that our whole attitude towards working has changed. The attitudes of staff have changed. They are not prepared to work long hours, weekends or evenings. They would rather leave because they are under such a lot of stress. I can understand that because we are under such a lot of stress. The expectations are so high from our clients, and we struggle to maintain the service that we run in an excellent way.

We are losing a lot of staff but, at the same time, we cannot recruit anybody. The applications that we get have dropped from maybe 10—we used to get 10 a month—to about two or three. We are very lucky to even get one person through in a month. Those are some of the reasons, I think. It is hard to explain.

Q111 **Chair:** What about the immigration system? Is that causing you difficulties?

Prema Fairburn-Dorai: We are now allowed to recruit from overseas. We are recruiting a few more from overseas. I actually recruited about five staff from India, but I have to tell you that the experience was not very good. We waited patiently for them to arrive. They were not as good as we had hoped, despite intensive training in cultural differences in the UK as well as care training. They were not able to settle into the job as well as my previous recruits in the 2000s. Driving lessons were provided because that is necessary in domiciliary care. Training lasted for two and a half months. I had to dismiss three of them because their performance was unsatisfactory. This experience has not been helped by the fact that our existing all-UK staff had been intolerant, judgmental and unhelpful to the new recruits.

Our clients in the community have been overtly racist in some of their comments and have refused to allow overseas staff to care for them. There are, of course, exceptions. I find good communication makes a difference to how overseas staff are received by our clients and our staff. From the lessons that we learnt from the first cohort, our selection process has now been tightened up. We are looking for individuals with near-excellent English speaking skills, care experience, a pleasant

personality and confident driving skills. That is what we are doing at the moment.

However, the costs involved in recruiting from abroad are phenomenal. An investment of £6,000 is needed for each new recruit to pay for the Home Office fees, legal fees and the training that we put on in care, cultural awareness and driving lessons—safe driving—as well as providing accommodation and a car. We have many small domiciliary agencies in care homes in Suffolk who simply cannot meet those costs. That is an issue.

Q112 **Chair:** Let me bring in Dr Wen Wang. We also have Nina Hemmings here from the Nuffield Trust. That was a very stark story about racism experienced by care workers in the community and from their colleagues. You have done a lot of research into why people from minority ethnic backgrounds leave the health and care workforce. Is that outright racism very common?

Dr Wang: The answer is yes. I looked at more than 100,000 healthcare workers from black and Asian ethnic minority groups. What I found is that the experience of personal discrimination from managers and co-workers can increase to a 48% propensity to resign from the sector. What they have experienced in discrimination from managers, co-workers and patients is unbelievable. As Prema said, we rely on them a lot. We have more than 200,000 Filipino nurses. They are the second largest group after British nationality. At the beginning of the pandemic, they were considered as carriers instead of carers. They were attacked because of Covid. Discrimination from the public is disheartening, but it is more disheartening from managers and co-workers.

I talked to doctors, nurses and care workers. They do not mind the discrimination from the public because they had the confidence to turn it around once they started to care for them, but they felt that the discrimination from managers and co-workers was demeaning, disheartening and destroyed their confidence. Shift patterns were different and less favourable. They were watched doing their tasks. They were timed, and they said there was extra stress.

I found two parts. One was discrimination from managers and co-workers as a direct cause of burnout. The other was discrimination from the public. When they were late, they were shouted at in front of patients and colleagues. That seemed to encourage discrimination from patients, relatives and the public, which makes it worse.

Q113 **Chair:** Thank you. Let's bring in the Nuffield Trust and the King's Fund. Nina Hemmings, do you echo that in your research?

Nina Hemmings: Absolutely. Everything that Prema and Wen just described definitely seems to be borne out in the workforce data such as the NHS staff survey and the data collected by the race equality

standards team. It is also reflected in interviews that we conducted with NHS trusts.

I will start with the NHS workforce and describe some of the research that we did last year. This was a project that was funded by NHS Employers. They tasked us to investigate what NHS trusts are doing to attract, support and retain a more diverse workforce. We were keen not only to look at the experiences of ethnic minority groups but to consider the entire suite of nine protected characteristics: everything from age to gender to sexual orientation. We conducted interviews with five trusts of different types, speaking specifically with equality and diversity leads and their wider teams.

What seems to be sadly the case is that, despite persevering efforts by those teams to overturn years of structural discrimination, what we see in the data is that in 2020 more than one in eight members of the NHS workforce reports discrimination. If you look more closely at black and minority ethnic groups, it is twofold; they are twice as likely to report discrimination by colleagues and, sadly, it is prevalent at every stage of the career pathway. If you look at shortlisting and appointing from the shortlist, you are less likely to be appointed if you are from a minority ethnic background. That is particularly stark for people from Bangladeshi, black African and white and black African backgrounds. You are more likely to experience bullying and harassment and to enter a formal disciplinary process. You are only about a quarter as likely as your white staff counterparts to make it into a very senior management position.

Q114 **Chair:** Is that feeding through into more people from minority ethnic backgrounds leaving the NHS and care service?

Nina Hemmings: Absolutely, although the data is notably patchy in quantifying the impact of that on retention and leaving rates, but we know that there is a knock-on impact in terms of the human toll around sickness rates going up, staff absence levels going up and even things like productivity in teams.

Q115 **Chair:** Thank you. Shilpa Ross, does your research say the same kind of thing?

Shilpa Ross: Thank you. Unfortunately, yes, it does. We know from the research that we did, and from datasets such as the workforce race equality standard—the WRES—that the NHS does not treat all of its staff equally. Black and minority ethnic staff continue to face unacceptable inequalities and discrimination in the NHS.

As Nina just said, ethnic minority staff face higher levels of bullying, harassment and abuse. They are more likely to experience discrimination that comes from colleagues and are more likely to be the subject of formal disciplinary processes than their white colleagues. Addressing these inequalities is absolutely essential to make the NHS a better place to work, to stay and to thrive in one's career.

Q116 **Chair:** Everyone would agree that the picture you paint is totally unacceptable. If you were Health Secretary for a day, what would you do tomorrow to try to address that issue?

Shilpa Ross: It is important to say that there isn't any one single solution. It is very complex and there are deeply ingrained structural challenges that need to be tackled. It will require sustained commitment over a long period of time. I think that is the number one thing to say.

It is possible though to see some positive change. The research that we did focused on what NHS trusts are trying to do to tackle inequalities and promote better inclusion for the staff they employ. We took a look at the interventions that they put in place. At local level, it is possible to introduce things like staff networks to make it easier for staff to talk about discrimination at work and to raise their concerns. It could be through the freedom to speak up guardian role. It could be other peer champions for inclusion. There is also important work to do around developing staff so that they can gain skills and be ready for promotion to more senior levels when that is possible. I would say, overall, that the NHS sector—this is likely to apply to adult social care as well—really needs to focus on improving recruitment and HR processes, supporting career progression and increasing diversity in boards and senior leadership teams.

Chair: Thank you.

Q117 **Lucy Allan:** It has been fascinating to hear what you have all had to say, and very concerning. How could we be doing something nationally that helps us to retain care workers particularly? We have talked about tackling this, but how would we actually address how we behave, and cultural behaviour, towards other people? I find it so shocking to hear what we have just heard. Prema, what would you like to see done differently to change a culture where this is prevalent?

Prema Fairburn-Dorai: The first thing is for all staff in adult social care to have parity with the NHS. They feel that they are second-class citizens and there is no parity in pay, conditions, and so on. That is one thing.

Secondly, I would say that the racism issues are probably less prevalent in adult social care than they are in the NHS. I have been in both, so I know. There are more opportunities for career progression in adult social care. Many of the people I brought over in 2000 are now managers, so I know that that is available for them. The key, of course, is good communication skills. A lot of training in that area helps them to progress.

The other thing that is concerning in adult social care is the fact that when we talk about stresses, especially in domiciliary care, the same problems are faced by the BAME community and our UK workforce. It is the travel time that is taken, plus the mileage costs, and so on. The local authority does not pay us enough to be able to meet the fair cost of care and payment. We should pay them a rate that is comparable to the NHS

and to the retail and hospitality sectors. We proposed a figure of £12 an hour, but the local authority has made it clear that it cannot afford that because it would cost £25 billion and it does not have that money. A lot of the reasons cited for people leaving have been because of pay, and in particular travel time.

Q118 **Lucy Allan:** Conditions are certainly one aspect. Can I open this more widely? Is there a management culture within the NHS that is actually discriminatory? Is that what we are faced with? Dr Wang, is that your view?

Dr Wang: You are quite right. There is some good news in the data. The data was collected from 600 NHS staff. What I found is that in one trust there was no incidence of discrimination for BAME groups. There was no discrimination from the public. In a quarter of NHS trusts, 55 of them, more than 25 to 40 BAME staff reported experiencing discrimination.

I have come up with four Rs to address this, as well as the four Ps. If you look at any strategy, it is the people behind it. If we can hold senior managers accountable in reducing incidents of discrimination among staff, that would be helpful. We have procedures and policy there. Some trusts link that to diversity groups. If we have the NHS staff data we can monitor discrimination year by year, with reduction rates related to senior managers' pay, promotion and performance. That will work because we know that what gets measured gets done.

Secondly, at middle manager level, I want to see respect for all. Some middle managers or team leaders are very nervous. They do not know how to deal with anything related to race. We need training to support them in how to deal with race and to have acceptable conduct among staff, and not to use banter or jokes that are hurtful for staff.

The third thing is reward. We should have fair career progress. We need to ensure accessibility, with learning and training opportunities for the BAME group. We have 42% of our doctors from the BAME group and 20% of our nurses, but in lower ranked job roles. In the lower ranks, you have more tasks and less job autonomy. They probably cannot access training and learning, and therefore it impedes their progress and career.

The last R is recognition. The NHS is such a great cause and has such a diverse workforce. It could be a role model and play its part in celebrating and highlighting the achievements of all groups of health workers. We could better use the space in waiting rooms, showing inclusivity on the walls with lady doctors and Asian male cleaners. They all make a great contribution. There could be local heroes on the wall. It would manage patients' expectations that this is a workforce that is going to serve you.

Q119 **Chair:** What are the other two Rs? I got reduction and recognition. What were the other two?

Dr Wang: Reward to ensure accessibility to learning and training opportunities. The last one is recognition.

Q120 **Chair:** Was it three in total?

Dr Wang: Four.

Q121 **Chair:** I got reduction, recognition and reward.

Dr Wang: Respect. Respect for all.

Chair: Thank you.

Q122 **Lucy Allan:** Nina, do you want to come in?

Nina Hemmings: Yes, I would like to echo and agree with everything that the witnesses have said. I do not have four Rs of my own to bring forward, but we found that the equality and diversity teams we spoke to recognised that this is not an intractable problem. We are able to overcome it. At a number of trusts they are trialling things. At Coventry and Warwickshire Partnership Trust, they have an investigation team to look more closely at cases of formal disciplinary action. There, they have managed to reduce the number of staff suspended, reduce the amount of time each case takes and make savings of around £150,000 on things like agency cover as a result. That is really positive.

At Barts trust, they have introduced inclusion ambassadors, who are members of staff trained to sit on recruitment panels and act as an independent voice to raise concerns to the chair of the panel if they suspect that some sort of bias or unfair treatment is happening. That has been particularly powerful in promoting black and minority ethnic staff to band levels 8 and above, which again is really promising.

Ultimately, the bigger picture is that we have pockets of good practice with motivated equality and diversity teams based at trusts, but they do not always have the sort of building blocks that they need to make meaningful movement on the challenge areas. The big three are better data and a more comprehensive picture of the challenge; evidence-led solutions with a really clear idea of what seems to be working in what context, for which staff groups and why that is; and, lastly, simply the resources, capacity and funding to spread and scale those examples.

We think there is potentially an opportunity for the Cabinet Office, given that addressing inequalities is a cross-government priority. There could potentially be something like a What Works centre to look at issues of discrimination in public sector workforces, and grow an evidence base around initiatives that have been trialled and tested and that work. Then they could co-ordinate learning across other public sectors, which could include education and policing.

Q123 **Lucy Allan:** Shilpa, do you want to contribute?

Shilpa Ross: Sorry, what was your original question?

Lucy Allan: It was around management and what more we could do to change culture.

Shilpa Ross: As I said earlier, there are some steps already being taken to address culture at local level. As Nina pointed out, there is not a lot of evaluative evidence on what works, why and for whom. It is really important that that is addressed.

All I can add to what I have already said is that it is worth looking at the data on where there have been more positive signs of change. Referring back to the workforce race equality standard—the WRES—it seems like there have been degrees of progress in tackling inequality in the relative likelihood of entering the formal disciplinary process and in certain regions of England where it looks like ethnic minority staff are more likely to access non-mandatory training and continuous professional development than their white colleagues. There is some increase in the diversity of NHS boards. It is worth exploring those three areas and seeing what factors drove those changes.

Q124 **Dean Russell:** Can I come to you first, Nina, if it's okay to call you Nina? Any form of racism or discrimination is appalling and should be removed at the first possible opportunity. You have talked a lot about nurses, doctors and staff. How far did the research that has been happening look at porters, cleaners and staff who work in the NHS and social care and also do an incredibly important job?

Nina Hemmings: That is a really good question. We did seek to cover it in our reports. I do not have some of the key stats to hand, but we would be happy to follow up. We found that the NHS standard contract sets out expectations about equal treatment for staff. Obviously, that stems from the constitution in 2009 as well.

Our research didn't look at porters and cleaners specifically, but it is likely that those roles and other types of outsourced staff are being overlooked when it comes to some of the initiatives that trusts are trialling.

This might be something that Shilpa could talk more about. Some initiatives like staff networks are definitely open to staff who work under "Agenda for Change" conditions, but what is less clear is whether forums like that are also open to roles like porters or other outsourced types of workers. I know that is something that trade unions are very keen on, of course. It boils down to the point of looking after all staff who work in the health and care workforce, particularly as we come out of this pandemic and given everything that they have contributed and that they have worked so tirelessly. It is definitely an area that warrants more investigation.

Q125 **Dean Russell:** Absolutely. I was going to go to Shilpa, but Dr Wang has her hand up too. I will go to Shilpa first. What are your thoughts on the expanded workforce? The porters, cleaners and those teams provide such an important part of the NHS and social care, but sometimes when we

are doing these sorts of reports they can get sadly overlooked. I imagine that might be the case in this instance as well.

Shilpa Ross: That is absolutely true. It is definitely an oversight. There are staff who can fill in key data collection surveys, such as the staff survey, which contributes to the WRES, but staff who are working in bank or agency—those who are subcontracted—do not get to fill those in. We have quite an oversight about what their overall work experience is like, but lived experience data is so important. There are ways to seek that at a more local level from members of the wider workforce, as you say.

Q126 **Dean Russell:** Thank you. Dr Wang, I noticed that you had your hand up when I was asking the question.

Dr Wang: I agree with what Nina said. I would also like to address your question. We have had the Equality Act since 2010, so why does racism still prevail now? One of the issues that came out, and the solution was addressed by NHS staff, was that they told me it is not accessible to report. It is also very difficult to collect evidence to prove racism. We have a Covid tracking app. Can we use the report and support app? It has been used in Bristol in some medical schools and has proved very successful. They can report incidents of discrimination through the app, anonymously or not; they can choose. It encourages a speak-up culture because many BAME workers fear for their job security because they have not been given their visa, or for their career progression if they speak up. They might suffer. We started a good innovation during Covid, and I wonder whether we can use it.

Chair: Yes. Very good.

Dean Russell: Can I ask a couple more questions, Chair?

Chair: Yes, please do. Then we'll wrap up.

Q127 **Dean Russell:** On the point about the app, is it accessible to everyone? It sounds brilliant. I think it is great that you can do that reporting, but I worry that the invisible workforce are the people who are working the night shifts, working in the basements and doing the cleaning. It is all of those things that, as I say, are such an important part of the workforce. Often, with racism and discrimination, it is top down. It can sometimes be a power play. Many other things can come into it. Actually, if you are working in those sorts of jobs there is probably a bit of a fear factor to report those things, even if you know it is anonymous. What work have you done to make sure both that the people who might use the app know that it is safe to use it and that it is anonymous, and that that part of the workforce is embracing it?

Dr Wang: It is really hard, but I recently did a project for a union. I interviewed many people. They were very good at using technology, even in their 50s. I integrated job review data and Glassdoor data on people post their employment experience. Based on this, we produced rating evidence. People talk of a toxic culture in their organisation. They are

good at picking up the technology. The technology started during Covid, and we can push that momentum to keep going.

You are quite right that it is very difficult to collect evidence. A member of staff told me that there are three layers. There is an inner circle, an outer circle, with immigrants as outsiders in choosing shifts. She told me that everyone can pick up to do the night shifts. For three months, she was picked up. She said the names were put in a jar with a certain way of folding the name. That kind of evidence is very difficult to collect. If senior managers are held accountable and middle managers have training in how to deal with it, and we have the app, hopefully, that can help to address the issue.

Q128 **Dean Russell:** If I may come to you, Prema, on that general theme, is there an app for social care? What is the feedback from frontline workers in the care sector?

Prema Fairburn-Dorai: On the percentage of racism? I honestly believe that it is not as widespread as in the NHS. The initial problems are when somebody comes to join the team and they cannot communicate as well. Communication is always a problem. Once they have settled in and the staff get to like them, the atmosphere in a care home or even in domiciliary care is very much, "We are the team." If anything is put on, a party or whatever, everyone is included. They really care for each other. If there are sickness or mental health issues, they support each other.

As I mentioned before, it is the first few months of getting them to settle in. Our existing staff do not have the patience and tolerance to bring them on. Once they are there, they are great. I have to say that my experience of overseas workers—we include Europeans too—is that they have a better work ethic. They take their responsibilities very seriously. They are loyal and committed. I have had staff working for me for upwards of eight years from this particular community and they are still loyal, even after they have left to go to another organisation. It is the very first few months of nurturing, supporting and helping. In every other way they are actually quite equal. They have good career opportunities because we support them. I am speaking not just as me and my organisation but as the chair of the Suffolk Association for Independent Care Providers. I see that right across the board in Suffolk.

Chair: That is a slightly more positive note to end on. Thank you for that. Thank you for your evidence, Prema, Shilpa Ross, Nina Hemmings and Dr Wen Wang. Thank you all for your very valuable insights into this very difficult issue. It is a very important part of our inquiry because such a high proportion of the NHS and social care workforce are foreign born. If we are looking at how to address workforce pressures, we have to give proper attention to this. Even though the evidence has been very stark, it has been very important. Thank you all very much for joining us. That concludes this morning's session.