Written evidence submitted by Group 1 (Event 1) (EPW0076)

Transcript of roundtable event with members of the health care workforce held on Thursday 5th May for the Health and Social Care Committee Workforce Expert Panel.

Group 1

Jane Dacre: Thank you everyone. During this discussion we're going to spend about 10 minutes on each of the pledges that we're reviewing. As we've already said this is being recorded for the purposes of transcription, and we'll use qualitative research techniques to pull out quotes and themes, and we'll mix the information that you have told us with the information that we've received in written form from stakeholders. So, the three pledges that we've selected are: planning the workforce, building the workforce and the wellbeing of the workforce. I'm going to start off with planning the workforce, and one of the pledges that we've selected is that the staffing levels meet the needs of the service. So, do you think that this commitment, which says that staffing levels meet the needs of the service, is currently being met? And the sub questions are, is there an appropriate mix of skills, levels and roles to deliver high quality care and ensure safety? Are there enough doctors, nurses and others in the workforce? Don't just all say no, say something in addition to that.

Participant A: I won't start off by saying no (*sounds cuts out*). It's broad, isn't it? Numbers can be found, but the quality of work, and autonomy of the practitioners that's where I…I'm frontline in emergency medicine and that's the issue: you can put bums on seats- to use a colloquialism- but they won't be able to fulfil the role autonomously. Thereby the work, the output, is slower so it can be quite wasteful. And being a trainee at the same time I know how labour intensive it is to train. So, whilst we may be able to get people into roles, I don't we've considered the fact that everybody that we do take on needs an awful lot of supervision and training, and invariably within medicine that is going to be a three to five year process, depending on the role that they're taking on.

Jane Dacre: Thank you and thank you for kicking us off.

Participant B: As a psychiatrist I think that the historic underfunding of mental health services has been a real issue and given the fact that it takes years and years to train a consultant, I think that's been a real factor for us. So, although the number of training places have been increasing for the last three years it will take a while before that filters through in consultant numbers. And the same thing holds true for nursing numbers, even on the most optimistic projection we are going to be quite a significant margin away from where the workforce needs to be in mental health. I think in consultant numbers we are probably going to be 60% short, and only about 40% of the projected increases are likely to happen there. And in nursing I think we will have that level of shortages again. To give something positive, I think there are new roles developing in physician associates and ACPs etc. But to follow Participant A's point, how do we create time in the busy clinician's life to supervise these new trainees. I think that's a real challenge, and that's one area that I'm really keen to try and make a difference in: how we increase the training capacity within a clinician's role. Unless we institutionalise that we won't be creating a pipeline for the new workforce to emerge. There are a few other points that I want to make, but I know there are hands up and I'll stop there for now.

Jane Dacre: Thank you very much for that and we'll come back to you.

Participant C: I guess the first thing to say is what we don't have across the whole of the workforce is really what is safe? What is safe staffing, and what is the correct amount of staffing in different areas and who should that staff be? And within physicians working around how many doctors you need in

a ward, and how many doctors you need at night, how many doctors do you need in an acute take. So, there's a gap there and I don't think we've delivered on that. In terms of then working out where the gaps are, we fundamentally can't do that without some sort of mandatory reporting because we simply don't understand, across the whole of the country, where the gaps are in the workforce to understand how better to resource them. And I think within that there's a bit around understanding that all members of the healthcare workforce, but particularly doctors, are working differently since COVID and want to work differently. I'm sure that most people on this call will be aware, but the ability to work and train less than full time is coming, and if you ask trainees if they want to work less than full time the majority of them do- in fact 80%. And this idea that we're going to have more doctors coming in with more medical students is all very well, but we actually need to work out what the impact will be of the fact that many of them will want to work a four day week or will want to work flexibly. We haven't got that mapping or modelling, and it isn't joined up across the healthcare sector.

Participant D: Dentistry is the Cinderella service of the NHS, and that's why we're often referred to in a grouping with 'other services', even though we see a lot of patients. In terms of our staffing levels, one of our major problems within the NHS is that nobody really sees a future in staying with the NHS. At all. None of our younger generations of dentists want to or have a desire to. They don't see a future; they have no career prospects, and they have no way of levelling themselves up. They're born an NHS dentist at renumeration level, and they will die an NHS dentist at the same renumeration level 30 years in primary care. So, it's little surprise that despite a 5% increase in GDC registration numbers there are, in fact, 2000 fewer dentists in 2022 than there were two years ago. So, in terms of staffing levels, I think the gradual erosion of any goodwill towards the workforce in NHS dentistry is starting to really make an impact on recruiting and retaining workforce for the NHS in dental. In terms of skill mix, the current contractual arrangements don't allow us to utilise different skill mixes to maximise the delivery that we could do in primary care settings. So, both of those things are a huge problem and that's as much as I will say for now, but I will happily speak again.

Jane Dacre: That's great, thank you.

Participant E: In support of what Participant C said, I think there's good evidence from the US that minimum safe staffing levels are linked to centre's failing-to-rescue rates. And certainly, across many specialities in the United Kingdom there are no minimum safe staffing levels and that surely has to be the starting point for any workforce planning. And to go into what Participant A said, I think there is a minimal safe staffing level, including skill mix, for care delivery and then there is a minimal safe staffing level for care delivery and training, and they're two different things and they're often not appreciated. In terms of skill mix, I completely agree with what Participant D just said. In surgery, which is quite a good example, there's a huge push for including members of the extended surgical teams, such as allied healthcare practitioners, in emergency rotas, but because of contractual restraints and a lack of currency equitability between the roles it's hard to merge an allied healthcare professional with a junior doctor on an on-call rota. That's really hampered things from a surgical perspective.

Participant F: I'd echo everything that people have said. As a long-term condition specialist, I think we also need to think about the different challenges between more surgical models, see and treat, hopefully do something and discharge, and long-term conditions in workforce planning. The way that people are trained, and the plan to group the next generation, has to be built into the way that we view the patient journey, and we design the workforce. I completely agree about the safe staffing levels, please don't forget long-term conditions, out-patients, and unstable long-term

conditions. You can plan everything you like in long-term conditions, and then somebody has a flair up of their arthritis, which keeps them off work, and they need to be seen in an emergency clinic. So, there's a predictably unpredictable amount of workforce planning that has to be factored in. I know it's difficult, but along with mandatory safe staffing levels there has to be a sort of mandatory flexibility for predictably unpredictable work to be done. I'm in the interesting position of having a son who is about to start medical school, and it's been interesting to see his view, and we're not doing a good job of persuading him that after five years he is even going to have a foundation job, let alone it being worth being £100,000 in debt- particularly when he's seen whole load of stuff on Twitter about the disparity between pay on bank holiday rates between the AMPs and the junior doctors. This is not about money- I'm also married to a doctor- and we've always said to him that we earn a very good wage, but it's gone down in real terms, and I've been persuaded that renumeration has to be addressed as part of workforce planning. We do a very responsible job, it's a 24 hour job for almost every single doctor and dentist in terms of what you take home, and that has to be accounted for. I personally think one of the reasons that people want to work less than full time is because a full-time job is actually undoable, as well as having your own mental health in training. And we shouldn't be setting up people for failure; the job should be doable in a full-time role if that's what people want to do. We shouldn't have people battering down our doors to work less than time because the full-time job is impossible. If people want to work less than full-time for a better balance great, but not because it's the only way you can sustain 40+ years in the same job.

Jane Dacre: Very well spoken. Participant G

Participant G: Again, I agree with all the points that have been made. I'd just like to add the observation that there's an inclination to talk about training posts when we're planning workforce, and I'd like to broaden the scope of that to consider the reliance that we have on non-training grades in many of our services- a way of working that seems to rob Peter to pay Paul from a lot of systems. Also, those who are in training grades are often covering, at very short notice, gaps in the system that runs with an expectation and a reliance on a complete lack of redundancy. Without any redundancy in the system, the slightest bit of stress means training and care quality goes out of the window. We saw this very clearly in intensive care during the COVID pandemic where we were providing a service, but we were not providing intensive care.

Participant H: Just to raise a separate issue, in addition to everything else, I think we need to think about community services. In the world of community child health care, we've got increasing problems recruiting into that particular service area, and it's historically underfunded and sort of unloved. We are very reliant on SAS doctors, and for every SAS doctor that retires in the community we're not replacing them because there isn't a pipeline of SAS doctors doing that kind of work. So, we have an impending crisis, where we're just not going to be able to deliver community child health services just because of a lack of that overarching workforce planning.

Jane Dacre: Thank you. Participant A, you've got your hand up.

Participant A: It was just a comment on safe levels. We've had them, I think in 2014 and 2015 the Royal College of Emergency Medicine very clearly published, per amount of attendance, what was required in terms of consultants, what was required in terms of nursing staff. And they're almost seen as aspirational. Consultant numbers where I work are fine, but everything else is not fine. I think if there's ever a take home message it's that if we're going to have these safe standards, they need to come with some degree of bite so that they can be used to actually change provision.

Participant E: Just to pick up on what Participant G said about out locally employed doctors. I think this year they've surpassed the number of trainees in the UK and the Republic of Ireland, and without them our entire workforce would collapse. The interesting point to pick-up on is that they are reliable workforce for rota planners, whilst trainees are seen as a headache. That is because of the processes that exist to communicate number of trainees, status of trainees, the short notice that deaneries give to trusts. Essentially rotas are done of the cuff. Rota gaps are a bit of a misnomer; there shouldn't be any rota gaps if there is enough notice, and you can rewrite the rota for the number of people you have. But one, rota positions are under-funded and two, there just isn't the time give to trusts to be as agile as they could be to create these rotas with minimal staffing level, which doesn't exist in a lot of specialities albeit, I understand, in emergency medicine. So, I think some value on that role and some input from clinicians on the ground that know the job, and not just some manager in an office with a spreadsheet, could really go a long way. But I think valuing locally employed doctors is huge. The final thing I want to say, and sorry I don't want to overstep the mark, in certain specialties we're getting to the point where trainees in training positions, with national training numbers, are asking the question "why aren't I a locally employed doctor?" They say things like "I get to stick around the same hospital for a number of years, I don't have to go through all the hoops and additional cost of ticking the boxes, I can develop my mentee/mentor relationships in a place where I can start having children." When those question start to get asked that is a failure of the training and recruitment method. And when that happens, I think we're in for a stormy ride.

Jane Dacre: Thank you, Participant B

Participant B: Just a couple of quick points. The first think is that in the COVID period, we've seen a significant increase in demand, as 4 million new referrals have come through and that waiting list is humongously long. That initiative is likely to place a further demand on the stretched workforce and that's not been factored into workforce planning at all. The Mental Health Act review, which is specific to us in psychiatry, has also caused a significant increase in the requirements, as per the Health and Social Care projections we need about 350 more psychiatrists alone just to manage the extra workload created by the Mental Health Act. And again, there is no provision for that, at all. I think we're already about 500 consultants short and we're looking at the highest level of locum numbers. So, I think there is a further demand creeping up on us in the immediate future, let alone in the longer term.

Participant D: Just to say that in dental the training opportunities beyond your first year in primary care are very, very few. So, the NHS will support training in the first year after qualifying as an NHS dentist and after that, in primary care, there is nothing. And if there are DCT posts for training in secondary care they're hugely oversubscribed for. So, there aren't any training opportunities that encourage people to stay in the NHS and build themselves and grow (in primary care). I hear the same thing across other specialties too, that the encouragement to stay and grow is not there.

Jane Dacre: Thank you. I think we will come back to training later. I just want to ask a slightly broader question, we're a very medically/dentally related group here, but what about other professional groups. I know that we have other focus groups looking at other professional groups, but what is your views on the number of other people working in the service? Are there enough of the other professional groups as well, and what are the issues there?

Participant E: So, I can speak from experience in surgery with our allied healthcare professionals joining the workforce in the last few years. We're in a bit of a funny stage where the senior nursing staff have gone on to do higher degrees, and they're taking advanced practitioner roles and that has

had a number of effects. They've often had a negative effect on more junior colleagues, so foundation doctors, and their ability to assess unwell patients. Their pay scale is far beyond that of foundation year and senior house officer colleagues, with a lot of people saying, 'why didn't I just do that and save myself from all the debt which I've acquired through medical school.' The other scenario is that for a lot of my colleagues, who have worked in these roles for a number of years, they're getting to the top of their allied healthcare professional roles and realising that they don't want to do that for the next 20 years, but there's nowhere to go after it. So, we've created this subgroup of specialists and advanced care practitioners, who on paper are probably much cheaper than training a load of doctors, they deliver a really good service, they stick around the same centre for a number of years, and they provide a really great service to local patients. But in the long run, I'm struggling to see how that's going to work, as I've seen numbers leave already, because that ceiling comes quite quickly, and these are ambitious people who have changed roles. To steal Participant G's saying it looks like we're just robbing Peter to pay Paul and I don't think it will work long term. That's my prediction.

Jane Dacre: Thank you. Participant B

Participant B: Two quick points. The first is that we welcome the idea of allied health care and developing them professionally, but I think we need to, as Participant E said, create a pathway for them. Especially, for example, physician associates and ACPs, as I think mental health is a very small component of their training. So, we really need to think about how we invest specifically in PAs who can work in mental health. Right now, it's only 2% of PAs who go into mental health, which is a very small number. The second thing is that I think there is geographic inequality, and unless we see some incentives created locally for people to say on, I think there is a real issue that we might have the training numbers, but they all gravitate towards the larger urban centres, and we will continue to see shortages in areas where shortages have always existed. It will get exacerbated. So geographic inequality also needs to be thought of.

Participant F: We don't have enough nurses, and we must look beyond the confines of nursing and doctors. So, psychology, psychology, psychology with liaison psychiatry is unbelievably lacking. And for all age groups health trainers to work in partnership and youth workers to help our young people to engage. They're a massive drain if we don't get their transition between health services and their career in healthcare as young adults sorted out, and we just simply lack the people to do that. I'm the most highly paid youth worker in the world, I'm not good at it, I'm not trained, and if you ask me what I want, I want a psychologist and a youth worker and I could revolutionise engagement and non-communicable diseases in this adolescent physician age group. But nobody's interested in talking to me about extending the workforce in that way, but it would release senior consultant medical technical time.

Participant C: I think if you are asking if we have enough healthcare professionals, I'd say the honest answer is that we don't really know because we don't have enough modelling of what safe staffing looks like. As Participant F alludes to, so much of the work that we do as doctors could be task shifted effectively, and we have to move away from saying we need X number of doctors, or X number of senior decision makers, towards saying we need X number of people who are skilled in this area, and they could be from any background and training.

Jane Dacre: Thank you. There is a document from the College of Physicians about the safe staffing, can you make sure we've got it?

Participant C: Yes, I can send it to you. I've just been looking at it.

Jane Dacre: It rings a bell. I've got Participant G and Participant D, and then we'll need to move on to the next section.

Participant G: It's a point about receptivity, because I think this problem is well understood by many of the medical colleges and professionals across the NHS and speaking about expanding the workforce to people with a skill set, rather than a particular role identity, is hugely important and well understood. But the receptivity to that on the other end is lacking. And when you have the additional loss of existing roles because of poor working conditions and better pay elsewhere then that situation gets exacerbated.

Participant D: The skill mix in dentistry in primary care is difficult because of the contractual arrangements in primary care. In salaried services, skill mix is essential in order to have enough capacity to see patients and treat them along the pathway, and without the skill mix of therapists we would be hampered. However, in the primary care contractual model, no therapist would want to work in it and take the knock on renumeration. They would be better off working as a private hygienist than coming to work as an NHS therapist, under a UDA arrangement.

Jane Dacre: One more quickie on targets. There are all sorts of targets for all sorts of professional groups, and I have to say it's hard to tell whether they've been met depending on how you define them. Are they helpful or targets a waste of time? Participant D is shaking their head, does anybody have anything to say on targets?

Participant G: There are no consequences for missing them.

Participant D: The targets in dentistry are so abhorrent. I think medical colleges are aghast at the way dentists are treated within the NHS (in primary care), producing units of dental activity- irrespective of complexity or volume- in order to meet a financial target based on producing a widget that, whether you have one filling or a mouth that's full of disease and needs 20 fillings, you will have the same unit of dental delivery. And if you do not perform to target you will have the money clawed back from you either as an individual or as a practice, which is why it's not an affordable and sustainable model.

Jane Dacre: So that's healthcare delivery targets, do you have workforce targets?

Participant D: No. Because we are independent contractors, in the same way that GPs are, the NHS doesn't have an obligation to have a certain level of performance. They contract based on how much activity they want to buy from practices, and that is purchased based on a 2006 model of the population, which funded 50% of the population. So consequently, as that funding has been squeezed and squeezed and squeezed, we can deliver to less and less.

Jane Dacre: So, I think we've got Participant B then Participant A. I'd just ask everyone to be quick so that we don't run out of time.

Participant B: For us, targets are helpful. We've historically been underfunded, and I think without targets it would be difficult to measure the shortfall. Having said that targets have been missed consistently, as Participant G mentioned, and we asked for an amendment to be included in the Health and Social Care Bill that would hold the Government to account but it didn't happen. We would like to see the Government held to account for its workforce targets.

Participant A: I think workforce targets are helpful and realistic, but to come back to Participant F's point that we need to define what we do. I would say that at least 35-40% of my consultant role is not delivering consultant care. For my trainee role - I mean it's like walking through treacle,

especially having the perspective of being a consultant at the same time- I deliver maybe 25-30%, and I'm a good trainee. So, if we're going to have workforce targets lets offload all the other things and focus on the role that we're being trained to do that other people can't do.

Jane Dacre: Thank you. Participant E.

Participant E: I think targets are only useful if they're generated in a way which is evidence based and based on figures. In surgery, there's only been a couple in the last few years, and they were plucked from absolutely nowhere. They just thought this a good idea, a good proportion, let's stick that on there and make that a target. I know my colleagues have mentioned healthcare delivery targets and they are often very similar. So, I think without that good quality data, and looking back on what we have struggle to achieve and what we will need to achieve in the 5-10 years, targets are useless.

Participant F: I was just going to say the British Society of Rheumatology did produce, for example, a peer reduced planning document regarding specialist nursing in rheumatology which is a really good model. It was a very thorough piece of work, and it had a health economic assessment. But you take it to a Trust, and they say that they're not interested because it doesn't relate. So I think targets work both ways, and professional societies put a lot of work into trying to define these issues and they have absolutely no clout. So, there's lots of great work being done, but nobody is joining it up. I completely agree with Participant E in that nobody takes responsibility for closing the loops, and the Government should help be held accountable for closing those loops and they should expect us to provide our professional duty like that.

Jane Dacre: Participant F can you send us the rheumatology nursing report. I'm actually at risk of being fired for being a useless Chair, so I'm going to move on and just ask a broad question about the relationship between local workforce and national workforce planning. So, is there enough of a relationship? I'm hearing from the conversations we've already had that the answer is no. Is there anything anybody would like to add to that, or shall we say that we have the answer? Ok, so we've got no hands up and we'll move on. So local workforce planning isn't solving the problem.

Participant C: Jane, I guess the only thing to particularly mention about that, for all of us who are doctors, is that for example if trainees who get appointed in one area of the country may move to where there is a need for, perhaps a future rheumatologist, and we're just lacking the joining up of training posts and not being able to move is just madness. There is no national oversight on where the demand is and getting people in the right place for the rest of their careers.

Jane Dacre: So, another big call for national oversight and it looks like people are nodding about that. So, I'm going to move onto our next policy area which is about building the workforce. And this essentially is on training and developing people, so CPD is obviously very important. Is there enough opportunity and resources for CPD? We've heard a bit about it from you already Participant D, do you want to expand on that, or do other people want to come in to talk about resource and funding for training and development.

Participant D: In dental there is no funding for any continuing professional development outside of secondary care and specialist training. SAS doctors have the benefit of having some training pathways open to them, there are no training pathways or investments in the primary care workforce or in dental care professionals. And locally, commissioners are just not interested in training pathways or spending the limited budget in a different way. They're hampered by what is nationally led, so local flexibility just doesn't exist for training.

Participant G: So, a comment first, not a single consultant in my current department has job planned time for educational supervision, and that is not atypical. And the other comment I had was that I think the average cost that a trainee personally invests in their training is north of £12,000, and that is a significant investment that is a real deterrent for people pursuing training. And the arrangements around being reimbursed, partially reimbursed, or not being reimbursed at all for undertaking professional development as a trainee is onerous and really deters people from developing in their departments.

Participant C: I think there isn't enough investment in training. In general for physicians going through their careers, the erosion of SPA time at the cost of DCC time particularly since COVID. We've seen time and again in our census that consultants are working at least 10% over their contracted hours and the main thing that has come down has been SPA activity. 50% of consultants in last year's census said that they wanted to reduce their PAs and ultimately, we have not built enough time into their jobs for doing this stuff that makes them more competent.

Participant E: I agree with Participant C. Trainers are burnt out and there's no financial incentive to train. I think relying on consultant colleagues to deliver care above and beyond their SPAs out of goodwill, and then train above and beyond their SPAs out of goodwill is just not a good model, and it doesn't work- certainly not in surgery. The Modernising Medical Careers documented that was released a while ago called for generalists in surgery, and there is now a concern that all of our specialists are retiring, and everyone has been trained as a generalist and there is going to be a consultant workforce crisis. So, we've come full loop against what many spoke up against. Another example is that there is a general feeling, amongst many medical specialities what we're very reactive in the way that we recruit. We see a gap and fill it, rather than being proactive and recruiting for what we will need. So, in urology, for example, 85% of prostates are now taken out robotically, and that's probably going to go to 95% in the next two years, but there is no mention of robotics training in any curriculum in surgery and there is no one being trained in robotics. Again, I know that's quite a niche example, but it's one which is applied to many specialities not just in surgery.

Jane Dacre: Thank you. Participant B.

Participant B: So, three things. The first thing is that in terms of upskilling the workforce, I think we definitely need to match it with clinical demand. We've seen that when service configuration has happened, funding is given for that, but the human beings who work in that continue doing exactly what they've been doing. There's no provision built in and so training is almost trying to play catch up, and it's never really woven into the service transformation. I think that really needs to change. The second thing is specifically in relation to digital literacy, and in relation to Participant E's point earlier. I think we all have electronic patient records, and since COVID times digital working has moved on, but there is no real training in digital literacy, and data literacy specifically, and I think that is a real issue. Every trust is putting in about 25,000 pieces of data that goes upstream and as clinicians we hardly get anything back that is relevant and meaningful, and that helps us to work with our patients. The third thing that, I think, is quite critical is public population health. Our training generally in medicine, and specifically in psychiatry, is very focussed around managing reactively acute mental health, and there is very little in terms of population health. I think this is woven into our training, if you look at good medical practice it's all about the doctor-patient relationship, there's very little about how we as doctors are responsible for the care of the communities that we practice in. Local education providers don't really invest in the training in local communities, so there is very little investment in the trainees and the workforce that is passing through in the local communities. So, we put this in our curriculum, but how do we implement this

in the ground level, and I think there is a real challenge in bringing together public and population health and person-centred care. I think unless we have significant investment in making that happen, that won't happen. I really feel that is an area of critical importance.

Participant H: I think if we want our medical and dental workforce to work until their mid to late 60s, which is going to be increasingly essential in order to maintain the level of expertise and seniority and sheer numbers, then we have to allow people to develop their careers over the totality of their working lives. That, by definition, is going to mean that they should be encouraged to go away and develop other skills, develop that kind of portfolio careers. It might be about picking up new clinical skills, but it might also be about going through more leadership development, it might be training to be the next digital officer for the trust. We have to start investing and have that kind of overarching plan which basically means that it is not ok to just sit doing the same job for 30 years, because you will burn out and retire before you're 55. Let's proactively think about how we're going to grow and develop staff. But there isn't even the space and time to have those conversations, never mind allowing people to go off and spend a short amount of time developing those interests. I'm not at all surprised that increasingly people are looking at their pensions thinking about how absolutely exhausted they are, they can't carry on doing out of hours work. In my speciality we have consultant paediatricians, aged 55 and above, begging to come off the on-call rota because they're in all night and they can't sustain it. And the consistent answer is no, and if you don't want to do that job by all means retire, because we could probably replace you with two people fresh out of training who are prepared, at that stage of their career, to do nights. I think the idea that we expect people to work until their late 60s is absolutely farcical, unless we think more proactively about this.

Jane Dacre: Thank you. Participant A.

Participant A: I just think that there's a risk of merging sustainability of job practice with opportunities for job development. If our jobs were sustained and balanced and doable, that would mean that weren't all grabbing hold of those SPA sessions with all out might because we're off the shop floor. I'm fortunate that in one of my departments we do have adequate CPD time, we've got consultant led CPD, there is opportunity for development, and we've got a relatively stable workforce. But I sometimes just think that I'm actually exhausted, quite frankly. I've gone back into training to study a different speciality and there is such a disconnect between my training, my paperwork filling- I'm sure that Participant E and G have probably got better comments on it- but there's a bit of disconnect between development and the process that we have to do to prove that we're developing as the trainees. The amount of never-ending paperwork that doesn't seem relevant to what we do. And then there's this other side as a consultant where, yes, I want a sustainable job and part of that is development, and as Participant H says we have this longitudinal idea of flexibility. But you can give me all of that, but if I'm burning out on seven and a half PAs, delivering frontline care that's non-sustainable and utterly exhausting, even if you gave me another session to develop myself, it would actually be used for recuperation and rebuilding and recovery. Does that make sense?

Jane Dacre: Yes, it does. It sounds very depressing, but yes, it makes sense.

Participant A: Sorry. I think CPD is so, so important. Sustainability is important, flexibility is important, and I've gone back to get a second CCT, so I obviously thoroughly believe in professional ongoing development. I think portfolio careers are great, but there is a risk that they can be used as a substitute for actually sorting out our working conditions.

Jane Dacre: Yes, so it's all coming out of the same pot.

Participant G: I just wanted to highlight the importance of the pensions issue as a driver that's behind losing a lot of very experienced clinicians, that often have primary roles in delivering training and education for trainees. And once those people go that capacity is gone forever, and it's really hard to build alternatives to provide it. And the second point that I was going to come to was around whether we are training in the right things and do our development options accord with what we need for the future of the service. And just on that point, probably half of the courses that I've done in the last couple of years on things like digital literacy and research skills are not anywhere on a curriculum or on approved study leave courses, so they're completely out of my own pocket and not seen as valuable to the service.

Jane Dacre: So, it's not targeted enough.

Participant D: For us, in keeping with what's been said, the whole-time equivalents have reduced across the whole healthcare sector. People are no longer wanting to work five days a week. So, in terms of capacity of the workforce the numbers don't reflect the whole-time equivalents that are on the ground. Government and successive planning haven't recognised that in dental, the historic model of how dentists progress in their careers isn't as relevant now. 30 years ago, people would qualify, work as an associate and buy their own practice, but now that is financially so hard to do, certainly as an independent practitioner. The model has shifted, and there are far more associates now than there are practice owners which means that the work and the career structure doesn't favour associates and leaves the associates behind. So, the recognition that how people actually want to have a career, and stay in the NHS, has changed isn't recognised. It's changed substantially.

Participant C: I think picking up on what a lot of people have said already, I was just reflecting that something that we haven't picked up is the role of people who have portfolio careers by definition because they work as clinical academics. And, the fact that training, as we've all said, doesn't stop when you finish as a trainee and become a consultant. We have the consultants who are not retiring early, they've got portfolio models of careers, they're embracing their time in the NHS and we need to keep those doctors contributing to the NHS, because otherwise they will just entirely base themselves in research. And it's not just those in research, it's the doctors that have gone into pharma, the doctors who might have gone into other careers, or want to be in media for example. We've got to recognise that one model does not fit all for doctors. Being able to keep people in and not worry about whether they're doing two or three PAs and getting people to contribute what they can into the NHS is key to keeping people working longer and more of us.

Jane Dacre: Thank you. I understand from The Times that a letter has gone out asking people to do that. I don't know whether trusts have seen it. The other thing that we've been asked to ask about, and I think it's probably relevant to other groups rather than this group, is about the development of digital services and the rollout of digital services and how helpful, or unhelpful, they have been. The commitment was specifically in the community. I don't know whether anybody has a quick comment on that in relation to community.

Participant F: The integrated service I run runs across the community and part of our backbone is digital literacy, and I could talk for hours about that, but I won't. The massive concern about reliance on digital technology to deliver healthcare is the approximately 30% of the population who will not be digitally literate or, more importantly, not be able to afford data. They cannot physically engage because they cannot afford data. And this potentially worsens health inequality. So please can we stop thinking we can solve workforce problems by putting everything to digital, because we will make the 30% who are already struggling to engage have even worse outcomes. People have

phones, but they cannot afford the contracts to maintain the data required and the video consultation burns through data like you wouldn't believe.

Jane Dacre: What about the staff though? What about staff and their access to, and understanding of, digital?

Participant F: It hasn't been difficult to deploy that. I was responsible for deploying the digital technology through the workforce, and the staff like it, but struggle with key hard to reach groups. So, I think before we have the discussion on staff, we need to think about the purpose of digital deployment. I think it's very important, but the bit about health inequalities is often missed in the whole purpose of digital deployment.

Participant D: In terms of digital and wellbeing, my fear is that the wellbeing agenda, as well meaning as it is, disguises the fundamental problems of inadequate renumeration. If your pay doesn't cover your bills, doesn't cover your mortgage, doesn't cover your debt from student-hood, then no amount of digital well-being resources is going to fix that. So sometimes I think that you're trying to invest in something that's a lot cheaper than trying to fundamentally improve the working environment for the workforce. These digital platforms that discuss what your problems are and where your future is, are ineffective it there is not future for you.

Jane Dacre: Thank you. We're going to go to Participant A, and then I'm going to move onto wellbeing because we're running a bit behind, and we need a bit of time to talk about that.

Participant A: We've had a couple of digital interventions, and it's an unhappy merge. For example, the 111 during the pandemic was an absolute disaster, giving people set appointment times to then to rock up at an A&E department, blending in with the model that we've got. And I was going to make the point that Participant G made, that as a trainee I gained very little from it…I need to be integrated into part of developing the service, and intruding digital services needs to be properly evaluated. When we've done long COVID projects with deprived communities, building on what Participant F said about data, we've ended up having to facilitate and put somebody in the community to literally hold the iPad and provide the data, and I fail to see how that's actually saving anybody anything.

Jane Dacre: Right, so it may not be saving the time that it's cracked up to?

Participant A: Or the money.

Jane Dacre: Or the money. The next area that we're talking about is the wellbeing of the workforce. One of the commitments that we're looking at is introducing new services to employees to give them the support that they need, including quicker access to mental health and musculoskeletal services, and to reduce bullying rates in the NHS which are far too high. So can we have comments on wellbeing, support services and bullying rates. I will start with Participant B.

Participant B: In COVID times, we have seen a dramatic increase in the number of staff members reporting mental health problems and our own survey showed that. I think in the Government's initiative for the COVID Wellbeing Recovery Plan, they've funded £30 million which is about £30 per NHS employee. We saw 750,000 people accessing that care so there is a huge demand out there. I think there are logistical issues, and Participant D made a point about the focus on wellbeing, and I think a lot of the focus has been on just resilience, but there isn't enough focus on systems and making them systems better at supporting staff. Instead, the focus has been on individuals. I think we need to go and look at that. I think there has been very little focus on people who are on the severe end of the illness spectrum. There is a small, but significant, minority of people who have

mental illnesses which are treatable, and that's not picked up early and there's not enough support available. For some people, even taking that time off to access that care has been a real issue. There are also issues around confidentiality, especially if you require inpatient admission or crisis teams' support. We don't even have a system in place for members of our workforce to access support locally without their confidentiality being breached. All of that is left to the individual manager on-call on the days. So, there is a lot of work that we could do to make the system better in terms of not just wellbeing, but also illness. It is such a large workforce that we could actually have an NHS wellbeing and illness service and sustain it because the demand is so huge.

Participant C: I thought a lot about this, and I completely agree that there is something around supporting the top of the pyramid, as Participant B said, the people who are most in need of support and I'm afraid that I don't really know how well we have met the commitment to support those people. But in a way I come at it from a different part of the pyramid, if you like, and I'm there with the issues around culture, and the microaggressions, and the undermining that's happening on a much bigger system wide level. Because whilst it's super important absolutely that we address the staff that are at the end of the spectrum who really need the specialist input from psychology, for me what we haven't had is a commitment to address the culture change that is desperately needed. We see that from the staff survey, and all of our surveys, that they're feeling undermined, and nothing is happening. It's a vicious circle. I really worry that we ask people a lot about how they feel, and we measure burnout, and the absence of burnout, as being a surrogate for wellbeing which I don't think is the same thing. I think there's something around us measuring wellbeing and celebrating the things that are making people feel good about their jobs and having an impact on staff, and then calling out the behaviour that is not ok, those microaggressions that may be around racism, sexism and undermining for all sorts of different reasons. We need to get better at calling that out across the system. I've got some ideas of how we can do that, but I'll stop.

Participant E: Just to pick up on a couple of my colleagues' points, I think the concept of wellbeing is often governed by your workplace and the conditions that you work in. And certainly, if you're a trainee, the job has changed massively over the last five to ten years, and it's almost as it the system hasn't kept track with that. The days of travelling up and down the country and moving on a whim to go and work in an amazing job, just doesn't really happen anymore. I think a lot of trainees don't feel like the fruit is worth the squeeze, and ultimately geography and stuff outside of work is more important. That's quite a sweeping statement, and not based on any data, but I think that's what trainees are feeling at the moment. So, I think a system where when you're pregnant on maternity leave applying for an intermediary transfer should be an ok thing to happen. This nepotism of moving trainees around deaneries within certain specialties just needs to go. And that whole process needs to be looked at, will undoubtedly have a massive effect on wellbeing. Talking about measuring, I don't even think we do the basics right. So, in most specialities no one has an exit interview, if they leave their training programme there are not exit interviews. We don't know why people are leaving. It's just like, they've done and they're not our problem anymore. Finally, there was a Category 3 less than full time programme introduced last year by the educational bodies, and the data suggested that most of the people that would take these up are individuals who suffer from problems with their mental health and wellbeing. And when asked whether or not the educational body would therefore look into how they can support these trainees within that category, the answer was no. Again, and example of not wanting to measure, look at or support these trainees and provide a way to keep them in the system.

Participant H: Can I pick up on the second point around bullying? My observation of working with a variety of groups across, and inside and outside of, paediatrics is that there are some people who

are genuinely nasty, and are bullies, and they need to be dealt with and managed proactively. And sadly, I don't think it's done. I think of lot of these people, particularly in senior roles, are just kind of tolerated. But my point is that I think that the majority of workplaces that are deemed to have a lot of bullying, actually comes from the fact that they are working in incredibly stressful clinical environments. They're under resourced and they are not in a healthy environment. So, I think a lot of the bullying that we see in the NHS actually speaks much more of the system, and being under overwhelming pressure, rather than particular individuals, albeit they are responsible for their behaviours. I've seen departments where fantastically good people started behaving badly, and if you introduce an intervention, such as increasing the numbers of consultants, trainees or nurses, then twelve months later you've got a completely different pattern of behaviour. I think most of us go to work to do a good job, most of us do not get out of bed in the morning planning to behave badly, but I think if you're working in those incredibly intense environments then most of us, I'm afraid, have the tendency or the potential to behave badly.

Jane Dacre: Yes, absolutely right. There's a quote, one of my favourite quotes, from a Harvard professor of Business Management which is 'don't fix the people, fix the system' and that's coming through loud and clear.

Participant D: From a dental point of view, part of the reason that practices are leaving is because of the bullying from the commission side and the productivity thing. We're sort of on this treadmill: you produce, and you're penalised if you don't. And the commissioning discussions, if you don't meet your targets and your end of year reviews, those are the sort of things that affect practices. In terms of wellbeing, I think there is a real drive away from how to keep the workforce happy and to retain the workforce in the NHS, towards plugging the hole where you have the spaces with a cheaper workforce. So, for instance, in dental, they're looking at trying to change the GDC registration to allow more overseas dentists to come across to plug the hole that's missing. But these are short term measures, and if we can't keep the workforce happy, then over a period of time as has happened before, they will just leave. If you recruit from overseas, and they are unhappy, they will just leave after a few years which is what's happened before. It's a short-term fix.

Participant A: So firstly on the bullying side, I feel that it's really difficult as a trainee to be honest. I don't know if any of the other trainees on the call feel that, and I am a consultant of many years, so for me to have that feeling that I cannot, in a small speciality raise things is significant. If you're going to meet people at your CCT how do you tell them your feelings? Let's not put out another survey that doesn't offer real anonymity (mic cuts out) it just ends up with somebody going down the middle and saying yes it's ok, or not it's not. Even at the departmental level, there needs to be time to allow departments to be cohesive. And then inter-departmentally there needs to almost be an ethos that the trust supports investing time in communications between different departments. I just feel it's Groundhog Day, that you're constantly saying why were Specialty X rude to me? I fully agree Participant H, nobody comes to work to do a bad job or to undermine people, there are people that are probably more forceful in their ways of delivery, but I think it ties into wellbeing that at the same time as giving space for wellbeing we should also be giving time for civility and unit within the trust. More team building, and purpose and recognition. On wellbeing, sports and exercise medicine, it's our role to do MSK work, and the amount of kickback that we get- as Participant G's written in the chat- is "I can't eat, and I can't sleep, and I can't pee. I'm leaving work two or three hours late every night, can you please stop signposting me to somebody who's going to give me a yoga class." That's very common. If you start at the shop floor level, that message comes back at you.

Jane Dacre: Yes, I've seen that on Twitter.

Participant B: I just want to mention something that hasn't come up. I agree with Participant H, but I think that the experience is different for different groups of people. People from minorities have a very different experience and are more likely to experience bullying, more likely to experience poor career progression, and that's very well known and very well documented. International graduates are increasingly forming a large part of our workforce, especially in psychiatry and paediatrics, and 30-40% of our workforce is made up of those groups. While we import a doctor costing a quarter to half a million pounds, we don't event invest £50 in giving them an induction. They're thrown in at the deep end and that's a real problem. I think HSBC and other large corporations have proper relocation packages, and for an employer the size of the NHS it's remarkably shoddy that people are left to their own devices to relocate to another country, and setting up life there, and at the same time move to a different medical jurisdiction. No wonder we see the problems that we have. This really needs to be fixed. It's not just bullying and harassment, but it means that the entire system suffers when they don't progress. And the same is true of key transition points, like exam and career progression and the flexibility that NHS doctors have in coming back into training. I think flexibility is quite important.

Jane Dacre: Absolutely. And the issues for international medical graduates, I think, are significantly worse.

Participant G: Speaking about the international element to this, I think we should recognise that medicine is a global market, and when the environment that you work for in the UK is poor then you look elsewhere. And the attractions of other places are significant, not just in terms of pay and working hours, but the treatment as a professional. Just as an example, in Australia you're typically paid your study budget in advance, straight into your account, and you're trusted as a professional to do something right about it. Whereas here you spend three months chasing people through HR and accounting to try and get some of that money that you paid out back. I think unless we start aiming for excellence, rather than accepting mediocrity, we won't change that situation.

Jane Dacre: Thank you. We're going to be moved back shortly, so thank you everybody and you've given us a lot of really useful stuff. So, we're understaffed, under-planned, under-supported and underwhelmed by the response. Thank you. Let's get back to the main group.

June 2022