**Written evidence submitted by Group 2 (Event 1) (EPW0077)**

**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 2**

**Shereen Hussein**: So thank you everybody for coming. I think we will spend a few minutes introducing ourselves, and I'm going to go on the order of my screen.

**Participant A:** I'm a member of the British Thoracic Society, so I'm representing all form of respiratory specialists. I'm a consultant chest physician based in the North of England, but the majority of the time I work within the community.

**Participant B:** I'm a consultant orthopaedic surgeon in the South East. I am a member of the Medical Women's Federation, and I work with the Centre for Perioperative Care. I've got an MBA in Health Service Management.

**Participant C**: I'm a consultant anaesthetist in the South West and I'm a member of the Royal College of Anaesthetists.

**Participant D:** I'm a Nursing and Midwifery Researcher in the East Midlands. So I'm a nurse by background and as associate professor. I'm a clinical academic nurse focusing on frailty.

**Shereen Hussein**: Happy Midwifery Day.

**Participant D:** Yes, it's indeed International Day of the Midwife.

**Participant E**: I'm a member at the Royal College of Nursing, and I also have two clinical roles. I'm a consultant nurse, now honouree, but I still work within secondary care on a regular basis and my specialty in respiratory. I'm also an advanced nurse practitioner working in the 111 setting, so that's delivering out of hours care.

**Shereen Hussein**: Fantastic. And last not least, Participant F.

**Participant F**: I'm a member of the British Dental Association and a practising orthodontist in the West Midlands.

**Shereen Hussein:** Thank you, and welcome everyone. As Jane alluded to, we have divided the pledges into three themes. The first is planning the workforce, which is looking at pledges related to specific numbers for certain staff groups. The next is building the workforce thinking about career development and infrastructure, and the last theme is around the wellbeing of the workforce and reducing abuse and ensuring the wellbeing of staff. We've got a few questions, and we will take each one in turn and move around the questions. Obviously, there are no set answers, and everyone will be bringing their own experiences, and these questions are just to prompt the discussions. Each of you are coming from a different speciality so please bring in your experience.

When we looked at the pledges, we could see that there was a commitment from the Government to ensure that staffing levels meets the demands and the needs of the service. So this is an open question, but in your area do you think you currently have the appropriate mix of skills and the right roles to deliver the hight quality of care. I can already see some people disagreeing. Participant E, do you want to jump in and open up the discussion?

**Participant E:** From a nursing point of view, we certainly know that we have not got the workforce that we need. We know that we've got massive gaps. I've been really fortunate over the last couple of years in my role in the Royal College of Nursing, and we've set out the workforce standards for nursing. So we set about co-creating what would be that overarching set of standards that cover all settings. So we have got a blueprint from a nursing point of view, which is a step in the right direction. What we have got, from a very early start, is the accountability required for workforce; there's no accountability at Government level for workforce. And if we haven't got it at Government level, how can we look at getting it into the organisations never mind getting into other local levels. The other key point then is what is the correct skill mix? That's another piece of work that we are looking into at the moment as a professional body and will be leading on working that through. The problem is a massive lack of evidence, but a lack of evidence shouldn't stop us, and we know from expert consensus that it's not safe at the moment. So there's lots and lots to do and I suppose we all need to work together, but from a government point of view that first point would be accountability.

**Shereen Hussein**: Thank you. Participant F.

**Participant F:** At the moment in dentistry, we've got the highest numbers on the register with the General Dental Council, but we've got problems with the number of the workforce that are capable of delivering NHS care. We don't really know that the whole-time equivalent is of the dental population, not only dentists but the skill mix and members of the dental team. We've seen the pandemic having quite a detrimental effect on workforce in that a lot of people have retired early, and lots of people are rethinking their career and whether they want to be committed to the NHS. We've got a problem with recruiting and retaining ancillary staff become of the pay differential. We've really got some serious issues with access which are across the media all the time. So that's my initial contribution.

**Shereen Hussein**: I think dentistry in particular is really interesting because of the divide, and because people in the profession are leaving the NHS and choosing to do private care. And the point about ancillary staff, I think we will revisit when talking about the specific roles where this a deficit.

**Participant C**: From the point of view of anaesthetists, we've done quite a lot of work at the college looking at the numbers, so looking at the numbers that we had at the beginning of 2020 and the numbers that we're going to need looking forward to 2040. At the moment we're pretty short and we're going to be 10 times as short by 2040. The Government have, to be fair to them, given us more training posts, but what is disappointing about the response from the Government is the rejection to the call to undertake regular prospective workplace planning at governmental level. The NHS is such a big organisation that is so complicated, that if nobody is taking charge- as Participant E was saying- of looking at that then it is difficult to see how we can ever move forward. In terms of skill mix I would like to mention theatre nursing staff, and others working in theatre, as they are definitely lacking at the moment. We also have anaesthesia associates who are non-physician anaesthetists, a very small number at the moment, and again it's disappointing that the regulation of this group of professionals, which was due to come under the GMC this year, has been postponed/ the legislation is not going to come in until next year, and it's going to be so much easier for us to expand their numbers once the regulation is in place. So, I would say that the Government has done a bit, but it's not enough and the workforce planning is going to be a big part of it.

**Shereen Hussein**: Thank you. Participant D.

**Participant D:** I think building on Participant E's point, we don't have the evidence and there is a distinct lack of investment in workforce research- it's very industry led. We need the Government to

invest in workforce research with equal importance, particularly to understand skill mix. I think it's great to hear Participant C talk about theatre nurses, and the specialities around nursing, the investment in that kind of development of those specialist skills is incredibly important, and I think we have, as a profession, not particularly invested in that. We have two years worth of CPD funding which eclipses what we've probably had in the last 35 years put together, so I think that's an incredibly important point. But there's nobody taking accountability for this. Everybody's saying we've got a deficit of 40,000 deficit of recruited nurses in the UK, and the answer to that is international recruitment. Government legislation does not allow us to then develop international nurses, so they have to be in the country for three years to be able to access university education. So there are some real huge challenges in how we are going to skill up that workforce. People come in with incredible skills from other organisations internationally that aren't recognised in the UK, and we continue to do that. My organisation alone is bringing in 35 international registered nurses every month and has plans to do so for the next 24 months. We are one of the biggest NHS trusts in the country, and other NHS trusts are doing exactly the same things, so that's a huge part of the workforce. And again it's another inequality that we have as it adversely affects our ethnic minority colleagues. So that's my contribution for starters, thank you.

**Shereen Hussein**: Thank you. That is bringing in a lot of issues and overlaps with the other areas, so that is really good. Participant A.

**Participant A**: From a respiratory perspective, workforce is absolutely our number one priority. The British Thoracic Society has been producing workforce reports for 25 years and we've spent the last six months putting together a paper on the future respiratory workforce, because that is the priority that it is needed. In respiratory medicine, we are not delivering so many things that make a difference, and we know that our work isn't as cost effective as it should be, because we don't have the workforce. And this is across every area of respiratory medicine. I totally agree with other people's comments that sometimes we struggle with precise numbers. The GIRFT report was able to estimate that we're short of 375 respiratory physiologists up and down the country. When it comes to respiratory nursing, I agree with my colleagues that what we're looking at is often an ideal number for a particular clinical service, but nobody knows how to translate that confidently into actual numbers. And that missing data is so important. I agree as well that we are absolutely missing a trick about how we plan this strategically, and everything is being done in isolation. What we know and recognise, and we talk about it in the report, is the fact that every time you appoint someone you need a group of support people around them, otherwise you're never going to utilise those individuals optimally. But we have a situation where, for example, with a respiratory consultant, you'll appoint someone but there's no associated nursing time, no associated physio time, no physiologist type etc. and so that individual, even if they are appointed never gets to the point of being able to deliver their jobs optimally. And the key thing for us is that we need this now as, some of the posts that we're talking about take 3/5/7 years to train and unless we start to put some numbers to this now, address this now, we're still going to be talking about this in 5 to 10 years' time. From a respiratory perspective the people that I work with across the professions, all the respiratory professional groups, are absolutely exhausted. We have been flayed by COVID; we've been frontline throughout. What we want to do is to harness the enthusiasm to improve things now, but we're fearful and dread the fact that we won't be able to do any of that because we haven't got the staff, and that's when people will start leaving the profession.

**Shereen Hussein**: Thank you. Participant B.

**Participant B**: To follow up on that point about support staff, a lot of work that is done by the doctors, the senior nurses, the kind of decision makers is actually stuff that you don't need that

registrable qualification to do. In my trust we appointed doctors' assistants at Band 3, and we had a grant from Health Education England for £80,000 which paid the salaries of five people for six months, and they were fantastic. I have written it up in BMJ Leader. But to support people at Band 3, you're then freeing up your senior decision makers to actually do their work. In my view we need to work out what health is all about; it's not just about doing what we always do. You need to your senior decision makers doing the highly skilled stuff or making the decisions with patients. What you want to do is train up other staff to talk to people about the healthy behaviours that make such a difference, the cultural changes so that people get enough exercise or stop smoking. All of that sort of thing we can do at band 3 or band 2 level, with the Making Every Contact Count initiative. I worked on the 'Exercise: The Miracle Cure' report from the Academy of Medical Royal Colleges, and we can reduce the risk of stroke by 30% if we get the population doing the 150 minutes of exercise. But you don't need the doctor to tell them that. Similarly, we don't just need to be training staff to take on additional enhanced roles, we need to do that because we are desperately short of people with those skills, but we also need to support the band 2 and 3 workforce so that all the other things are covered, and so the senior people can work at the top of their license. One more point, while I have the floor, is that women are far more likely to drop out of training programmes than men, and we need to do something about those critical years of training. It may need some extra funding for, say, people with parental duties, to get through those bottlenecks because otherwise we're losing them. You recruit people and then the retention just falls off.

**Shereen Hussein:** Thank you. I think what you all seem to be saying is around task shifting, and task distribution, and understanding that we need certain numbers of certain specialists, but we also need a whole range of support. There is a lack of understanding or planning of how many do we need at each point. And that brings in the question around some of the Government commitments that have specific numerical targets, for example there is a target to have 50,000 more nurses and 5000 more doctors. And the question I have for you is how helpful to you think these targets are and do you feel that they reflect the truth of the situation? Because that is so interlinked with the planning, and it seems that there is no national tool for workforce planning. Planning appears to be localised to each trust or each group. So we're combining two questions: looking at the usefulness of government pledges on workforce numbers and whether you feel the mechanisms for workforce planning are appropriate?

**Participant E**: Just before I answer that question I'd just like to go back to that point about task, because it's not particularly about task shifting, it's about ensuring having the right person, at the right time, with the right skills and in the right place. Going onto targets, what we've seen is people looking at targets and targets can have positive and negative impacts. And often it's not just looking at the target, it's looking at the whole picture. For example, if you look at the decision in ED to move to 12 hour waiting target, and we should look at it from across the patient journey. When it went from 4 hours to 12 hours that was quite complex, because there's lots of interpretations of decision to admit. I work in a 111 setting clinically, I work every other weekend and what I've seen at the moment, across all settings- not just 111 or ED- is a representation of the whole health and social care system falling down at the moment. The pressures are unimaginable in every setting, wherever we go. For example, we in 111 we have triage, and the targets have changed and often there is a lack of understanding of where that change come from. All of a sudden, we've gone from 2 and 6 hour targets to 2/6/12/24 hour targets, which just happened overnight. I work in a national role at the RCN and obviously I've seen some of the targets- and we've been part of some of the communications and the discussions around some of the wider changes- but then I see in practice other targets which don't seem to have any rhyme or reason, and it isn't clear where they've originated from. Sometimes it feels like the targets are changed and moved around to try and make

it look as it things are a little better, or more achievable, when actually those people who are on the 111 list aren't going to be seen in the waiting time because the pressures on you are just unsustainable. So a little bit of a rant, and a lot of reflections, but I think it needs to be said and targets can be a double-edged sword.

**Shereen Hussein**: Thank you Participant E. Participant F, before I take your contribution, I want to reflect on the idea of whether you have enough data and national tools to support any strategic planning. Because a lot of people ask where this 50,000 number came from, how it's going to be distributed, how that has been projected and what is the timeline for that. So maybe in your answers you can reflect on whether you feel there is enough support from the Government in a centralised way, and the tools to help you plan this workforce. Also, do you have data because people talked about the missing data.

**Participant F:** We worked alongside Health Education England to actually get some data on whole time equivalents for the Doctors and Dentists Review Body, and it proved to be an insurmountable task. Health Education England gave up on it fairly quickly and then tried to relate it to the activities carried out within high street dental practices, which isn't a very good parameter of actually working out the workforce issue. One of the issues that we've got is regarding overseas registrations exams with the General Dental Council, and there is a real logjam and capacity issue there. So even if you set a target to bring in a set number of dentists from abroad there would be a logjam in doing that, unless there was a mutual recognition of qualifications of those trained professionals coming in. And, in the UK we've got a shortage of academics able to actually train up the dental team. So even if we were to expand the estate to deliver more training places, we haven't got the structures in place to provide that training and there would be a logjam there too. One of the other issues is that when I qualified 38 years ago probably ¾ of my year were male, and now in dental training more than 50% are female- there is probably a predominance of females entering into dental training. This can affect whole time equivalents going forward because of other responsibilities, largely family responsibilities. I hope that helps.

**Shereen Hussein**: Yes, it does. Participant D.

**Participant A**: My overall response in terms of the numbers is based on the work that we've done over the last six months, and the fact that we've had so much difficulty creating and finalising numbers for staff groups. Even when we're talking about a proportion of the NHS in the whole respiratory speciality, or when we're talking about respiratory specialist nurses or respiratory physiotherapists, our difficulty in putting numbers to our shortfall means we are often met with cynicism. The numbers in our reports are not someone licking their finger and sticking it in the air and coming up with a random number, but the data sources that we've used to get shortfall numbers are wide and varied. Plus, data can be deceptive. We know that 82% of hospitals have a vacancy for a respiratory consultant, and that's not good, but we also know that a load of hospitals have given up advertising for respiratory consultants because after 4 or 5 attempts they realise they haven't got a chance of appointing someone. The other thing that I would like to throw in though is that for my specialty, and I know this is quite specific, but we are a seasonal specialty in that twice as many people have acute respiratory illness in December than in July, but we always use the exact same work plan throughout the year. That's one simple way in which we could be more effective. The other thing to throw in, is that we're passionate about integrating care, and primary and secondary care working together but we know, without a shadow of a doubt, that our colleagues in primary care are on their knees at the moment in the same and sometimes more extreme ways than we are. The manifest effects of that are that the people who do the overwhelming majority of respiratory medical work are massively under-resourced. I work in the North West and I'm working

in one of the most deprived areas of the country, but we have swathes of GP practices with no regular GP. A patient of mine recently couldn't see a GP for six weeks because there wasn't one, there was just no GP in their practice. And the effect that this has on the ANPs and the practice nurses within primary care is enormous, because they're not getting support, they're not getting training, they're not getting supervision and they're not able to advance themselves. So, this just means that the work which needs to be done is just increasing and increasing so much across the patch. Ultimately my answer to your question is that our difficulty in identifying numbers means that I'm often highly sceptical about any overall number quoted.

**Shereen Hussein**: Thank you. We have two minutes left on this section, so I'm going to go to Participant C and then we will move onto the next theme.

**Participant C**: Thank you. Really just a quick point to say that I'm also slightly cynical about targets, because if you say X number of doctors are needed it doesn't express what type of doctors or where. And each college and each areas has some figures about this, but we've never been able to feed those in. The Government keep coming back and asking for figures, and we try to, but it's not taken on board. So again I'm pretty sceptical about it to be honest.

**Shereen Hussein**: Thank you. So Participant D, we've got two minutes on that topic.

**Participant D**: I'm agree with my colleagues. Targets are generally about the numbers needed now. Our 50,000 target is our 45,000 deficit and it does not take into account what we might need within the next 5-10 years. Unless it's underpinned by robust workforce planning and trajectories of need for the future, based on the last 10 years and the trajectory that we've had, then they're meaningless. We don't have national data sets in a sense either. Some of the really pivotal nursing national data sets have recently been removed, and while they weren't perfect, they were the only thing that we had. I'm sure I don't need to talk to anyone about ESR, but that is certainly a national data set that we could utilise much better as a healthcare system to support and help us with our workforce issues. And then just going right back to the beginning: if we don't have the evidence, and we don't invest in the evidence, then targets are meaningless.

**Shereen Hussein**: Thank you. That segues into our next theme, because we've spoken about how you need to have a structure in place with academics and examiners, and we're looking at continuing professional development. So it's not only about the pipeline to get into the profession but continuing the development. And then thinking about whether there are enough opportunities and resources to enable staff to undertake training and to develop their careers? Is funding available? Are there appropriate mechanisms in place to support staff? People talked about how even if you get a doctor, you will need support staff, and is there enough support to continue their development? Ok, we'll start with Participant C.

**Participant C:** I don't know if this will directly answer your question, but this is something that has come up in quite a few conversations, and it's about the time for trainers and examiners. I can only speak from the point of view of anaesthetists, and possibly surgeons who we work alongside, to say that because of the elective backlog there is a drive to do more and more work. It's short-termism, where you try to do as much as you can at the moment, but there will be a long-term problem if we don't release people to do the training and to be examiners. We won't have a workforce, or at least a medical workforce, in the future from that perspective. And I'm sure it's the same for other professional groups as well. So, I think it's really important that we continue to recognise (mic cuts out) There are also questions about wellbeing as well, because I think driving the workforce too hard in an effort to get something done quickly, is the wrong approach in my opinion.

**Shereen Hussein:** Yes, yes. Participant D.

**Participant D**: I think one of nursing's biggest challenges is the way we workforce staff and plan, which is the first part, but what that does within our teams is that it does not leave us headroom for anything beyond sickness and maternity leave. And that's a huge challenge. As I said before we've received a significant investment in the last two years in continuing professional development, and the biggest issue we have is that we cannot spend the money because we're coming out a pandemic and we've all had to be working clinically. My background is for LT, but I've been in both ED and ITU over the last year. It's not about throwing money at it, it's about having the plan in order to release the time, and it's a case of having to fit it in. So if you're in an area where you've got slightly better staffing, then you're more likely to get investment in development. And that could be anywhere, it completely depends on where those deficits are. I think it was Participant A who talked about our primary care colleagues, and I have no idea how they get time to enter into any kind of education. So it's not about funding. Funding is incredibly important, everything costs money, but unless you've got the infrastructure within the teams in order to release the staff it's not going to be of any use.

**Shereen Hussein**: Yes. The pledge is really interesting, it's not specifically about the money, it says help the million and more NHS clinicians to develop the skills they need, and the NHS requires in the decades ahead. So it implies that there is planning and looking forward, but what you're saying is that it's not comprehensive- that even if you've got some funding, there is no planning attached to it. So that is very helpful, thank you. Participant F.

**Participant F**: From the dentistry point of view, we had a report last year from Health Education England, that they called Advancing Dental Care, which were ideas about training pathways to actually help. The only problem is that the report came with no funding attached to it. So whilst it was great in concept, the funding wasn't evident of how you actually go through that pathway. Again, some of the things in it are very encouraging: a career pathway for someone who works in the dental team to actually progress through, to actually end up training as a dentist, and other people hopping in and hopping out of specialist type training rather than having a defined training pathway. Again, great idea, but the real problem we have in dentistry is that the more upskilled you become, the less opportunities there are within the NHS funding model to actually use that skill because there aren't contracts attached to those. So they end up upskilling and then actually leaving the NHS workforce to deliver that care privately.

**Shereen Hussein**: That's very interesting. I think it's specific for dentistry, but really important.

**Participant B**: The Association of Surgeons in Training have a mantra: No training today, no surgeons tomorrow. It's very difficult with the backlog to make time for training to, to prioritise the surgeons that are coming through getting trained. There is another aspect towards that, our perioperative care way of looking things, that we are quite inefficient in many aspects of care and there's a lot of variation across the country- that the Getting it Right First-Time reports have shown. If we can train-up people to be able to work across some specialties, so it's not like in multidisciplinary teams where you're waiting for the physiotherapists to come and interact with the patient, you've got everyone with a little bit of that skill to try to help and get that patient educated beforehand. That would improve some of the throughput in theatres. It comes down to a different sort of training for the staff that are in the post at the moment with more generalist skills, so trans-disciplinary working, key specialist skills and particularly perioperative care type of skills. The other issue is, as Participant D mentioned, about not being able to take up opportunities because they're stuck on the wards or in clinical areas, and I think that we need to go back to the point where we train people very quickly to pick up some of the things that do not require a registered qualification. When I was on the council

of the Royal College of Surgeons in England, we produced a report that showed that surgeons in training posts spent 50% of their time doing tasks that did not require a medical degree. At my Trust, we've got an apprenticeship now at Level 3, working as band 3 "Doctors Assistants" because there's no one else for doctors to hand their work to. This works really well and has won awards. There's no one else who can find out how the photocopier works, or make someone a cup of tea, or run back with a leaflet or how to put a drip in. We need specific skills for people in that healthcare support worker role because it takes a long time to train everybody else.

**Shereen Hussein:** Thank you. Participant E

**Participant E**: Just bringing it back from the Government level there is some workforce planning, you can't say there's no workforce planning, but it's very much siloed and it's not an overarching workforce plan that auto links in with job planning. I think job planning is essential, because that also fits into practice development etc. The nursing workforce standards that we at the Royal College of Nursing have published give that overarching plan and it does pick up on uplift, we know what we've set out what should be considered in uplift. And just as Participant D said, we know that there's not enough workforce to even consider anything above that sickness and maternity leave. However, we've set the standard of what should be included. And the workforce plan should be working towards needing a workforce that doesn't just plug the gaps that we have now but plans for the future and plans for those nursing workforce standards to be in place, and to be achievable. And we're not asking for massive standards, what we're asking for should be available. It also looks at substantive staff; so, it's often not looking at where the workforce vacancies are, it's looking at those unfilled shifts as well. Because we know, for example, that in social care, particularly nursing homes…For example, I visited a lot of nursing homes in my clinical practice, and I would say that 95% of the nursing homes that I visit are staffed at night by a registered nurse who is agency, so it's across the independent sector as well. So I suppose my key thing is that we really need workforce planning that is joined up and not across silos, we need that overarching plan. It brings us back to accountability as well, who is going to be delivering that workforce? It's not just about throwing money at it. I like that motto of: if you don't train today, you haven't got tomorrow's workforce and we need all the time for that. So lots to do.

**Shereen Hussein**: I think there is a lot here, and there are a lot of nuances to planning. People talked about the time it takes for training, we talked about international recruitment and the recognitions of skill, and how we can think about the skills metric of who is doing what and how can support each other. And as Participant E say, to do that we need overarching planning and not working in silos. The second commitment, that we felt fits into this area, is specific to community-based staff. Just to run you through it, it's all about preventative work- as Participant B said at the beginning- so the commitment says, "supporting moves towards prevention and support we will go faster for community-based staff. Over the next three years we want all staff working in the community to have access to mobile digital services, including the patient care records, that will help them to perform their role. This will allow them to increase the amount of time that they can spend with patients, and the number of patients that they can see. Ambulance services will also have access to the digital tools that they need to reduce avoidable conveyance to A&E." So we have two questions around that. The first one is, if relevant to your role and experience, do you have access to mobile digital services in the workplace? Has the implementation of mobile digital services made your work more efficient in terms of joint care plans or access to patient information?

**Participant E**: I've worked in the 111 out of hours setting for about 12 years, and for 10 of those years I think I've very rarely touched a piece of paper. We've had lots of digital, computers in the car etc. In my national role, I sit around a lot of tables where I'm told that all the computer systems

work, and that people who work in 111 will have access to GP records, but I can probably count on my two hands the amount of times when I've been on duty and it's all worked. I see a real difference between what they think happens, and what is happening on the ground. Sometimes it's very frustrating because it's simple things like smart card technology. There are often just bits of the system that don't work. It is improving, it is improving that we can get access to the spine, and we can get access to some GP records, but it's still very patchy and variable and we've got a long way to go. My other point is that with the integrated care systems that are coming, and in the Integrated Care boards, I think we're at a time when in the next year or so where we could really influence change. It would really improve the way that we work, the way that systems work, if we can get some of the governance…a lot of the time it's  governance systems that are processed locally that cause the problems, and I think some of that could be addressed. I also think, going back to workforce, some of the ICS could help with the workforce. As a consultant nurse, I fought to try and get a respiratory nurse within my local area and actually if I was to design it now, I would say to look at the ICS level and it would be easier to develop a better workforce. If we look at it from an integrated care system, and look across all requirements for that population, and how you have commissioning and organisational process like HR, which enable the workforce to work across that integrated care system and have access to that digital side as well.

**Shereen Hussein**: Thank you. Participant A.

**Participant A**: I think there are a variety of different issues here but firstly, in terms of mobile communications in the community, I am the best respiratory doctor I can be sitting in the community when I have access to the primary care records and hospital records at the same time. That is when I'm at my most effective. I know this because I've worked in the community for a number of years, and I wonder how I manged to be as effective without that access. But I'm lucky, I'm sitting in the clinic room and the systems work most of the time. The physios, the HCAs and the nurses that I work with are in people's houses or out in their cars. Their hair is etched with grey, and their faces have wrinkles from the times that they're 30 minutes into typing something up and the whole thing just disappears. We talk as if we've got brilliant connectivity when we haven't; I work in an urban area and goodness knows what it must be like for some people in rural areas. We're also missing an enormous opportunity; we are duplicating things and we are wasting hundreds of millions of pounds doing the same thing again and again and again, when we don't need to do it. I can give an example; I found a patient that had a diagnostic lung function test 11 times in the last 15 years when they only needed it once- that's ten other people who could have had the test. Does anybody, apart from the patient, know that they had had 11 tests? It appeared not. We've tried for a number of years to link lung function tests between hospitals and primary care, and we have not managed to do it. Plus, there is a challenge of access- some of my colleagues waited four and half years to be given access to the GP records, even though they were working in the community where referrals are only sent by GPs. So, there are still massive issues, and because everything is fragmented a lot of the time the system simply doesn't work together. I don't think that, at the moment, you want to talk about remote monitoring- is that to come?

**Shereen Hussein**: No, we're not looking at that. We're looking at the service, at things like digital communication and accessing the records which is a big thing. The other focus would be if you feel that the ambulance staff have enough information to direct patients away from A&E.

**Participant A**: OK. I'll make one last comment. Within my community service we have to have a nurse who remains in the office so that when the paramedics refer someone, they can phone up the office to make sure that the patient is suitable for that service. This is because the paramedic can't

access primary care record. That process helps the service to run effectively and safely but that's not really a great or efficient way to do things in 2022.

**Shereen Hussein**: Yes, so there's another layer there. Participant C.

**Participant C:** I just want to make one point: it's interesting that there's a correlation within the pledge that increasing technology will increase time with patients, and then increase the numbers of patients that people can see. I'm not sure how they've come to that conclusion. I think that shows a distinct lack of understanding about what technology brings to the clinical area, and in actual fact it can, in many cases, take very valuable and experienced clinical time away and reduce the number of patients that you can see. And this is because of all the problems that people have already very well-articulated today, connectivity, systems not speaking to each other, having to redo work that's already been done. So I think the pledge in itself is flawed, I'm afraid. That might seem harsh, and not a focussed comment, but I think it's largely true.

**Shereen Hussein**: As an academic I completely understand; we see technology sometimes as a workload generator, so we have the same impression with that pledge. But that's the pledge that the government has set and that we need to comment upon. Participant F.

**Participant F**: In dental practices we don't have access to the summary care record, which is a real logjam especially when you're dealing with people with comorbidities. It delays treatment because you have to contact the medical profession to actually get some of the information that you need- and that ties them up as well. So that's been a real bug bear. One of the things that happened during the pandemic is that we've actually started to develop better use of technology. So we've been able to triage by video consultation, and it's helped with referrals into secondary care where you can actually take photographs, and various other things, and send those in to help. Prevention in regard to dentistry is the thing that will obviously prevent the disease and mean that we won't have to treat anything, and we can do that remotely as well. There are real opportunities to do that. Someone mentioned ICSs and linking up the holistic-type care, for things like obesity and diabetes that dentists can be involved in and as part of a team we could prevent some of these. If you're eating sugary things then you're going to have a problem with diabetes and obesity, but you're also going to have dental disease. So we should all work together so that we can actually deliver the same messaging. Those are the things I think we can use technology for.

**Shereen Hussein:** Thank you. Participant C do you have any comments before we move on to the third commitment group.

**Participant C**: Thank you. I just want to reemphasize something that was said by Participant B. So perioperative care is a wide-ranging initiative which can have really beneficial effects on population health and heath inequalities, but it relies on very smooth communication between a number of professionals. And I know, as other people have said, that when I'm sitting in my pre-operative assessment clinical every now and again, I can get on and look at GP records, but it's only a selected number of GP records and not for referral patients who are coming from more distant areas. So it's going to scupper things if there's not that smooth ability to communicate between professionals, and with the patients. So it's relevant in our area as well.

**Shereen Hussein**: Brilliant, thank you. So we've only got around 17 minutes left for the last commitment, which is wellbeing in the workforce, and the commitment says that it will introduce new services for NHS employees to give them the support they need, including quite access to mental health and musculoskeletal services. It also says it will reduce bullying rates in the NHS, which are far too high. So we have two questions here. The first is do you think there is sufficient

access to support services for healthcare staff? The second part is thinking particularly about COVID and whether this has increased the workload and burnout for many staff.

**Participant C**: It's a really interesting question, and I think that during COVID there actually was really good access to mental health support. I think that was partly because, certainly in our trust, some of the psychologists were not needed in other areas so they were able to be brought in to support the staff. I think what has happened as we've moved on from the acute phase, and everyone's gone back to their normal day-job, is that we're seeing more and more people being encouraged to use apps and self-support mechanisms, and it's not as effective. Also, people will now have less time to access these sort of things. So I think there was a promising start during COVID, because there was just a little bit more capacity in the system counterintuitively, but it's not gone back to where it was. I accept that the intention is good, but I'm not sure that the reality lives up to it.

**Participant D**: Yes, I could clap because that is exactly what I was thinking. As Participant C some fantastic initiatives, but people need it now more than they did then because that post-traumatic bit has set in. I think that's the key point; if there was the innovation and services that were available during the pandemic, and people could have the same access to them, now then we would be a lot stronger and a lot better off.

**Participant E:** I totally agree with what Participants C and D have said. It's the accessibility and the need is absolutely so much greater now. Also, when we talk about the Recovery Plan for the NHS and how the activity is going to be increased, whether in primary or secondary care, it's often the same workforce that work in those different areas. So whether it's an extra elective list at the weekend or extra primary care- we know that in general practice there's a push for seven days a week and evenings- it's the same workforce delivering that, and the same workforce that works out of hours. Everybody's absolutely exhausted, they're burnt out. And they haven't got the access to services that they did. They've also not got the public behind them, as it was, so that's a doubled edge. There are so many extra things that mean now it's even more important to have access to that support, and it's just not there, or you can only access it on an app. What we're going to see is more and more people going off sick. More and more people have decided that now is the time to retire. And retire full time, not going back on a part time or more flexible basis.

**Shereen Hussein:** So what everyone is saying is that the apps have their time, but what we really need is in-person services and that is not available. The real kind of support services, rather than just using an app or self-help.

**Participant E**: Or apps should be in addition to support. There was a lot of wrap around during that first wave, and maybe during the second wave, but now it's very much that we've got to be carry on working as normal, whilst doing extra things and carrying the burden, without accessing the support.

**Participant A**: I'm going to completely agree with the first two points. It's needed now. What people have been through on the front line, in many cases, is not something you can deal with on an App. I cannot do anything but support my colleagues on this call on both of those points: we need it now and it needs to be more than just an electronic version. For example, our current President of the BTS is a respiratory physiotherapist who, as one of her missions post-Covid, put on some peer support sessions for BTS members, both seniors and juniors and in various roles. We were really unclear as to how many people would join, as it was a virtual session in the evening, and we thought people might think it scary to get involved with. But the number of people who attended those one-off sessions was very large; it was dozens and dozens of people, and so much larger than we

expected it to be. One of my colleagues is not easily shaken, and I think she found it one of the most salient experiences she had. The reason I'm saying this is because there is a really large unmet need out there, and it's going to have an ongoing effect, unless we actually start to come up with imaginative ways of dealing with this. Peer to peer support was feedback as what people wanted, as they really benefited from talking to other people who've been through the same experience. This could be developed into a model that could be very useful for some people.

**Shereen Hussein**: Brilliant. Participant F.

**Participant F:** I was talking to Clare Gerada recently about her Practitioner Health Support Scheme, and she was telling me that the people who came to her from our profession were people who had really tried to cope all the way through, and when they got there, they were really in a bad, bad way. There's a stigma attached to getting any help and support at an earlier opportunity. Despite the fact that across the profession there's loads of places where we could get counselling, the uptake is remarkably low. And sadly, the suicide rate in dentistry is terrible. There is an availability of services there, but it's the stigma attached sometimes, and the coping mechanism of healthcare people is unfortunately one where people keep trying to cope it with it until they topple over.

**Shereen Hussein**: I think that's a very good point. We could spend hours talking about this, but I have to move onto the last questions which is about bullying. The commitment is around reducing bullying rates, and I would ask you to reflect on the current situation regarding bullying in the area of your work, and it there is anything more that could be done to tackle bullying rates. Have you seen any local initiatives that have been successful in relation to bullying within the NHS? (Several seconds pause) No one is taking, Participant D.

**Participant D:** I think judging by our silence, you can see that this is not overly talked about to be honest. The organisation in which I work has just received an incredibly damning well-led CQC inspection, and this was a really big part of that from the staff feedback. So there's an awful lot of attempt to try and address some of this, and the activity around it locally in my trust has been incredibly welcomed and is open and honest. It absolutely does happen; you see it all the time. A lot of it, I think, is related to the job-related stress and as we saw in the previous conversation people are finding it very difficult to cope and often people will lash out. I'm not sure how that fits in with the systematic bullying, because of course there are people that are more systematically bullied, but we are seeing a lot more of that. It would be incredibly welcomed to see more activity nationally, because out of absolutely everything that we've talked about today, and from a senior nursing perspective and the different groups I represent on nationally, this is the one that's least talked about.

**Shereen Hussein**: That's really interesting, thanks Participant D. Participant B.

**Participant B**: In my work on the Royal College of Surgeons in 2016 we brought out the 'Avoiding Unconscious Bias: A guide for surgeons' but we lent very heavily on the Royal College of Obstetricians and Gynaecologists. This is saying that if you make a bullying allegation, that is called the nuclear option. The difficult bit is that if you make a bullying allegation, or you yourself are accused of bullying, everyone pulls back in and gets all their evidence and isn't allowed to talk to other people. I've done investigations of four bullying allegations for my trust, to help take statements from people and so forth, and it's really difficult getting into that adversarial thing. What we need to do is change the culture. Because a lot of people, as was mentioned before, don't realise that they're bullying; it's how they were brought up or it's a style that works for them, or they don't know how to deal with someone who is performing a bit suboptimal because they've always been a

perfectionist. So what we need is a culture change. The Association of Anaesthetists has done some work on a scheme hey call Knock it Out (in orthopaedics it's called Hammer it Out) and it's about stopping the low-level stupid things people say or throw away comments. The Medical Women's Federation has found that people say things to women who are just back from maternity leave that just makes them not want to carry on, and it's that low-level stuff that we need to deal with and not just walk past. It's about allyship and that requires a whole lot of changing, so that when people are at work, they are professional and don't just say the first thing that comes to them. We've got to change that bit and making it even more adversarial can actually be counterproductive.

**Shereen Hussein**: Thank you. Very important point about the nuclear option.

**Participant A**: I think most of us will hear and see examples of bullying on a not infrequent basis so, no, I don't think that bullying is sorted. But it falls into so many, many different levels. What I would say, is that at this moment there is a nurse in a hospital taking care of a group of patients, and one of them is wander some and staffing is unsafe. They are trying to care for that individual as well as everyone else, and then they're being pressurised to take another patient who also needs intensive input, and even though they know the situation is already unsafe, and they explain this, the nurse knows they are going to be forced to look after the new patient in addition to others. That nurse will spend the rest of their shift feeling unsafe, and feeling they can't do their job properly, and then they are going to go home with those feelings. And that is happening because staffing, certainly within acute medicine in most hospitals, is often falling apart. Those people transferring the patient are not bad people, but they are also at times under extreme pressure. There are bad people out there, such as the manager who once told me, about 10 years ago, when I wouldn't give up the last high dependency bed for someone who didn't need that level of care that he hoped something bad like that never happened to my parents. That was more overt but it's happening on a more subtle level. It's happening now up and down the country. But it's going to continue to happen unless we sort out some of the flows, pathways and workforce levels. With the conditions being as they are for those currently working in within the NHS- and I'm not excusing bullying- I would be genuinely surprised if bullying wasn't happening right now up and down the country.

**Shereen Hussein**: I think the whole situation, and the environment, induces this sort of behaviour. We're talking about bullying within the NHS-obviously, there is bullying from patients to staff- and Participant B made a very important points about inequalities in bullying and women being at the receiving end. I think you made a point earlier about career progression and the time that that can take. Participant F.

**Participant F**: One of the fine lines that we really find in our profession is about contract management form NHS staff, and they have a difficult role to make sure that contracts are managed appropriately. But there's a perception, and sometimes that perception is real, that bullying occurs when contract management is ongoing. This is certainly in primary care, and in secondary care, many of my colleagues feel that overzealous commissioners sometimes because a little bit of a bully, and that's an issue.

**Shereen Hussein**: So it doesn't seem that there are a lot of activities around bullying. It's unspoken, there's a fear to bring it up and the environment at the moment fosters these problems. We're going to be going to the feedback session shortly, so I'm really pleased that we covered everything, as I was worried that we were not going to cover them. So thank you everyone. I think we could speak for hours on each of these topics, but this gives us a flavour of people's experiences. And there's been a lot of agreements between people coming from different specialities. Thank you everyone for joining us today.

**Participant A**: Thank you to you as well for inviting us, and for giving us the opportunity to talk and give this information. That makes a huge difference to all of us as well.

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