Written evidence submitted by Group 3 (Event 1) (EPW0078)

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 3

Due to technical issues the beginning of the meeting was not recorded.

Anita Charlesworth: Hi everyone, I'm Anita Charlesworth and I'm a core member of the expert panel. Just to explain to everyone what we're here to do as panel is not the review all of workforce policy, but to look at the commitments the Government has made, in this case in regard to workforce. We come up with a rating, a CQC style rating, to the extent to which the Government has met those commitments by now, or whether they're on track to fulfil those commitments. So, we're not doing a general review of whether the Government's policy is any good. Alison is the workforce expert that's leading this and I'm here to focus on making sure that the way we're thinking about this aligns with the role of the panel if that makes sense. So, in the end we have to decide whether the progress on the workforce commitments is outstanding, good, requires improvement or inadequate, and you will no doubt have you own views on that.

Alison Leary: Hi everyone, I'm Alison Leary and I'm a Professor of Healthcare Workforce Modelling and I'm part of the expert panel that is brought in just for this topic. I'm a commercial demand modeller, so I work across different sectors, but I have an interest in workforce modelling, so the maths of workforce rather than the policy of workforce.

Participant A: I'm a physician associate, and a member of the Faculty of Physician Associates which is based at the RCP. Good to meet you.

Participant B: I'm an associate professor and a registered nurse.

Participant C: Nice to meet you all. I'm a consultant stoke physician. I'm also a member of the Royal College of Physicians New Consultants Committee.

Participant D: I'm a paediatric junior doctor. I am a member of the Trainee Doctors Group at the Academy of Medical Royal Colleges, and I'm also on the Junior Doctors Committee of the British Medical Association.

Participant E: I'm a member of the Association of Anaesthetists of Great Britain, which represents 10,000 anaesthetists, trainees, consultants and SAS grades. We have a very strong history of advocacy about the workforce, and we cover a lot the areas that I think you're covering today.

Participant F: I work in paediatrics.

Alison Leary: Thank you, everyone. So, Anita's given us a really good introduction, I think, to the piece of work that we're undertaking, and this is about getting your views. It's a very large area, and over the last weeks we narrowed it down to some specific areas, and some specific pledges, and today we will ask you some questions on these pledges. The first area is on planning the workforce, so that is essentially looking at numbers and pledges around staffing levels. The second area is around building the workforce, so here there are some pledges around developing the workforce and resourcing the workforce. And then the last area is the wellbeing of the workforce. So, let's start with the Government's commitments to planning the workforce, and here there are various pledges about the numbers of the workforce; so, 50,000 more nurses, 6000 more general practitioners. One

of the most interesting things I found about the pledges, as we were going through them, is that a lot of them are actually quite vague and that can make it quite difficult to look at them- and that's why we wanted to have a discussion about them. So, do we think that the commitments around workforce numbers, the level of skill mix, and the different roles are being met? Do people have any thoughts about this pledge? How does it feel in the real world?

Participant F: First of all, in terms of how it feels in the real world, I think it feels understaffed. I think that if you speak to any junior doctor that they will be able to tell you first-hand stories of how issues with rota gaps are causing huge problems with providing patient care. And that will be the case throughout the country. One of the issues that we have in this area, is that there isn't any kind of clear workforce strategy that the government has published. There used to be workforce planning done in some kind of way with the sense of workforce intelligence, but work done more recently on that has not been widely available or published. So, it's really difficult actually to properly quantify the extent of medical shortages. You'll have to forgive me because I am talking from a doctor perspective because I'm from the British Medical Association, but much of this will be applicable across the whole of the NHS workforce. So, BMA research- although that data isn't where we want it to be nationally- we can still use the OACD data per thousand people and the number of doctors per capita as a measure, and there is no getting away from the fact that in England we have a much lower proportion of doctors relative to equivalent countries in Europe. So, England is 2.9 compared to the EU national average of 3.7. I think that what we feel on the ground is that we are hugely under-doctored and understaffed, but that does bear through in some of the data that's there.

It's a shame that as the Health and Care Bill came through one of the parts that we were lobbying for was the workforce amendment, that had been championed by Jeremy Hunt and Baroness Cumberledge in the House of Lords, was rejected. Because that could have given the Government an opportunity to give these independent assessments of workforce needs, which I think are really needed if we're to have a meaningful approach to ensuring that we are able to meet the needs to patients across the country.

So, in a nutshell, I think that we need a comprehensive national workforce strategy that is clear and transparent, that takes into consideration the fact that we are currently understaffed and then has a realistic strategy for how that will be fixed in the future. That needs to include things like sufficient medical school places, but not just sufficient medical school places as there also needs to be sufficient places in the foundation program. And then beyond the foundation program for doctors, there needs to be an increase in national training numbers as well. The training programmes have been heavily oversubscribed, and that has increased over recent years, but despite that we still have rota gaps. So, we have people who want to train further within medical specialties, and yet the places just currently don't exist. And then those spots are filled by locum doctors, which is just madness, as that's not cost effective for the NHS and for patients, and it doesn't make sense for the professional development of those doctors as well. So, we need a strategy that works, it needs to be transparent, and it needs to increase the number of staff that we have across the NHS so that we can get rid of some of those rota gaps that cause us so many problems.

Alison Leary: That's great. So essentially the pledges are not specific enough.

Participant F: Yes, so the pledges are not at all specific. I think we can see from the document you shared just now, that it is incredibly general. But not only that, even with that specificity, all the evidence points towards the fact that they wouldn't be meeting safe targets anyway at this point- I think that's where I'm getting at. When the European Working Time Directive came in, many years ago now, it reduced the number of hours that junior doctors would be working but there was not

kind of commensurate increase in the number of junior doctors to fill those hours. And since then, these rota gaps have been right across the country, and we need a strategy to be able to deal with this.

Alison Leary: Thanks very much. Participant G.

Participant G: Thanks, and I'll follow very much on from what Participant F was saying. The question is whether we think the commitment to ensure that staffing levels that meets the needs of the service, and the quick answer is no. And I can say that immediately. As you said, the number of specific commitments is relatively small, and that may or may not be a bad thing. I'm not sure where they are on their specific targets, for example on 50,000 nurses, and they may be on track with that- though I think they're probably not on the GPs. So, there is a slight difference between whether they're on track for a specific numerical commitment that has been made in a few, but not many cases, and whether these relate to the overall commitment of ensuring that staffing levels meet the needs to the service. And I'm pretty sure that most people here would probably give a fairly resounding no across most areas. And it's not just clinical areas, and it's really important that we remember that there are other workforce areas as well in terms of staff support and IT support- all that sort of thing. But it's quite hard to measure what the precise thing we need is because, firstly, as Participant F said, we don't have that workforce planning process and secondly, apart from that small pledge around GPs and nurses there isn't a set measure to measure against. But the answer has to be-and I'm quite sure that colleagues in the service would agree- that there is not a sufficient set of staff across all areas.

Alison Leary: Thank you. Participant B.

Participant B: Just to echo I'm in complete agreement with what Participants G and F have said, in that it is woefully inadequate and does not meet the needs of current service provision. I think the 50,000 nursing workforce requirement was set pre-pandemic, and that hasn't been updated since. I think what we definitely require is a strategic plan, as well as a delivery plan, and within that it should get away from some of this lack of detail in the numbers. Because from the 50,000 nurses, that could be registered nurses, it could be nursing associates, it could be nursing assistants. A nurse is not a nurse is not a nurse, and as a safety critical profession we need some granularity in the targets to hold the Government to account around their commitment to the healthcare workforce.

Alison Leary: Thank you. Participant D.

Participant D: I'd agree that staffing levels feel inadequate across the board. I note that the prompt questions ask if there are any areas that are worse than others, and I think as a secondary care colleague, it feels as though colleagues in primary care are really suffering and stretched to the extreme. If I had to pick one area of the NHS it would be primary, but it's across the board. It also asked us to look at skill mix and I think it's really interesting that myself, and a lot of my colleagues, spend a lot of time not working at the top of our grade. So, I've been qualified as a doctor for about 11 years, but routinely I'll be asked to perform tasks that could be performed by a first year graduate. So, I think some of the way that staffing is set up is incredibly inefficient, and there is more that could be done with associate roles to help with that. But that is by no means all of the answer. Another aspect that I think is worth looking at is recruitment practices; the way that all individual NHS trusts are treated as separate organisations and there isn't joined up recruitment practices- I know that there has been work on passporting, so that a junior doctor is able to take their credentials with them in terms of mandatory training, occupational health history and GMC registration and things like that. We spend a lot of time renewing paperwork and that's incredibly

inefficient. Every time we change organisations, the way our training is set up means that we move through multiple organisations when that may not be necessary for the completion of our training, and also leads to the repetition of that work. I also think it's inefficient because we have to move so frequently throughout our training, that there's some delay in your progression because you're focussed on your new environment, your new building, a new team rather than progressing all of your clinical skills. The final thing I wanted to point out was that the medical workforce is still planned upon the assumption that one person equals their full-time whole equivalent doctor, and that whole time is 48 hours a week, and services are planned around the assumption that every individual doctor will work a 48 hour week as standard. And of course, we know, that the number of doctors wanting to work less than 48 hours a week is so much greater than when we first entered the workforce. And it's partly due to the intensity of the work, partly due to caring responsibilities, health conditions and all sorts of other reasons why people can't, or don't want to, work 48 hours a week. That leaves us with all of these rota gaps, that aren't there on paper but are very much there in practice. I think the targets around workforce that have been published sort of raise the expectations of healthcare staff, and also the public, about what the NHS is then capable of delivering. And then the public have very little sympathy when they see these targets out there that say we will have more nurses, or more GPs, and yet the service they experience is inadequate, or worse than what they're expecting, and that leads them to be more critical of NHS staff. I think that translates in the abuse that some members of NHS staff experience from patients as a result of those frustrations. I think that impacts on retention too.

Anita Charlesworth: I wanted to ask a little bit more about skill mix, because it came up as well in the cancer inquiry that we did previously, and we have seen a very substantial change in skill mix over the last 20 years. So not withstanding the points that were made about more not being the same as enough….we've gone to a more doctor centric mode, where doctor numbers have increased by much more than nurse numbers and some other professions, but one of the things that came through in the cancer inquiry was that some of the diagnostic related areas were particularly short. So, I wondered if anyone had any more observations about skill mix because a lot of what we see in the targets is around individual professions, but a lot of what has come out in the other reviews are concerns about team-based planning. And do you have any experience around team-based planning, and optimisation of skill mix more locally because strategies and targets are not national. Participant F, was that something you wanted to come in on?

Participant F: I was going to respond to something that Participant D, and I'll do that very quickly, but I wanted to agree with what Participant D said around flexible working. The other point I was going to make was that the more staff we have the better the intensity of work will be; I think part of the problem is that this is a self-propagating issue, especially in areas where people currently aren't that keen on working so you have less staff there. And so, the intensity gets worse, and the reputation gets worse, and less people want to go there. So, we get caught up in this vicious cycle. And you can also see that applying to the whole of the NHS as well, so it may be that more people are working flexibly at the moment, partly because of the intensity. But if we improve the intensity some of those people, not all because there's lots of reasons why people want to work flexibly, may be able to work more of the week because of the fact that they're not being absolutely destroyed when they are at work. One of my biggest bugbears in workforce planning, is that I haven't seen the evidence that we're being realistic about the fact that we have an increasingly diverse workforce who don't all necessarily want to work full time equivalent, and I don't think we should be making them do that. That needs to be built into workforce planning as well. So that appreciation of the fact that not all doctors, not all staff, will work full time and we need to have the numbers and the

training numbers, for example for junior doctors, to enable us to retain the diverse workforce that we should be aiming for.

Participant G: I wanted to pick up on Anita's point. I have noticed a considerable change, and again I'm speaking mainly from a medical perspective, in the approach to skill mix. To be blunt, the medical profession wasn't hugely open to ideas around skill mix at one time, and I think that has changed enormously. That is partly due to the fact of workload pressures, in that they can't complain about too much work and then say that they don't want anybody else to do it. The growth of PAs within the Royal College of Physicians is a prime example of that, but that wouldn't have happened 15 years or so ago. I think there are still areas of concerns at times, but I think that is hugely positive and there is a hugely different attitude towards team working and recognition of the benefits of teamworking. The slight difficulty, and I suppose it's really interesting to hear from people that are working locally, is that it is quite hard certainly for professional organisations that work, almost by definition, on a unit-professional basis to try and give estimates about what that team-based planning looks like at a national level. Some of that does need to be done from the bottom up because if you are the College of Paediatricians, you know that it's harder to get that overall picture. But it's quite hard I think for national professional bodies to do that or have the expertise to know how to do that, and some of that surely has to come from local levels both from employer and, one would hope, at ICS level. But it does seem to me that one of the problems is that planning has been on a really siloed basis, and surely the best way of addressing the problems in the workforce is to look across the workforce to see what they best workforce mix is. And I'm reasonably hopeful, because I think there is a much better approach and attitude towards that planning than there has been in the past.

Alison Leary: Team based planning is not unusual in other industries, but it's usually based on demand and there aren't the unique cultural nuances so it's an interesting one for sure.

Participant B: I think in response to your question, certainly from a nursing, midwifery, AHP perspective, I think we are seeing is cabinets being assembled to try and look at what the requirements are for population health and trying to align our workforce planning to meet those needs. But I think that it's really stifled by the lack of agility within different organisations and the infrastructure, and their appetite to deliver on that. I think we've got some great examples with our advanced clinical practice workforce where it can happen, and we've got great successes within our organisation. But for other professional groups who are trying to align and meet the needs of the populations, it's just not there. And I think that there needs to be some real impetus and drive at every level of the system to get clear alignment so that we've got a workforce that is fit for purpose, and that meets the needs of the patients and families that we see.

Participant A: I agree with Participant B. I think there are some areas where we see a wider group of professional working together in a well-planned, well-structured, way where people understand the different skills that people bring and factor that into what is required. Rather than the people that you need, you need to look at the skills that you need and who does those skills. I do think that it is rather isolated, and it's certainly not everywhere. So, I agree that some sort of national drive to get people thinking in that way would be good, using some examples of good practice, and I think that would go a long way. From a personal level it's pretty patchy, I've worked as a PA for 12 years now- I was in the first 40 in the UK- and it's been quite an experience in how we've been adopted as part of the team, and I can think of lots of examples where it's been done really well and lots of examples of where it's been done really poorly. So, I think there is a real need for national work around how people might do this, and how people might think about this, in their teams.

Alison Leary: Thank you. Participant E.

Participant E: I want to go back to the question that Anita asked about local solutions for local problems, and I don't think it works. And I'll give you a few examples where I don't think it works. It partly goes back to the point that Participant D made about central or lead employers for doctors in training, and the problems for people on rotations, and the same thing exists for the permanent workforce in London. Towards the end of 2020 there was a move towards passports for staff who were working in the elective care units to move around London and be flexed into departments or areas where they were need. The intense frustration of people who are trying to move and be flexible but are not allowed to do so because of petty rules developed and implemented locally by individual trusts and boards. It's incredibly frustrating. And I can say that as someone who recently retired and returned, as it's exactly the same for people who wish to retire and return. You go back and work at your same employer the next day- because as you're aware the rule for having time off was removed during the pandemic- and you have to restart everything from you as if you've never worked in the NHS before, having to do occupational health, mandatory training, the DBC etc. It definitely puts people off, who wish to be flexible. So, I think in terms of delivering a flexible workforce there's a huge amount that could be done, and should be done, at a national level because the local solutions aren't working.

Alison Leary: So, I guess we've covered the last part of that questions about recruitment practices. Several people have mentioned recruitment practices and how that's not really optimal. Anita, does that answer your question about skill mix?

Anita Charlesworth: Yes, it does. I think there might be something going forward as we start to talk about building the workforce about how some of the technology and innovation- which was a point made in the cancer work- is changing some of the requirements, and the extent to which the training and skill mix planning is adapting fast enough to that. In the cancer roundtable we heard that some of the changes in skill mix that arise from innovations, meant that innovation was not being adopted, or not being adopted as consistently across the system. It's probably a good time to move onto the second question.

Alison Leary: Yes, absolutely. Participant B did you want to add something?

Participant B: Sorry, I don't know whether this segues into that new point, but it refers to the previous point around a workforce that's fit for purpose. I think there's a lot of energy invested in getting the right people into the right team but, actually, how do we sustain and develop and enable people in our existing workforce to also develop their skills and knowledge? And I think one of the questions was around whether there is adequate resources and time, and certainly from a nursing perspective it is inadequate. There isn't adequate headroom in our establishments currently to enable people to do their mandatory training, let alone do additional courses and upskilling that is needed to meet the needs of changing population. From that point, with regard to workforce planning, we also need to be thinking about how we upskill for the future needs of our patients, not just today's patients. And that isn't considered currently.

Alison Leary: That does indeed segue into the next section which is on building the workforce. Participant F, did you have something that you want to add?

Participant F: I was going to talk about some of the training and development side of things also.

Alison Leary: Yes, it sounds like we're ready to move onto the building the workforce commitment, and I think we've got a long on what you all think about workforce planning.

Participant F: These things are kind of intrinsically linked, because part of the issue that we find- and this goes across the profession- is that because of the intensity, because of the workforce problems, because of the gaps, we find that there is less and less time for people to be able to devote to training. So, if you're a junior doctor that's time spent towards doing the aspects of your training programme that will enable you to progress through your training. And for specialist doctors, GPs or consultants, having that time set aside to be able to train others is also under increasing pressure. As much as I think there have been some really welcome statements about this as we're progressing through the pandemic, but on the shop floor we're not really seeing that come through. So, if some of the workforce issues are improved, that means there will be more headspace and more time for people to actually train effectively and properly. There also just needs to be a focus on it because if we're bringing more people into the workforce, we absolutely need the time for those who are already in the workforce to train those people who are coming into the workforce. And again, that goes across the profession and the NHS. There are also lots of other aspects that would free up some time for this. There's an ongoing problem with childcare, so access to childcare, and we've been told by our members that this is a huge problem- not just the expense, but the availability of it. And again, the pandemic has made that worse at times. There are other parts of the spectrum as well, such as support for staff who are going through the menopause, and that's something that our members tell us impacts their experience of the workforce as well. So, there are lots of different aspects in which this does feed into the workplace, but training absolutely needs to be a priority if we are to improve these different issues. So, I think to answer the question on whether there are currently enough opportunity and resources, the answer would be no, and this is one of the key issues that, I think, is facing the NHS at the moment.

Alison Leary: Thank you. Can I ask you how you think this 'enough' should be determined? Do you have any thoughts on that?

Participant F: Yes, I think that's a really good question. At the moment we're finding that some junior doctors, for example, because of the impacts of the profession, are going to find that they may not have met all of their training requirements that they need to be able to progress through. And that is more of an indictment of the system than an indictment of those as individuals. So part of this is just as simple as people being able to meet the requirements of their training to be able to progress through. But it goes beyond that, in that there should be opportunities for leadership, training, development and research as well, and at the moment people just aren't getting those opportunities. So, there will be some things where you can measure it, for example how many people can progress through their training and not get adverse outcomes for factors that are beyond their control. I think softer things are more difficult. Another objective measure is perhaps that the General Medical Council surveys trainers every year, and one of the questions that they ask is whether or not they feel they have the time available in their job plans to be able to do the training they want to do, and the results are always quite stark. So, there are some questions, surveys and things out there in the system that I think would be useful as a way of doing some form of measurement on these aspects.

Alison Leary: Thank you. Participant G.

Participant G: I support what Participant F said, but I just want to expand it a bit wider. I think that at the moment part of the problem is about headroom, not just for specific formal education and training that a junior doctor is on, but for all clinical groups of staff. Actually thinking about service improvements, service developments, QI etc. requires a degree of space to do that, and the NHS wants to utilise the expertise of staff to be able to do that, and the trouble is that if you're on the hamster wheel just running faster and faster then you just don't have the time for that. So, it

absolutely goes beyond just your formal educational training. There will be improvements to service if staff can think about how to do that, and that's really important. One thing that I would say, which might not make me entirely popular here, I recognise the pressures that have been said but I think there are probably staff groups that are even more pressurised in terms of time for education and training than the medical workforce. In some ways I think parts of the medical workforce are probably a bit better off because there are arrangements for that (which I know are under pressure) and there are other groups that are probably facing even more squeezes at the moment.

Participant D: I just wanted to raise two things. I wanted to point out the extent to which we are losing our senior medical staff in the NHS to pensions taxation. So, the problems that very senior doctors encounter when they work full-time and are hit by annual allowance and lifetime allowance tax charges, incentivises them to leave NHS work or reduce their hours. And there are some simple things that would really help to fix that. So, about a quarter of NHS trusts in England currently offer a full recycling of the employer and pension contributions for a doctor who has opted out of their NHS pension as a result of the pension tax charges. There are no late retirement factors in the 1995 pension scheme which means that some senior doctors are actually worse off if they stay working for the NHS after the age of 60, when that scheme is designed around them retiring at 60. And the NHS EI have published quite misleading information lately on their website, encouraging doctors- and we've seen it on the front page of The Times today- to delay their retirement to help the NHS. These are some things that would be quite simple to fix, and some of them at no cost to the taxpayer. Something that the BMA has been lobbying for is a tax registered pension scheme like the one that was offered to judges when they had similar workforce problems. Unless the pension tax problem is fixed, we're going to continue losing very senior medical staff which is, I would say, going to have a greater impact on CPD and training than it will, in the immediate future, on service provision.

Talking about CPD the other point I wanted to make is around the cost of training that is not covered by the NHS or training programmes and so falls on individual doctors. So, things like the cost of my portfolio which I have to keep up in order to stay in training, the cost of all of my postgraduate exams, and the cost of being a member of the Royal College for the speciality that I'm training in. The fact that our training budgets are inadequate to cover the cost of progressing up the levels of seniority, means that for doctors from widening participation groups there is an economic barrier to progressions. And that impacts on the diversity of the workforce, and we find ourselves leafing back to the points that were made earlier.

Alison Leary: Thank you. I was just wondering Participant C I think you had your hand up, but then it went down again. Did you have something that you wanted to add?

Participant C: Thank you. The majority of things have been covered, but on training and development I think there are two points to make here. One, I think we all recognise that we are trying to reset our thermostats after getting though COVID, and that we're learning about COVID as we're going along, and I think there has got to be some recognition that that understanding will take time. Clearly some support needs to come, not just at a local trust level- which happens- but also centrally, or some direction saying that there's recognition that we're coming out of a pandemic and that needs to be incorporated into thinking. That's not just for doctors alone, but for other healthcare professionals, because we're all trying to cope with the impacts of COVID. So, if a patient is being treated outside of the hospital, the paramedic needs to know how that impacts their safety, and how to deal with the patients etc. because that affects the whole patient pathway. So, in other words, COVID impacts outcomes because COVID has been cited for many things, and surely that has

also impacted how training and development has affected trainees, doctors and paramedics throughout the whole training ladder. So there needs to be some recognition and support for that.

Alison Leary: Thank you. Can I ask Participants A and B, as people who aren't physicians do you find investment in CPD to be an issue as well?

Participant A: Yes, that's a massive issue. I think for PAs at the moment with where we lie- we're not yet regulated- means that we have no access to any funding for anything. So, the bulk of PAs pay for pretty much everything themselves. In some places they are able to access things through departmental budgets, but actually that's based on there being some flex in the departmental budget, which isn't always the case. So, yes, it's absolutely an issue. But actually, starting from training, because physician associates are a postgraduate course there are no student loans. So, our PAs having just finished, or finished a short time before, an undergraduate degree then have to pay their £9000 a year with no access to student loans. There are some small bursaries in some places, but none of them pay a year's worth of fees, let alone all the living costs and everything else. And they're intensive courses, they're 46 weeks a year courses, so people don't have time to get jobs or do other things. I work in a PA course, so I see this first hand, and we're already starting to see a narrowing of the types of people that can come in, and if I'm honest it's the people that can afford to. It's such a shame because my profession has been around for less than 20 years, and originally it was designed as a different route for people who wanted to do something different, if you wanted to support medicine but didn't want to be a doctor, and now it's at risk of not becoming that because people can't afford to do it.

Alison Leary: Thank you. And Participant B, what do you think from a nursing perspective?

Participant B: From a nursing, AHP and midwifery perspective we don't have personalised budgets for training. So, we do complete a training needs analysis, but if you're 1 of 6000 plus workforce within an organisation you may not get selected for a course. There was a promise from HEE around everybody being able to draw from a budget, but that hasn't reached the people. So, I think there are issues around CPD funding, and the availability to progress and develop along different career tracks for nurses, AHPs and midwives. But I think that the problem is bigger than that. We have not got enough headroom in our clinical establishments for people to at least attend the mandatory training. And, you know, if you work in critical care you've got 100 pieces of equipment that you have to keep updated on, that you have to update every three years, and if the number of nurses that you've got in your establishment budget don't allow for that, then that's a problem. So, in relation to your question as to how much training, or funding for training, is enough, I think we've got to start from the ground and establish what is going to enable people to be safe as practitioners and build from there. Basically, it's a massive issue and I think it's also an issue in relation to recruitment and retention. If you're a bigger organisation, with access to bigger budgets, then you may be able to retain those individuals, but if you're not and you struggle with you workforce, then that's going to be a problem.

Alison Leary: Before we move onto the wellbeing of the workforce section, the next question here is around community technology. The commitment here considers technology that makes community services more cohesive, and we're asking people about experiences of mobile digital technology in the community. Does anybody work in the community, and are you affected by that?

Participant C: We don't work in the community, but we do link and feedback straight from paramedics for our stroke intakes, advising them because we have time critical treatments and otherwise certain treatments will not be effective. And I have to say that the word to describe it is

patchy. In our county, for example, we have our local paramedics who are well trained in digital technologies to be able to access us directly, call us and ship in the right patients. But I can say that it's sadly a postcode lottery, and it's not spread through different areas. Say, for example, we have a patient coming in from a neighbouring county and their paramedic crews are not in-sync with us, are not able to access our systems, and so they can't access us. When I say access, I mean communication of a patient who they think has a problem and who they want to ship across to us in a timely manner. We also run remote clinicals, and I don't think that's unique to our field as I'm sure that across the NHS we've wandered through the pandemic trying to manage patients through remote consultations, and again I would say that they're fairly ad-hoc and it's almost driven locally. I've yet to see anything in terms of guidance about how we continue this process going forward. There are certain conditions where that has helped, but there are conditions where that hasn't helped. We are able to access GPs much more quickly, for example, for advice and that does work. So, there is positivity there, but again that's patchy. Again, there needs to be minimum standard for incorporating this. And that isn't just for GPs, but for hospital medicine, because colleagues will have links and people in primary care will see patients from secondary care, and likewise people from secondary care will include primary care physicians. I think as we're moving towards a hybrid model of living and working surely more careful thought has to be given to how this is incorporated. We are all accepting hybrid ways of working, for example I'm currently in France presenting at a conference and attending this meeting which shows the opportunities for hybrid working. So, I think there needs to be more thoughts about this working; it's got positives but there needs to be more thought going forward on standardisation and incorporation.

Alison Leary: So, there were some specific commitments around technology in the ambulance service and community settings, so it was really helpful to hear about the paramedics' experience. The last area of the workforce is around wellbeing of the workforce and the workforce experience, and we've got some meaty topics here. It's looking at bullying, staff experience and access to support services such as occupation health and MSK services. So, I'll open the floor because I'm sure that people have got things to say. Participant E, do you want to kick us off?

Participant E: As a membership organisation these are areas which really concern us and are at the core to our very existence. I would say that on mental health services, and health services generally, it still feels incredibly piecemeal. One might have hoped that with the impact of the pandemic, and the clear mental health issues that that raised in so many staff across the whole of the NHS, that there may have been more of a centralised response, but it still feels piecemeal. Even within individual trusts and boards it is piecemeal what is offered. We've all seen the poster put up on a wall in a corridor somewhere saying, 'if you're suffering, ring this number", but that is surely not the way we should be dealing with such an important topic. And I think that even going back before the pandemic, the People Plan was woefully short of any detail about how these services to look after staff would be provided. There are clearly some beacons, such as the Practitioner Health Programme, but we need more. I think this may be a theme from what I said earlier, but I've moved completely now to the idea that we should have much more of a centralised delivery and planning of these services, and that piecemeal local delivery is not meeting the needs of staff with these key issues. One possibility, for example, is should the NHS have an institute for healthcare of its staff, so I don't mean occupational health but an organisation that is set up specifically to measure and oversee the delivery of healthcare to its own staff.

Bullying is clearly a very topical subject and I fear, again, that it's been left to individuals or individual organisations, who have a keen interest in this to take up this, and to investigate it, and to come up with suggestions of how it should be managed. So, I know, for example, that at the moment there

are a number of membership organisations like our, and some colleges, who are quite rightly looking into bulling, but surely it should be a more key part of the NHS. And this is not down to a staff survey once a year that asks whether you've been bullied, it requires a much more intensive investigation of the causes and solutions. Of course, both of those will be quite complex and it's not enough, in my opinion, to leave it to volunteers or organisations. This requires some heavy lifting, and the NHS could be much more active rather than just saying good words.

Alison Leary: Thank you. Participant D.

Participant D: I'd agree with what Participant E said. I think it would really help to have a single point of access, that signposting could come from, for NHS staff members. The organisation is so complex, that if you're a staff member who is struggling it can be really difficult finding out where you're supposed to turn for support. There's lots of different avenues, and it's really difficult when you do get the courage to speak up, and say that I need help with something, to then have somebody else turn around and say, 'I'm sorry, that's not my role' or 'that's not my job.' Or worse to go to somebody who thinks it is their job, but then they fulfil that role inadequately. So, to give an example, when I was working whilst I was pregnant the person my supervisor, who is a paediatric neurology consultant, was the person I was supposed to go to for my workplace risk assessment, and he had no training whatsoever to undertake that role. I didn't feel confident in it, and a lot of other doctors are put in that same place. So, a single point to access for support services would be really helpful. The other point that I wanted to make was that the NHS probably needs to walk before it can run when it comes to supporting the wellbeing of its staff, because we still don't have basics like access to hot food on extended shifts. We don't have staff rooms, we don't have locker rooms, we don't have changing rooms and we've got staff expressing breast milk in toilets. The cost of parking is high, and people walking far away from the hospital to their cars in the dark after a late shift, putting their safety at risk. All of these things impact staff wellbeing. So those support services are a sort of nice to have, but we haven't even got the bare minimum in terms of what the NHS should be providing to look after the wellbeing of its staff.

Alison Leary: Thank you, so it's those basic work factors. I'm going to bring in Participant A in as she has to leave.

Participant A: Thank you very much. I get fined if I'm not there by 5:30, so you can add that onto the list. One of the points I wanted to make was around bullying, and it was a conversation that we had in the college this morning actually. There are a lot of surveys going out at the moment to training doctors and colleagues at the moment asking about bullying, but yet there is seemingly not action on those results. And someone asks again, there's no action, and someone asks again, and it becomes a cycle. And that's actually really demoralising. I presume that the data gets worse and worse, because you either have less people addressing it, or people just writing it off as nothing is going to happen anyway. We need to be looking at what people are going to do about bullying, rather than just how we hunt it down.

Alison Leary: So, it's a bit like datex then? People always tell me about datex?

Participant A: Potentially. I think datex has become its own thing, with a whole load of different connotations attached. But yes, I think that it's that repeated surveying and questioning, and thinking about it, and talking about it, without actually providing anything that will somewhat change the data.

Alison Leary: Thank you, Participant A, and thank you for coming this afternoon. Participant F.

Participant F: So as Participant E says, this is core to a lot of work that we do as a membership organisation and trade union, and again I'm going to sound like a broken record but some of these things will be helped if staffing and workforce was improved, because some of these things come from burnout and the stress of being in an overstretched service. Moral injury gets talked about in terms of the fact that you feel like you're not providing a good enough service to patients, and that will contribute to burnout. These things will also contribute to bullying and unhappy organisations, so again, some of these themes will come through all of this. There's also a lot of cultural issues. So with regards to the NHS we're still a long way from being a no-blame culture, and that has a huge impact on the wellbeing of staff. We did some research recently at the BMA around mental wellbeing, and we found that 7 out of 10 doctors feel that they would feel less comfortable with taking a sick day for their mental health as opposed to their physical health. So, we're trying to do so work in that area, but again the culture there needs to be improved to make people feel that they are able to take that headspace, and that they're able to take that break. There are also issues around occupational health in general, which just seems to be a problem across workplaces and across the NHS. So, improving access to occupational health will then assist with many of those things including, as you said, the MSK type stuff. But to the question 'is there more to be done to tackle bullying rates?' I think the answer is yes. I think it's a yes to all the questions in these sections.

Participant G: I just have a couple of points, and I support a tiny bit of pushback on some of the things we've heard. I'm not absolutely sure that national solutions for everything are going to work. The history of the NHS is not joyous, so there has to room for local initiative as well. In regard to bullying, I think it is really important that this a collectively owned thing and that it's not always somebody else's responsibility. Professions are indeed partly responsible for it, and the medical profession is often quite guilty. It's professionals doing it to other professionals, and there are things that professional organisations, and not just employers and the individual professionals, have to do to tackle this, and this will only be done if it's tackled by everybody. The stuff on access is quite interesting, and there was something in the NHS J the other day that the numbers accessing mental health services and wellbeing hubs has declined recently, and it was quite unclear why that was. That's clearly important.

Alison Leary: I think there's some research going on into that, and certainly we've found that in Pulse surveys when we work with organisations, that people tend to go to informal networks for support before they'll go to the staff assistance programme. That's a fairly consistent finding.

Participant C: The only thing I would like to add to what has been said is that bullying, and harassment is the tip of the iceberg, and that below is something that simmers and leads on to that behaviour. I'm not sure that this is something that is being looked at, but it certainly needs addressing. You could argue it is a symptom, that it's something that builds up over time, and then comes to the surface, but what happens underneath it, or the behaviour that leads onto that overtly is probably not captured. Equally, and I'm talking not from a physician's perspective but from all angles, but these discussions can happen at a private level when we have appraisals, and these conversations tend to happen at those points. However, I don't think recordings of these happen at that level, and I think that work needs to be done at that level because at the moment we're not documenting it. You might say something to a colleague that might not quote the word 'bullying', but would certainly they could be behaviours or trends, which are what you call micro-aggressions that could actually lead on to the macro-symptom. You can talk about it confidentially, but it's got to be recorded and action needs to be taken before this symptom builds and leads onto something big. It's like how we talk about preventive medicine; you can always prevent a heart attack if you exercise, and we can work to prevent symptoms of bullying becoming something big.

Alison Leary: Thank you. I don't recall in any of the pledges anything around workplace cultures, and generally one of the things you do first is talk about workforce culture before trying to tackle bullying because one usually underpins the other. But I don't think there are any pledges on workforce culture. Participant B, is there anything you would like to add?

Participant B: I think it just leads onto that. We probably need to shift our focus around the health and wellbeing agenda from a reactive approach to being more proactive and shifting the focus from the individual to looking at the culture, the wider organisation, the environment. We are setting people up to fail and really harming them. As Participant D said, we can't even meet the basic needs of individuals; we can't give them a drink on their shift, or some good quality food, or a safe place to park let alone all of these additional things, which I absolutely 100% support. But actually, we need to think bigger. Also, there is a lot of impetus on the individual to recognise that they need some support, and not on the organisations and teams that should be caring and supporting our staff and workforce. So, I think that we need to shift out focus.

Alison Leary: We're not being called back to the main room but thank you to everyone for giving your time. Some really interesting points have been raised.

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