**Written evidence submitted by Group 1 (Event 2) (EPW0081)**

**Transcript of roundtable event with members of the health care workforce held on Wednesday 11th May for the Health and Social Care Committee Workforce Expert Panel.**

**Group 1**

**Jane Dacre:** So, I've already introduced myself, so if it's ok, I will go around my screen so that you can all introduce yourselves.

**Participant A**: Hello. I'm an adult psychiatrist and I'm representing the Royal College of Psychiatrists.

**Participant B:** I'm a consultant geriatrician. Thinking about workforce, I've previously been the programme lead for geriatric training in my region.

**Participant C**: I'm a paediatrician and I'm a member of the Royal College of Paediatrics and Child Health.

**Participant D**: I'm a cardio-thoracic surgical trainee.

**Jane Dacre:** It's really great to have you here, and what I'm going to be doing is prompting you with questions around the pledges that I think have been sent to you in advance, and then trying to steer you so that we get a rich picture of what, from your perspective, is actually going on, and what your view is on how the Government have been getting on in meeting those pledges. Sorry, Participant E I'm going to stop and let you introduce yourself. I do apologise.

**Participant E**: Good afternoon, everyone. I work at the Academy of Medical Royal Colleges, which facilitates work across the 24 medical royal colleges and faculties across the UK and Ireland.

**Jane Dacre**: Thanks very much, and apologies for that. So, we looked through all of the Government pledges on workforce, and there are a huge number of them, and some are very specific, and some are not. What we've done is divide them up into three areas that we thought would be helpful to review in our deep dive, and those are: planning the workforce, developing the workforce and the wellbeing of the workforce. Within that we've selected the Government pledges that have been made, and I'm going to run through those and spend about 10 minutes seeking you views on each one of those. The first commitment area is on planning the workforce, and there are a few commitments in that area. One of the commitments that we looked at pledged that the Government would ensure staffing levels meet the needs to the service. So, do you think that this commitment is currently being met? Just saying no is not an answer. If you could, perhaps think about whether there is an appropriate mix of skills and roles to deliver care. And thinking about patient safety, are there enough nurses and doctors to deliver safe care?

**Participant B**: No. But I will qualify that. For me there isn't enough staff, and I'll say staff rather than doctors because I think we are now starting to recognise and realise that the blended workforce, such as using advanced care practitioners and physicians associates, is giving us much more flexibility. For me the pace of change of the way that medicine is conducted, and the reforms that go on within the way that services are organised, is greater than the rate at which we flex our workforce. It takes a long time to train people, but it only takes an emphasis, like the one four months ago, to push SDEC up to the front of the queue, and everybody needs same day emergency care, but the workforce for that is a number of years down the line. I don't think I've got an answer

for it, because I think that the rate of change of the way that we practice medicine has outstripped the training that we do.

**Jane Dacre**: Whilst I've still got you on that, could you comment on the impact of COVID on that? Quite often the pushback that we get from the Department when we talk about workforce, is that COVID made it like this. Do you think it was like this before?

**Participant B**: I think it was like that before. As with many disasters there is a silver lining, what we would refer to as the corona bonus in our trust, in that many people changed the way that they worked and have realised that that is better for patients and for staff, and we should keep doing it. But I don't think it was all that, I think that there were moves afoot in the way that medicine was practised prior to COVID. COVID may have made things happen more radically, but I don't think it can all be laid at the feet of COVID.

**Jane Dacre:** Thank you. Participant E.

**Participant E**: I would echo what Participant B said about the importance of the multi-professional perspective when it comes to workforce planning. I was also going to add my thought that the answer to this was no. The Academy was one of over a hundred health and care organisations that called for an amendment to the recent Health and Care Bill, that would place a duty on the Health Secretary to produce long-term workforce planning that drew on various data sources that we know are available. I know that that was turned down by the Government, and I know that there were allusions to the Framework 15 review being undertaken by Health Education England, which we look forward to seeing the results of, and I know that that is going to look at thematic drivers around workforce supply and demand. I think that's really crucial, but I don't think that piece of work is going to include actual projections and numbers. I know that the Government has also commissioned NHS England to produce a workforce strategy, although I don't know the details of what that will include at present. For me, what is also very crucial is that the workforce planning takes into account the likely pattern of patient demands that we're going to see; so how the demographic of the population is changing, which areas of the country have patients ageing more rapidly, and what medical practitioners are going to need to be in that area. So, I think it's important that workforce planning includes the practitioner and staff numbers, but that also needs to relate to what healthcare conditions we expect to see from the population.

**Jane Dacre**: Thank you. So, Participant B you talked about the different roles that people have been taking on, and do you think there are any roles that are in particular difficultly or underserved. Or is everybody in the same boat. I don't know whether people from other specialities would like to comment on that as well.

**Participant C**: In acute specialties, gaps in rota are particularly challenging, and if there is a gap, you're struggling to find people to fill it. And that has a knock-on effect because sometimes consultants are stepping in. It affects morale as well. And often we're running rotas where people are filling gaps so they're doing more than they should have been, and when an acute thing comes up, such as illness, it's harder to get that covered. I think it's a big challenge for acute specialties, and paediatrics is certainly one of them. There are interesting models afoot that are looking at different ways of proving acute care, which I'm sure we need to look at closely because that might be part of the solution. But we're still going to have to keep running rotas, because that's a fundamental part of the healthcare profession.

**Jane Dacre**: And what about other professional groups? We're quite a doctor heavy group, but there will be other medical professionals in the other groups, but what is the picture like for nursing, health associates etc.

**Participant B**: Just from personal experience in my local area, our same day emergency care for older people is really held together by nursing staff and advanced health practitioners. They are brilliant. They are at registrar level in their decision making and their ability to support patients, and it's an absolute pleasure to work with them. I think other groups are invaluable in how they can work together, as I said, in a multi-disciplinary way. So, I think there does need to be a blended response to all this, but it doesn't feel like it's planned at the moment. If I could just put another plug in, you asked about other specialities, as a geriatrician I am obviously very interested in how social care is doing and I think they are woefully understaffed.

**Jane Dacre**: It's interesting looking at the pledges that have been made in social care, as they're just not really pledges. It's quite a difficult area to grasp at the moment, it needs a bit of work at the moment, I think.

**Participant A:** Factoring into the more general response around the commitment then I think, no. And thinking about mental health nurses, so very specifically, there was an intention in the Mental Health Five Year Forward View to have 570 consultants and 8,100 nurses by January 2022. And we only had 212 consultants and 3,221 nurses, so under 40% of the target recruitment to meet that particular programme of change. Which of course means that we start the Long-Term Plan- well we're midway through the plan- already down on what was planned previously. Psychiatrists have increased in number at a much slower rate than other doctors, particularly around acute care. Obviously, there are all sorts of increases in demands around new services, new ways or organising services, plus at the other end we have people leaving and retiring. Early retirement is a particular issue for us, but also people are looking for a more flexible work/life balance and are moving into flexible working. We have tracked nursing, as well as psychiatry, and clearly the two are incredibly interlinked because, as Participant B was saying, you don't have a team of just doctors but a whole multi-disciplinary care process.

**Jane Dacre:** So, there is quite a lot of evidence that we've seen that suggests that targets having been met, so does that mean that targets are not very useful? What is people's view on how useful targets are in workforce.

**Participant C**: I think you've got to have targets. It is a moving field, as we've observed, and lots of things keep changing, but that doesn't mean that we shouldn't do our best to plan ahead and factor in all these different themes. At least it gives us a chance of having the right workforce, five or ten years ahead- better than if we didn't have any targets and keep putting our heads in the sand. So, I think targets are essential.

**Jane Dacre:** OK, so I'm going to move on a little bit. We're talking about the here and now, but what about the trajectory? Is this getting better, getting worse or staying the same over the length of time that you've been in your posts or working within the NHS? Have you felt there have been changes to the way that the NHS has been functioning?

**Participant D**: From a junior perspective, I've worked in the NHS for about four years now in the surgical field, I think an important aspect when looking at this is retention rates- especially amongst surgeons. I've noticed that a lot of my colleagues at my stage are trying to get the training and the development, but because of staffing issues we are seeing a lot of surgeons leaving the specialty, moving to specialties that fit their social patterns. They might move to General Practice, for example,

because they want a better work/life balance and they're noticing that in hospitals, with the way that post-COVID surgical recovery systems are occurring, they're getting burnt-out, and their mental wellbeing is being affected. So, a lot of my colleagues, at my stage, have left the surgical workforce and moved to different specialities that align more with their priorities.

**Jane Dacre:** Ok, so things have changed. Participant C.

**Participant C: I** think it has gotten worse over time; I'm not seeing evidence that it's getting better, and there may be various trends behind it. One is that there is move towards people doing less than full time working and I think the GMC made it a rule where you don't have to have a particular reason to go to 80%. In paediatrics, we're forecast to increase from having 30% of staff working less than full time in 2019, to 60% in 2040. That's a big challenge for the system because that means there are less full-time hours overall. Another trend is the F3 year. Nobody used to take time off between foundation and specialty training, but some years back that developed, and now more than half do an F3 year, where they might contribute to the health system in some way, but they can also travel or do something different. So, we've lost a good chunk of that year of trainees who would have fed into the system, so I think that has also contributed some of those gaps and added to the challenge.

**Jane Dacre**: Yes, I think I've heard that those taking up F3 year is up to 60% in some quarters. So, the F3 year is quite a big deal.

**Participant A**: Just on that subject, we have a particular piece of work that was commissioned, I think it was by UCL, which was looking at the trainee trajectory through training. And it was certainly less than 15% of trainees who actually complete their training in the eight-year foundation course and specialist training. So, we know that people do other things, sometimes career things or research or F3 posts, sometimes it's personal things such as caring responsibilities, but it is very much a minority who are actually training in the Modernising Medical Careers designed pathway. If planning assumptions are made on the basis of that eight-year trajectory, then that may be one of the reasons why we fall short. We've made some very strong strides with recruitment. For a long time, we had really poor recruitment rates in psychiatry, and I think we had a bit of an image problem, but we've had a very successful Choose Psychiatry campaign, and we've been able to recruit 100% (or very close to) for the last couple of years. For some of the increases in posts, which have again been a COVID bonanza from the failure of the school exam system, we have some positive thoughts on how that can continue into further recruitment into psychiatry. We track the NHS digital data quite closely, and it shows a 10% increase in consultants over several years (probably close to 10 years), but the felt experience is not that, and people are quite shocked when they hear that the numbers are increasing. Our census shows that the proportion who are locums is increasing, and that may well be having an effect on sustainability and morale, because locums are a very mixed group; some locums are very committed to an organisation long-term, others may be very transient, others don't have the same qualifications as a substantive consultant. I think the felt experience is that things continue to get worse, which I'm not sure is always backed up by the data, but some of that is because the increased demand is not being met. And that is backed up by the data.

**Jane Dacre**: That is really helpful, and it reflects what we've seen in our investigations; that although the numbers are higher, the experience is not necessarily better.

**Participant E**: I think the points raised about retention and flexibility are really important nuances to workforce planning. It's not just about getting more people into the system, it's also about the

experiences of people once they're there and whether they stay. In terms of what's changed, or how is the picture changing, I would also add that back in 2018 there was the expansion of medical school places by 1500 but I don't believe that that has yet translated into a commitment for extra specialty training places. So, there is an unanswered question about where those people will be going once, they've completed medical school, and I think that feeds into what was said about the F3 year and time out of the training pipeline. I think the other aspect to that is that there is this growing pool of SAS and locally employed doctors, which are quite a diverse group as well. We know that lots of international medical graduates are SAS doctors, but there are also people who are taking time out of training, or who are trying to re-enter training, who are also in this pool, and there seems to be a lot less data available on this group compared to trainees or consultants. So, in terms of issues that we might need to address quite soon, I think there is an important question about this pool of doctors within the workforce, and how they're supported and developed as a group, and what opportunities they get.

**Jane Dacre**: That's a really important point, isn't it? I want to move on now to talk a little more about workforce planning and strategies in the workforce. I don't know whether all of you are actually involved in developing strategy but do speak up if you feel the need. One of the pledges is on whether local recruitment practices have impacted staffing levels, and the other point is whether you think that there's enough in place nationally to support workforce planning- we might have covered that already, but if you have anything to add please do. Is there enough data available to help with workforce planning locally through national data sets? Participant A, you said something earlier about career choices in psychiatry.

**Participant A**: That was the paper I referred to earlier that showed the transition through training being not exactly as defined. And I guess that one of the challenges around the data is that sometimes assumptions are made about what we're looking at, when in fact it turns out to be different. For example, the way less than full-time employees is counted can be an issue, and then whether locums are counted in or out of data, so you're often slightly uncertain about what the true picture is of the substantive, committed, long term people.

**Jane Dacre**: So, looking at data again, you talked about concerns with data. Is there enough data available to make national and local decisions? Do you get help that? HEE make lots of predictions.

**Participant B: I** don't think I can answer the question about whether we get enough data, I'm uncertain. I have concerns about whether the data would be of use anyway. If you look at a paper that says you should now be ablating a tumour rather than resecting it, then suddenly, within a short period of time, you're looking at developing interventional radiology, and boosting that up, and not employing surgeons. That process takes years, so the data is limited against the changing practice of medicine. The changing practice of medicine is moving too fast for the data to keep up with it. Perhaps people are able to see the future better than me, but I'm always amazed by these changes, and then I think, how long is it going to take for us to change our service to do that. People just aren't there.

**Jane Dacre**: Yes, that's always a problem. Participant E.

**Participant E:** On the data, I just wanted to say that there are various, often quite rich, sources available. We know that the GMC has data on the medical workforce and HEE, and the other statutory training bodies have data. Royal Colleges also do workforce census. But I'm not sure that there is one clear unified picture of what the agreed vision of the medical workforce is- either for now, or how it should be in the future. That's where I would say that workforce planning is lacking;

there are pools of data, but how far these are brought together and what conclusions are extrapolated from them is an unanswered question. I'm not sure I really have an answer about the balance between the national and the local aspects to workforce planning, but I think it remains to be seen what function the Integrated Care Boards and Integrated Care Systems take on for workforce planning at a local level. I think it's very important that those decisions are informed by the place-level picture, but there are also lots to aspect to workforce planning that need to be taken up nationally, or the drivers are only in the Government's hands. If it's to do with things around immigration, or funding for training places, then these are decisions that need to be made at national levels but informed by local pictures.

**Participant C**: There is data there, but I'm still trying to get my head around where that data is. It does feel a bit sketchy. We do our own college census, and that helps us, and we work with HEE who have helpful stuff, but it still doesn't feel enough. I take Participant B's point that it's a rapidly changing world, but I still think that we have to use the best that we can to try and predict needs in the future. I guess ideally, we would have a more agile system, so that it doesn't take so many years to get to the next step of where we need to be. I think that there is a whole shift happening in education, before you could only be in medicine if you started that way, but I think that there will be other routes in. Do we really think that physicians associates will stay as SHO level for their whole working lives, or is it not reasonable to think that some of them can transition into medicine as they progress in their careers? If we look at a more flexible approach to the whole workforce, maybe within that is some solutions to a more agile system that can flex to the changes.

**Participant A**: I don't know if it applies to other specialties, but we've certainly created some of the agility that is required by using credentialing. This is particularly in liaison psychiatry where there was a whole programme of Core24, increasing the amount of liaison psychiatry in general hospitals, because it was seen to be a cost-effective thing to do for the systems. That's the first of the credentials, particularly liaison old age. Eating disorders is the next one, where there has apparently been an explosion in instances, but also greater expectations in the standards of the medical and psychiatric component to the management of it. So, data is useful in that respect, because it's spotting those trends as they emerge and help us to try and find a response to it. In terms of the scale of ICS planning, I have grave concerns about that, that may be because that locally, in the South West, the ICSs are quite small footprints. From a mental health point of view, I've got some concerns about the focus on mental health at an ICS footprint level.

**Jane Dacre:** I'm probably out of date now, but I haven't heard the term credentialling used quite as frequently recently as it used to be, and I wonder if it is still a thing in other practices. It would be useful to find out. I think we need to move on to area two, which is about building the workforce. The commitment that we're looking at here is, 'to help the million and more NHS clinicians and support staff to develop the skills they need, and that the NHS requires, in the decades ahead.' So, this is about flexibility, but also training and education. The first question is about CPD- obviously this is important for all healthcare professionals- so do you think that there is currently enough opportunity and resource to enable staff to undertake the training and development that they want and need?

**Participant C:** I think that there is an imbalance. In general, I think doctors have quite good opportunity for CPD, and funding for it, but when you look at the rest of the workforce you do get the feeling that it's much more difficult, especially for funding. That's the way I see it.

**Jane Dacre**: Thank you. Participant A.

**Participant A:** I totally agree. I think that the supporting professional activities in most doctors' contracts, combined with the requirements for re-validation, and the consequences for an organisation if those requirements aren't met i.e., if the doctor failed to re-validate and lost their license, has put more emphasis on the importance of CPD for doctors. But I think those opportunities are less good in the other professions. The NHS staff survey for example, also shows inequalities around who gets the additional non-essential CPD.

**Participant B:** I completely agree that doctors have it much easier than other professions. I would say that a Corona bonus is that a lot of things moved online, so suddenly everything was more accessible. However, that means that people are more willing to do it in their own time, so people actually end up dedicating their own time to work. I think these questions around retention of the workforce, wellbeing of the workforce and CPD are all linked; if you don't have enough people, and if you don't have enough time to go to a conference, then that impacts on wellbeing. All of these three questions are intimately linked and tied together. For many junior staff, we get people say that they weren't able to get to specific training because there were too many people off, so rotas aren't robust enough to allow it to happen. People cancel things at short notice; I was supposed to be doing someone's appraisal, but I had to cancel it because there were not enough people to cover me. Those are stories that we hear all the time. So, it's available, but it can be difficult to get. Moving it online means that it's more accessible, but we should remember that some people like the networking that comes with traditional face to face, and if it's online it can start eroding into the rest of people's lives which affects their wellbeing. So, lots of inter-related things.

**Jane Dacre**: It's interesting, isn't it, those inter-collated rings of difficultly that all spiral into each other. Participant D, you're a trainee, so do you have a comment from that perspective?

**Participant D:** I just wanted to echo what has been said already. I think there are plenty of opportunities out there, at both local level via trusts, and at national level via the royal colleges, for example. But I think the issue is the accessibility of those resources for professional development. For example, from my own training perspective, we have local teaching that is delivered to us once a month, but service provision and rota flexibility it might mean that I am not able to attend those teaching sessions. And those teaching sessions are necessary for me to be able to develop and get to the next stage of my training. So, I think it's having the workforce there to allow that rota flexibility, so that you can do those professional development opportunities within work time.

**Jane Dacre:** So essentially, if there is a gap you can't leave and attend a training session.

**Participant D**: Yes. If there is a gap, and there is no one to cover you, then unfortunately you're not going to be able attend it. As has been said, there are more opportunities now because of virtual sessions and virtual events, but it cuts in your own time. As a surgeon professionally, the level of service provision means that it is impossible to meet all of my service needs at the moment, so I'm having to go in during my own time to make up for that. And I think a lot of that does stem from the fact they there are just simply not enough people on the rota.

**Participant E:** I just had a couple of extra nuances for different groups. One of the things that I wanted to raise, and that I've heard about through the Academy Trainee Doctors' Group, is about geographical variation in access to study leave and the study budget. So, there is not a clear national picture, and there are gaps in specific regions. The other thing I was going to add is around SAS doctors, in that they often lack the same access to SPA time as some of their consultant colleagues. If this is a growing portion of the medical workforce, then I think there are questions to be raised around how those colleagues are going to have access to development opportunities.

**Jane Dacre**: I suppose then that that is on top of looking at how other healthcare professionals who don't have the study leave and access that we have. Thank you that is really helpful. Moving on through the questions, I just want to start to ask you about community services. Within this group I think all of you have clinical services that cross over into community, although maybe less so in Participant D's area. Could you tell us about your experiences of mobile services? How is the community interface working? Are the digital interventions that have been promised been helpful? Any comments on that?

**Participant C:** Community paediatrics is a big part of paediatric practice in the UK, and it is an area that is struggling in terms of recruitment; there are more gaps proportionately. And we're looking at how to address that. Contrary to what is happening elsewhere, in paediatrics the number of SAS doctors is declining, and they've been significant contributors to that community workforce. It's key that community service works well, because the better that happens then the less children you see coming into acute. If you keep children at well then there is less demand for acute services. However, budgets tend to go more towards acute services, and that is a big challenge across the whole system when we're putting an emphasis on preventative action wherever we can.

**Participant B**: Community geriatrics is obviously a growing area, and being thought about more and more, but I think it's very diverse, depending on the locality you're on, on how well it works and how effective it is. The biggest hinderance is probably having the support services around you; it's all well and good as a community geriatrician to be able to go and see someone who has fallen at home and saying that we think it's safer for them to stay at home but we need XYZ *now* to keep them out of hospital, but having that rapid response is not universal. So, it's not the same across the whole region in many places, and many places are far behind others who are leading. It's growing, but it's not growing as fast as it needs to be. And just quickly about IT. I can't see the psychiatrists' letters etc. because different trusts have different rules. When I see a patient with cognitive impairments who is well known to the psychiatrist, I'm trying to work out their baseline and the risk assessments that says they're allowed to remain in the community, but as soon as they get to the hospital, we can't allow them to go home. That lack of information is an issue. So, we're still hampered by IT, I regret to say.

**Jane Dacre**. Thank you. We'll go to Participant A next, but then I won't to come back to that point about IT.

**Participant A**: Psychiatry has been practised in the community since the early 1990s, and we were place-based before place-based became a fashionable thing to say. But what I see currently is that because of workforce shortages, particularly in mental health nurses but probably also in psychiatrists, the emphasis is on staffing wards. You have to have a certain critical mass of staffing to provide safe, or safe-ish, in-patient services, and therefore the community teams are very depleted, both by attrition and sickness- all of the Covid and post-Covid phenomena. We have a community mental health framework, which is part of the long-term plan, which really requires a complete blurring of the primary/secondary care interface and moving community into a whole new domain. I don't think that that we have yet got jobs that are fully described in terms of what a consult psychiatrist does in that context, but I know that there are job descriptions are imminent. When it comes to the digital development- moving onto that- imminent is probably the word that comes to mind. I know from my own local patch that we are nearly there with the shared care record, which will make a phenomenal difference. I don't think that our IT colleagues understand quite what a phenomenal difference a shared care record will make, I just don't think they get it. But we're well behind Manchester, and those other places, that already have a shared care record. Digital interventions I think are coming, it's happening, but it's slow, and I think that taking a depleted and

exhausted workforce with you in trying to do things in new ways is pretty challenging. My day job relates to digital stuff within the trust, and I think that the workforce transformation is not there yet in terms of getting the best out of all the digital opportunities for both prevention, self-management and treatment management, and actual treatments that are digitally developed such as apps. It's coming, but it's not there yet.

**Jane Dacre**: So, you're talking about the workforce development, does anybody have any comments on the digital development? Because some of the things that we've heard in other workshops is that it sometimes takes longer if you have to log-in to shared care, and not everyone may be able to access that information, but I don't know if anyone had and specific comments in relation to that. But you haven't got it, so you can't evaluate it, I suppose.

**Participant A:** It depends on what you do otherwise, I guess.

**Participant C**: I think it's patchy. Speaking for my city, a care record is coming together across the city, and our colleagues in community organisation teams can all log onto it through mobile devices and access the records. My impression is that it's on its way, and quite patchy across the country, some places have it really well sorted and others not. I'm sure if it's done well then it can really enhance both the care that is delivered, and the ease of delivering it.

**Jane Dacre**: While we still have you on this, I was wondering if you had any views on the relationship between the impact of digital and ambulance services. So, things like redirecting patients to different A&Ws if one A&E is busy. Does anybody have any comments, or know anything about how that is working?

*Participants shake head*

OK, that might be an area that comes up in other groups. But this is the idea that the ambulance goes to the most appropriate place, and not necessarily the nearest place, and is digitally directed. We'll leave that one and move to the next point, and I apologise for the speed at which I'm romping through all of this, but it's great to have your input on this and I'm going to take advantage whilst I have you. So, the next point is on the wellbeing of the workforce, and the commitments are to introduce new services for NHS employees to give them the support they need, including quicker access to mental health and musculoskeletal services, and to reduce bullying rates in the NHS which are far too high. So how is the first commitment around access to support going? Would anybody like to make a comment on that?

**Participant D**: I think locally, at the trust level, I've noticed post-Covid that there has been a significant improvement in the information available in regard to mental health and wellbeing. There's a push via local bulletin boards, from ambassadors within my trust, with regards to support services that are available to them whether that's within the trust itself, or through private organisations and charities such as Mind or You Okay, Doc? for example. There is a big push to try and make staff available of the facilities that are available. I think it's important that trusts send out regular messages, but unfortunately, it's still not translating across in some aspects and we are still getting staff that are burnt out. I think there still needs to be a big push in terms of wellbeing and mental health amongst doctors and wider healthcare professionals. The British Medical Association have a charter for rest and wellbeing which was published, and they put new facilities into hospitals that are available for doctors, such as rest facilities, that we're taken away from hospitals at one point. So, I think that it's good that we're starting to see this again post-Covid.

**Jane Dacre**: So, although the need is greater, you think that the response has been good?

**Participant D**: Yes.

**Jane Dacre**: Thank you. Participant B.

**Participant B**: I think that Covid saw massive improvements in what staff are offered, and that is great, but I think that is because we were lagging behind and hadn't really had things for staff before. But it goes back to that point about all of these things being related. We need to support our staff with their mental health and their wellbeing, but if you look at the fact that actually gaps aren't being filled, and the rotas are bad, and you can't get leave then it all goes back to this vicious circle. So, there is stuff that is being offered, there is much more than there was previously, but it's probably not enough when people look up and say, 'it probably won't feel better because we've still got gaps.' So, they're all interlinked.

**Participant A**: Just a couple of things. I think that any large employer might want to ensure that common conditions are rapidly treated, and that people can return to the workforce, and I would agree that there is evidence of that. But I think that the classic dissonance, is the sort of wellbeing initiative- things like mindfulness, colouring books, yoga- when exactly as Participant B was saying there are not enough resources, not enough people, people are overworked, expectations are greater. I think there is a balance, and there is only so much wellbeing that you can do if the job itself is intrinsically stressful. I don't just mean the stress of the medical job, or the health job, I also mean that there is a shortfall in what the person feels that they should, or could, be offering, or what the system is offering to its population.

**Jane Dacre:** So, the concept of moral injury is something that is coming up a lot amongst physicians with Covid. Thank you. Participant E.

**Participant E**: I think what I have to say is on a similar theme. Obviously during the pandemic, we saw things like the roll out of access to health and wellbeing hubs at trusts, and we saw lots of movement, but I think when we go out to colleges and faculties and ask things like 'what are your short-term workforce solutions' we still hear a lot about the importance of getting the basics right. People don't have access to water, hot drinks, food, rest areas and these are such recurrent themes. Also, from trainees we hear things about them not getting paid on time, or not getting the right amount of pay if they're on rotation. In addition to access to services, the other aspect is also thinking about how far people's job plans, and ways of working, are able to flex to changing circumstances. I'm thinking particularly about conversations that there have been about how to support doctors who might be approaching retirement to be able to work differently- for example, they might want to spend less time on call, and more time doing education or research roles. So how far that is supported by job plans is an important aspect to think about, as well as access to dedicated services.

**Jane Dacre:** It's interesting that the conversation has drifted back to saying we wouldn't need these dedicated services if the service was working better. In addition to flexibility is there something that the NHS should be offering to staff?

**Participant C**: I think a big part of it is changing the whole culture. The Kings Fund have published some really interesting stuff on compassionate leadership, and there is the ABC of Caring for Doctors, Caring for Patients that the GMC published. I think that's all pointing to the idea that if we can have a different culture of how we all treat each other in the NHS, that in itself will have a huge impact on wellbeing. So often communication is bad, and things are done to people without explanation, and a different way of communicating that might have meant that it felt completely different. Our president talks about the importance of kindness, and I think that it's a big thing that's

needed in the NHS, because if we had more of that then there would be less challenges for our wellbeing. Of course, we're dealing with really difficult situations, there is an integral part of our work that is stressful and difficult, and that is even more reason why it's important how we look after each other.

**Jane Dacre**: On that culture of kindness, I noticed that what it actually means is being debated in the new re-write for Good Medical Practice, isn't it? Trying to define what exactly is a culture of kindness. So, if we move on to the second part of this area, which is around reducing bullying in the NHS. So, what do you think the current situation is in regard to bullying in the NHS? This has been spoken about a lot recently on social media and other places, and where are we with bullying in the NHS.

**Participant C:** I was trying to look up the figures before, because doesn't the GMC report allude to bullying figures, and I thought it had been improving.

**Jane Dacre**: Was it the State of Medical Education and Practice? Does that cover it?

**Participant C**: I think that's it. But I think the previous point links to this, because if you have this culture of kindness then you won't have the bullying. But it's partly about relieving the pressure on services because when you have rota gaps, I think that trying to get people to fill them can sometimes feel like bullying. When you're desperate to fill a gap, it's hard to say, 'don't worry about covering it, if you can't come in.' So, it's how you balance these things up.

**Jane Dacre**: Yes, it is difficult isn't it. Participant A.

**Participant A:** One of the things that I've noticed is the explicit link between bullying and patient safety. So, things like the Civility Saves Lives campaign, and the fact that the Patient Safety syllabus now has quite a lot to say about psychological safety and enabling people to speak out, and how important that is to improvement. I guess that it's coming at people from a range of different directions in terms of an area for action. I think that previously it may have been tolerated, and perhaps not linked with safety. The staff surveys would say that we still have a long way to go, and I think that it's another area where inequality is absolutely massive and still needs more attention.

**Jane Dacre**: Can you expand on that bit about inequality.

**Participant A**: I guess particularly racial inequality, but I think that any of the protected characteristics may experience it. I think there is still a culture within health, and probably within medicine specifically, around some of those things still being ok. I think it's changing, but it still feels like it's happening too frequently. The concern about that is the effect on attrition, on workforce retention, and potentially on patient safety.

**Jane Dacre:** Thank you. Participant D can I put you on the spot, as the only trainee in the room, to get your views on that. And also, as the only surgeon, because I think there has been a lot of talk about bullying in the College of Surgeons.

**Participant D**: Yes, there has been. A lot of work has been done in terms of sexual harassment, which was published in their bulletins quite recently. With bullying, it's about trying to create a culture that eliminates the fear of repercussions for raising concerns, and that's still a big issue. I think that people still feel that if, for example, they were to put a datex in a critical incident that there is going to be feedback that will come back to them. So, it's about trying to remove those fears from the system and trying to get rid of that responsibility from the individual, which is still contributing to this atmosphere that is still prevalent in the NHS. Removing that fear of

repercussions for raising concerns is, I think, really important. Especially from a trainee perspective, because often there are fears around raising concerns regarding your own training; you're often working with these surgeons on a day-to-day basis and trying to make sure that that won't have implications on you day to day jobs is important as well.

**Jane Dacre**: In terms of addressing it, are any of you aware of any particular examples of good practice within your trusts or royal colleges? Is there anything that people are doing that is particularly innovative to stamp out bullying?

**Participant A:** We've got two presidential leads on inequalities, looking at inequalities within the profession and also inequalities within outpatient/client caseload. Obviously, people are aware of the massive inequalities in terms of treatment under coercive legal frameworks in mental health, and by resolving the staff issues then it might help to resolve some of the inequalities in the patients and citizens.

**Jane Dacre**: Thank you, so having people specifically responsible for looking at it within the college. Participant C.

**Participant C:** It's not directly on bullying, but within our college we've got a big initiative around equality, diversity and inclusion. This will run for a long time I'm sure, but it's great to hear it actually being faced and talked about. There is also work around lifelong careers, and how we make sure everyone thrives throughout their career. This, again, is a huge piece of work, but it's opening up all these different conversations; at each point of our careers there are different needs, and it's looking at how we make sure that at each point that person can thrive and play to their strengths. I think if that's happening then things like bullying will diminish.

**Participant E:** On a similar theme, I was going to add that there is important work underway, but still in relatively early stages, nationally about trying to improve support for international medical graduates. I'm thinking specifically about some of the work around inductions, which seems to be very patchy and very variable. I think that this work is really important for trying to counteract some of the professional isolation, and the lack of support networks that are available to international medical graduates, which I think then ties into this picture of bullying and harassment. That group has been previously neglected, so I think that it's really important that this work is taken forward.

**Jane Dacre:** So, the intersection between equality and poor behaviours and bullying is something that needs to be addressed. We're going to be pulled back to the main group shortly, but I'll just feedback our main talking points. The first issue that we talked about is the lack of being able to predict the future and therefore there is a need to be flexible. Training is great but, again, everything is interlinked, because if you don't have the staff to cover you then you can't go to the training. And then we talked about how focussing on wellbeing is all very well, but if you had enough staff then you wouldn't need to focus on it so much. And finally, bullying is still a big problem, but it sounds as if the royal colleges are taking action to minimise it. Is there anything that I missed?

**Participant E**: Maybe just something about retention and flexibility in workforce planning as well. I think they were common themes.

**Jane Dacre:** Yes, I'll add that. It just remains for me to say thank you for joining us today, and for your honesty.

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