Written evidence submitted by health and care workers (WBR0111)

Transcript of interview conducted by the Select Committee Engagement Team and Participant A on Tuesday 9th February 2021. Interview conducted as part of the House of Commons Health and Social Care Committee inquiry "workforce burnout and resilience in the NHS and social care."

If I could start by asking you roughly how long you've been in the NHS and some background about your everyday role and what that looks like.

I qualified as a pharmacist in 1998, so I've been a pharmacist 23 years this year which is quite a long time. I worked initially, for the first five years of my career, as a hospital pharmacist in various trusts, acute and hospital teaching hospitals as well. And then I took over running this family community pharmacy- which I still run- in 2003, so eighteen years this year that will be. It's a family business that we've had for over 40 years. Community pharmacy is contracted by the NHS, so that's my relationship with the NHS. 95% of my income is from the NHS, in terms of what comes into my pharmacy. We offer all the NHS services like dispensing, flus jabs, medicines, advice services we also do a lot of the local services like the morning after pill and stop smoking. So that's the relationship that we have with the NHS.

Thanks, definitely a long background. My first question is around the idea of burnout. What does burnout mean for you and what does that look like in terms of you and your colleagues?

So I can speak for myself and then I can tell you about my colleagues. I think increasingly over this last year, especially because of COVID, there has been a lot of stuff in the media about burnout and I read it and I think that's really interesting, why haven't I burnt out yet because I should have technically with all the stress I carry. I've been reading a lot about it, and thinking a lot about it, and questioning myself; am I burning out? And my answer to that is because I know about burnout, I think I have tried as much as I can to balance my ability of working and balancing that burnout risk versus wellbeing. But that's one thing I've had to really work on personally. But in terms of my team, I see them as less resilient to burnout. I feel like I've self-grown and self-cared for myself to build that resilience so that I can try to avoid the burnout. I think any other person in my position, if they were probably doing what I do, would have burnt out ages ago, but I think because I've learnt the techniques, and I've learnt the signs and symptoms, I know when to slow down and stop doing certain things if I feel that I'm getting to that stage. But I know for my team for example, not because I'm a horrible boss or anything like that, but sometimes they're not aware of those things within them that they're reaching a point of burnout. So I have a very small team, I have two pharmacists that I employ, three dispensers and a trainee pharmacist, and of my three dispensers over this last year each has got to a stage of burnout without recognising it, but I've recognised it for them. So one of them, her dad was diagnosed with cancer and she was coming to work, but it was that kind of presenteeism where she wasn't really there, and I could just see that she was getting to a stage where she was burning out because of her inability to cope mentally with what was going on, not because of work pressure. So I allowed her to have some time off so that she wouldn't get to that stage where she was burnt out. Another member of my staff was really dealing with some severe mental health issues, but was hiding them, you know when you can just tell when someone is battling something and it took one conversation one morning and I said things don't seem right, let's have a chat. She burst into tears and basically ended up quitting after three months of sick leave because she's still really poorly ill with her mental health, in a really bad place. But she'd been bottling it up and you know she'd got to the stage where she burnt out because she was dealing with

all of these things outside of work, and while work is a really great distraction for many people, it spills over into personal life doesn't it. And for my third dispenser, because the other two were having all those issues, she was having to work so much harder and she felt bad because she wanted to reduce her hours, as she was getting older and she wanted to cut down, but she was too terrified to tell me because she knew how much I needed her at work. And when she finally did say it to me, I said of course you can, I totally get why you'd want to work less, and since then she's been such a happier employee because she's not working the full time, and she's able to have that time off, an extra day over the weekend for example. It's really interesting how everyone manages it in different ways, but I feel personally responsible to avoid burnout in my team, and that's a lot of pressure that I carry.

I can definitely imagine coming at it from a manager's perspective of supporting yourself but supporting your team as well. And for those that did struggle with burnout what were the challenges that that had on you. You've spoken a little bit, but did that have additional challenges on how you could run your services.

Yes, absolutely. It pushed me to the limit of burnout because I was then coming in really early in the mornings, staying back until 9/10 at night, trying to get my prescriptions checked and my deliveries out. I got to the stage where I would get home on a Saturday after doing a six-day week and I would literally go to sleep for a few hours because I was getting absolutely exhausted. I couldn't see a way out. And during the pandemic, I couldn't find staff that were willing to work in a pharmacy because it felt dangerous to people, they just didn't want to work, because we were open, we are open, letting the public in. Obviously, there is social distancing but it's still frightening. And I did manage to take on a delivery driver, so I had to take on new staff just to support the fact that some of my staff were off or had left. Also, I guess the pressure is greater because I'm an independent, I'm not owned by Boots or Lloyds or a big company, and because I'm an independent there isn't a head office I can go to and say please can you give me more staff, or please give me this. Over the years pharmacy funding has been really squeezed to the point where you have to make the books balance. During the last year I've struggled to make the books balance, because we've been busier, drugs have been more expensive because we haven't been able to get them into the country as well so I couldn't afford more staff so I ended up putting that pressure on myself and working all hours and that's how I managed it to be honest.

It sounds like a lot of pressure and we'll come onto funding later, as I think that will play into one of the later questions that we have. So we were talking a bit about the staff, and you mentioned earlier before I move on, about the media and how they've been reporting on burnout and do you think that when you were trying to get new staff that reporting had an impact on whether people wanted to join.

Quite possibly, yes. People are kind of frightened aren't they of catching COVID and I think when I advertised pre-COVID for a dispenser I would get 150 applications, whereas this time I only got a handful which was really surprising because we would normally get so many people, and I thought people are furloughed, people may want jobs but I guess maybe people are frightened. I don't know it they would be scared of burnout, but I think they'd be scared for their safety.

Moving on then to the other side, do you think that you've seen an impact- maybe through burnout and some of the other things you care about- on the people, the patients, and the customers that you care for?

I think that's probably why so many of us have got to that stage of being close to burnout or at burnout, because we put our patients first. So, we've done everything we can to make the service feel as normal to them, and not give them any delays in their prescriptions, and try to do everything business as usual, but then that's added a lot of pressure on us. During that real peak of the COVID there were times when I had to be really honest with patients, and say I'm really struggling, you don't need your prescription today, is there any chance we can do it tomorrow and just being really honest about it. Nine times out of ten the patients are really lovely and they will say I've never seen you look so tired, I've never seen you looking so stressed, so don't worry next week is fine, next time I'll give you a week's notice so I'm not having to run out of my tablets. So the majority of people when you're honest, that you're facing pressures have been really nice. I guess there is always that one in ten that have been really challenging. We did have a few of those people, and you just feel like saying to them, look we're in a global pandemic, I've done a 15 hour shift, your medication is not urgent, you don't need it delivered today but people get demanding and people have reasons for what they do. I think of one particular example, I've never lost if with anybody but this woman I nearly lost it with, because there was a queue outside my pharmacy, it was a Saturday during that first peak of COVID, and loads of people coming in and out. She could see there was a queue outside and she rang from mobile outside, rang into my pharmacy and said I've bought my dog with me so I can't come into the pharmacy, can you bring my medication out for me. I thought come on, you can see the queue of people. Would you ask you doctor to do that? Would you say to your GP, sorry I've bought my dog with me can you come out and see me for a consultation? It just felt like she was taking the mickey, and I thought I can't believe you're even asking me. In some people you just think how do you even live in life doing something like that? But that's been the one in ten, even less to be honest, the majority of people have just been so grateful, so appreciative, so lovely and so respectful of our burnout and our pressures.

It's great to hear that most of your customers have been really understanding during this time. To move onto the coronavirus, how has that specifically had an impact on the burnout. I know a lot of this will be understandable, but just so we can understand and then if we could compare to maybe 2019 to see whether there is a real marked difference.

So there definitely is a marked difference and if I concentrate on the differences that will help you. So for us what's been the difference is suddenly people became very frightened about their supply of medication, which has never happened before, people have always assumed their medication will be there. So we had the import/export issue early on because China and India closed their doors and a lot of medication come from there, but we also had stockpiling with people wanting to order more prescription as they were scared they wouldn't be able to come out. We also had lots asthmatic patients coming out of the woodwork who hadn't used an inhaler for 10 years but thought they better have one. So we saw a big demand, plus we had Brexit bubbling away so I think that's been a big difference in that suddenly that supply of medication became really critical to people so there was a demand and a pressure on us to deliver. But actually one of the biggest things has been the fact that GPs work differently now, they work behind closed doors, and most patients don't even know how to access their GP anymore, and what we've found is that we've done a lot more of what I call Primary Care Navigation. Lots of people are ringing us and saying that I've got this problem, what should I do, is there anything I can buy over the counter. So that pull on our services for the advice, sometimes it is a simple minor condition that we can help them with, but there have been people that have had clots on their lungs that I've diagnosed and sent them to hospital and I've literally had to force them to go to hospital to say you need to go, there is something seriously wrong with you. And people have said, no I'm not going, there's no way I'm going to catch COVID, and I will say well if you don't something is going to happen. And they come back and say thank you for that because you

were right, I had a clot on my lung, or an anaphylactic reaction to something. I've even driven a lady to A&E myself because I thought by the time, I call an ambulance there's such queues for ambulances, she would be dead. So that's been the biggest thing, that supply of medication plus that advice and people just ringing in, emailing us, coming in advice after advice after advice, and these are people that I would only assume would usually have gone to the GP first. The sort of advice that we're being asked is high-level clinically which I can deal with, I'm not worried about it, but it's different to anything we've been asked before.

And that will obviously just have an impact on you because that's more people to see and in more depth than you would have seen before so I can imagine that would impact on the burnout. I know that you're looking at this from a managers perspective, but what support do you find is available, particularly around this idea of burnout and workload and barriers to accessing it.

I think for me as an independent pharmacy it's quite hard to find that support, I think if I was a big chain of pharmacies, like Boots or Lloyds, they would probably have a big team that looks at things like that and gives you some guidance on what you should be doing. I guess for me, its from my own personal reading, through things like LinkedIn, through Twitter all these different things and you start reading and following people who self-help gurus and coaches and mentors are. I watch a lot of these sort of videos, because I quite enjoy learning about how to improve my well-being. For me the support I look for is not from any formal place, or network or pharmacy body, it's from all sorts of avenues. And I think that the barrier to it, is sometimes, like I said my team didn't recognise they had burnout, they didn't have that self-awareness, and I feel that's probably the barrier, because people don't have that self-awareness, that they don't then realise they need help. So I think that's one of the biggest barriers. When it was self-care week, I think last October, and I was posting these videos on my staff WhatsApp group and saying watch these videos because I thought they would be really useful for them so that they could recognise some of the signs in the. But half the staff didn't even watch them because they thought it was gobbledygook and they couldn't relate to it. Plus I do think the other things is time. Everyone comes to work but life is very different now at the moment, so you go home, and you might have family members at home because they've been at home all day, home-schooling, working from home and people's home lives are very different. So I think people don't have the time to think abut these things, people are adapting at a fast pace and just kind of dealing with things without having that awareness.

Part of this inquiry is looking at the experiences of BAME staff who are working in the NHS and social care and do you feel that there are additional barriers for people who are from BAME and other minority ethnic backgrounds with experiencing support but also in their experiences of burnout. And this could be in your current role or observations within the wider field.

When you say that the image that comes to my mind is from quite early on in that first COVID outbreak. I had to go and deliver some end of life care medication to a lady who was COVID positive, living by herself, she was bedbound, so I had to enter into her property to deliver the drugs. I drove up and I'd taken my full PPE with me, I had my goggles, my screen, my gloves and my apron and I went into this lady's property and in there was a Somalian lady who was a carer and she was giving personal care to this women with COVID. I was just going in to drop-off the drugs and I had better PPE than she did and it broke my heart, because she looked at me and she said "where did you get all that, I need to wear that, because my employer- she worked for a private care agency- hasn't given me anything, they made my buy these gloves and they're so expensive at the moment, and they're not giving me masks." She didn't have an apron, or any eye protection and she said she's got an eight year old son at home with asthma and she's absolutely petrified to go home to him in case she gives him COVID. But she said she can't not work, she needs the money, she's a single mum,

Somalian so come to this country as- I don't like the word immigrant- but as an immigrant and I wanted to cry. Quite honestly, I wanted to cry. I told her to come to my pharmacy tomorrow, I'll give you everything. So I just gave her all my PPE. And she wouldn't have had the guts to stand up to her boss and say you need to give me more. And that would have been because of her background, her need for the money, her need for the role. And I think often, that's where a lot of the issues come from BAME communities; that often they're scared to speak out. And I think that's probably very apparent in COVID actually. If I look at a lot of my BAME colleagues in pharmacy, a lot of my colleagues who own pharmacies are from the BAME communities, we have this kind of inherent attitude of 'we don't give up, we keep going' and I think we're probably at greater risk of burnout because it's a social stigma within our communities to give up. To say that we've broken down would be an absolute social stigma, you would never tell anybody that you got to that stage or that you couldn't make something work and it failed. And I feel that that pressure is greater in my own Asian community than it feels for my counterparts who aren't from a BAME background. I also feel like I've got more to prove, I know I shouldn't that we are in 2021, but it still feels that way. It feels like I've got more to prove and often have to wear that cloak of resilience even if I do want to burnout and that cloak of resilience is greater from BAME backgrounds.

Thank you for sharing with that. The Committee are really interested to hear the experiences of all people that work in the NHS and they know that the experiences of people from different backgrounds is different so thank you for sharing. My last question is kind of a broad one, and you've spoken about some of it before, is what more could be done to support you and colleagues to prevent burnout. And again this is both during the COVID crisis and in the years and months that follow it.

I think the number one thing is funding because if I think about what stopped me from hiring more staff during that time when I was close to burnout, as I have been in this whole year, it was the fact that I thought 'God I can't afford to take on new staff.' If I do, that means I might not be able to continue and I might not be able to offer the services I do. And I didn't want to compromise on my patient care, I didn't want to have to say to customers sorry we don't sell that anymore, no I can't deliver to you or I can't give you your prescription in 24 hours, it's going to take 48. I felt like because I didn't want to compromise on the care, I ended up doing everything myself. And also if I earn less, I'm not too fussed, I just don't want my staff to earn less. I don't want to have to say I'm really sorry I can't have you anymore, I can't give you a job because actually one thing that we are really grateful for is that we have a job. We have had a reason to get out of the house every day and a reason to work and have had lovely, grateful people appreciate what we do and that gives you that thing that keeps you going when you are feeling worn out or burnt out. We had a funding cut back in 2016, that really pushed us to doing that More for less- what the NHS wording was, but you get to stage where you can't do any more for any less. And actually, I've also got to the stage where I want to do more, but because I haven't got any more funding, I'm restricted. So for example all these patients who are coming to see me, rather than going to their GPs, I want to be able to offer them different services. I want to be able to say I can listen your chest, I can look down your throats because I have all those skills but I don't have the time to do so because I'm so stretched because I can't afford to take on more staff. And that's probably one of my biggest frustrations as to why my sector is getting to that point of burnout and it does boil down to money. And also once you have a better funding structure it allows you to have time out of the business so that you can work on the business, so you can work on growing your people and supporting them better to avoid them having a burnout. I'm not a horrible boss and I will never make my staff work more than me, but there are bosses out there that are having to do that because they've got not choice, and I'd hate to get to that stage, rally hate to get to that stage. And I feel like that stage is coming in community pharmacy. While

we've stayed open during this whole pandemic, it feels very underrecognized and it feels very undervalued. I feel sorry for an NHS that doesn't value community pharmacy because they don't recognise the social capital that's in community pharmacy and the fact that people rely on us and if we weren't here where would they go? They would clog up A&E, they would clog up GPs. We're this hidden sponge that soaks up all these people, but just people forget about. And I think that would be a real travesty. So funding definitely.

A lot of other primary care teams, GPs, nurses have dedicated access to mental health support. They have time where they're allowed to close their practices and departments for some protected learning time, but we don't have that luxury. We stay open all the time, we can't close. And so if we are going to do any protected learning time about wellbeing, resilience any of those sort of things it's done in our own time which then impacts on our family time. All our CPD, all these videos I watch on LinkedIn or whatever is done in my own time, I'm not watching them while at work and then I'm taking them back to my team to support them. And that's a shame isn't it because we haven't got that learning time.

The last point I wanted to say is that community pharmacy teams are very small, we don't have a Practice Manager like a GP would have or we don't have a lead for well being like some organisations. And I just think, not only do I manage the staff, but I'm the pharmacist, I'm head of pay roll, I'm head of HR, I'm head of marketing. I'm head of every department as my one person. Whereas other dental practices, GP practices, optometrists would have a different structure probably which would take the pressure off which we don't get in community pharmacy.

You spoke earlier about how you've been able to spot the signs of burnout and been able to work on that, but maybe your staff haven't. Do you think there is more that could be done then to teach staff what burnout looks like and what that means?

Yes absolutely. I think there have been any points in my career where I've reached close to burnout and I think only when I first started learning what it was did I then recognise it. And I think my staff won't have been exposed to that sort of level of burnout possibly, but everyone reaches burnout at different stages, I'm sure there's a different resilience scale for everyone. And I definitely think more needs to be done to support better wellbeing. All we talk about is work and productivity and more for less and things like that are starting to really grate at me. I've always said work to live not live to work as a sort of motto of life but unfortunately, especially over the last year, that's blended, the working and the living has very much blended. And that makes it even harder for people to recognise that. So yes, if we could have an NHS campaign on recognising signs and symptoms of burnout and supporting self -awareness around that. For me that was the first thing; are you having trouble sleeping, are you being pedantic about certain things, do you overreact to certain things those are kind of signs. Are you losing control, are you emotional those are all signs that things are going wrong and for me as soon as any of those signs start happening to me I can say 'Right, I can see you're going the wrong end of this scale, lets step back and do some things that improve your wellbeing.' And I think the more we can support people to have that self-awareness, it would reduce mental health problems, it would have such a wider impact than just burnout at work. I think the more resilient we can grow the nation the better we would all be.

And now just a chance to share any final comments that you would like to share with the Committee.

I just wanted to say that I feel different as a pharmacist, compared to my GP colleagues, my nurse colleagues, and my dental colleagues all the other professionals, bar ITU nurses, I feel on par with

them but in primary care. We have been absolutely bombarded in community pharmacy. We didn't close our doors; we didn't turn to telephone triage we've really maintained business as usual and done more. I feel like there hasn't been enough recognition of that from the NHS, or support to recognise that we are close to burnout. And I guess that's the message I wanted to get across; I feel like I've been treated differently to other healthcare professionals. I think about when people stood outside their houses and clapped for the NHS, were they thinking of me? Were they thinking of the ITU nurse? Or that GP who is sitting at home and not exposing themselves to COVID patients. I think that's really interesting, what do people think of the NHS, and I think it's a real shame that pharmacy feels side-lined when it really shouldn't be. We're the third largest health sector so doctors, nurses and then it's pharmacists. I just feel whenever you watch the TV it's always doctors and nurses and you think what about me, I'm doing stuff too. So I feel it would be good if that was a message that could go into this as well.

Transcript of interview conducted by the Select Committee Engagement Team and Participant B on Tuesday 9th February 2021. Interview conducted as part of the House of Commons Health and Social Care Committee inquiry 'workforce burnout and resilience in the NHS and social care.'

Are you able to give a background on how long you've worked in the NHS and your everyday role?

I've worked in the NHS since 1993. I have been a consultant in Intensive Care Medicine for nearly 20 years. Initially I worked in quite a big district general in an inner city, so a busy large intensive care. That was until 2015, when I decided to move jobs to have a change of scene really. I moved to a small country hospital, still doing intensive care, but the balance is probably a bit less intensive care and a bit more anaesthetics. So I made a big move mid-career about 5 years ago - that takes it out of you as well. I think it is relevant, because we used to become consultants and think that that would be our job for life, but like most professions we move around a little bit more now. But moving jobs does come with quite a lot of pressures. So all of my training and my whole professional network was in my old region, and I moved region, so I had to start again.

Did you feel when you made the move you had the support in making that change?

Not really. It's something that you have to do on your own. I had to form my own network. I settled into the small hospital that I'm at quite quickly, because it's easy to get to know people in a small place, but it's quite a big region. I was quite well known in my old community and then suddenly I was someone who was not really considered a specialist because I worked in a small hospital. I found that quite hard for a bit. And it took me a while to find my feet and work out what I wanted to do. I did a lot of medical education in my old city and I thought I would carry on doing that, but I haven't. It's been a change of direction really.

So my next question is what does burnout mean to you? What do you feel burnout looks like to you and your colleagues? We're asking this during coronavirus, but we understand that burnout is not new to coronavirus so if you have any views and experiences from both before and during the pandemic, we're looking at both sides.

It's certainly something that I notice in other people and that I've been thinking about for a lot of my career because I work very hard. Some people have mentioned to me that I might have been at risk of it, so I've done some reading about it. However I don't think I had it, until I had it.

It feels like you're a jug that's pouring all the time, into all the areas, and you're driving yourself fairly hard. Being a consultant, and especially doing leadership as well, or developing other aspects of your career, means there are quite a lot of balls in the air all the time. I think you just push and push at that and then eventually other things come along and it kind of empties your resources and suddenly you can't cope anymore. The jug is suddenly empty and it comes as quite a shock.

One of the things that empties that jug, that I've seen in myself and colleagues, is complaints, court hearings and difficult coroners cases. The Bawa-Garba episode shook the foundation of our profession and made us all feel much less secure in our everyday work. Doing intensive care, I make difficult life and death decisions a lot. It's a very high-pressured speciality so as you start to feel a bit more paranoid, and if you have those decisions challenged in court, you start to question yourself. That's exhausting because you have to be confident in what you're doing for the team and second

guessing all decisions cripples you. I think burnout is caused by the undermining of confidence and that often is complaints and things like that, combined with chronic high levels of stress.

The speciality in itself (Intensive Care Medicine) I never had trouble with until I had a complaint. However we do see a lot of tragic and sudden deaths, and devastated families. That does affect you at a subconscious level.

I had a few events in a row which seemed to coincide to cause a problem on the background of this high pressure, high stress speciality. I had a career move which removed my professional support network. It felt like losing your work family, who were really important supports for me. Then I had a difficult coroners case and that was really stressful and only resolved just before COVID hit. That was part of the reason, why I didn't want to talk openly, because with that coroners case I was at risk of being charged with manslaughter, and I carried that knowledge for about a year before the hearing where I was exonerated. I still carry the fear that if I say something wrong about that I will end up in court with my liberty and career on the line again. It has changed me forever.

It was all sorted out in the coroners court but that was an enormous amount of stress that I'd carried for a very long time and I don't think I had recovered when the pandemic hit. I was a lead for my speciality in my small hospital without other intensivists really to support me. It just felt like an insurmountable task for a while. I was under pressure to lead the clinical work to treat the patients as I had the most intensive care experience, but i found that difficult to do as well as lead the service. I had to do a full-time clinical job (10 sessions of DCC including nights and weekend resident shifts) as well as lead the service. The pressure of that was just enormous and there wasn't really any downtime or time with my family to regroup. I think it all combined and at the end of it all, when we were resetting around June, when they were talking about going back to normal and getting waiting lists down, that I just realised I couldn't cope with that. I had no hope for the future, I couldn't see how we could possibly go back to normal or deal with waiting lists. I was really snappy, bad tempered at work. I felt disconnected from people and isolated. I preserved my work with patients, I was still doing the same job with and for them but I was not connecting with my colleagues. It was like I could isolate patients and care for them but everyone else, including myself, I was neglecting. Relationships at work were ok, but I think people started to worry about me because I'm normally quite cheerful and I suddenly wasn't any more. I wasn't optimistic, so every time someone suggested something I would have a negative view.

I saw similar things in a colleague, again after he went through a difficult court case and a traumatic death.I've seen him change since that's been resolved. It was also resolved in Jan just before the pandemic but the difference for him was that he didn't have to lead the service as well as do full time clinical work. So he just did his job, built his confidence back up and had a support network in place. I think I just had too much of a cognitive load to deal with all of it.

Thank you so much for sharing that and passing it on, and I hope that you're moving onto the other side of that now.

It took quite a surprising amount of time to recover. The Practitioner Health Programme was essential for my recovery. It was set up in London, and I had heard of it in those days due to my educational work, and I also knew that now any doctor in England could self refer to the service. I couldn't get an appointment with my GP in June; it was just impossible. I'm in a rural area and there is a shortage of GPs. Because I'm a doctor and it's really hard for us to talk about these feelings of lack of confidence, the fear that you're not going to do the right thing by your patients, fear of making mistakes, you can't talk about that with someone who is not a doctor. There were only

appointments available with an advanced practitioner. So the Practitioner Health Programme was a lifesaver really as I was thinking about suicide every day as a way to escape. I referred myself to them, got an appointment, and then they immediately signed me off sick for a long period. I didn't realise I was as sick as I was until I stopped working. It took me about 6-8 weeks before I felt well again. It's a physical thing as well - exhaustion, concentration problems, I couldn't make decisions about anything, even what to cook for tea. It was only when I stopped that it got bad and then it gradually got better again.

I went back to work in October, so I had three months off, and I probably had about three weeks of that of feeling ok before I went back to work. Work was fairly supportive on my return; I managed to do slightly less than full time and they let me do just one speciality. It's quite a lot of pressure doing intensive care and anaesthetics and being up to date in both when your confidence isn't very good, so I started off just doing intensive care. It was a non medical manager that was really supportive rather than my colleagues which is interesting.

I'm happy to hear that you do have a supportive manager in place, and you do have the programme that you were speaking about as well. You've touched on it as well, but did you feel like your colleagues were also feeling burnout at the time? In terms of around the coronavirus did you feel that there was a burnout amongst your colleagues as well, or did you feel the impact on them?

Yes. I could see another colleague that had been struggling for a while. Sort of similar to me, different problems but perhaps just about coping for a while. I could see the same symptoms in her that I had. We didn't really talk about it, because I think when you talk about it it makes it real, but she went off sick just before me and had longer off. She's returned to work but isn't returned to doing everything that she did before. It's interesting that we're both a similar age, she was suffering with anxiety beforehand, and she puts a lot of it down to being to being perimenopausal. We're both in our early fifties and I think there was that in the background as well which can mess with your confidence in decision making, you get anxiety as well, and you get sleep disturbance. They're actually quite major things that go awry with you. It was difficult to get understanding about that at work, for both of us, so we share tips about hormone patches and things like that now. For me maybe it wasn't entirely hormonal, it was a bit of everything , but greater understanding of the neurocognitive effects might have made my medical bosses more empathic. I think menopause is a burnout risk factor for women, and perhaps the hormonal flux all women experience puts us at higher risk, as I know that burnout is more common in women.

In Intensive Care you make decisions about life and death all the time, and when you get challenged about that in court it's really difficult to then carry on making those decisions objectively. Some of the people that have died over the years you carry with you. That's what I meant by that chronic stress of just the speciality of intensive care medicine. I had some counselling after the court case, which was curtailed by COVID, provided by the Medical Protection Society after my court case. I didn't realise that carrying these deaths with me was an issue until the therapist gave me a safe space to reflect. We're so good at supressing all of those feelings, those human feelings, because we have to to do our jobs. I think years of suppressing all of that does damage.

We have a Schwartz round in our trust, but it's difficult venue to share the horrors that we see as that's very much a multi-disciplinary thing. This is specifically about making life and death decisions and having people die horrifically in front of you. I don't want to share that with lay people so if I don't have a professional support network I carry that alone. If the public really understood the decisions that we have to make, I feel we would not have their support in this age of social media.

We sometimes have to decide to stop treating people and then explain that to their families - I think it does damage.

One of the things that a friend once said to me is that she thought we should have supervision, and that is what my counsellor also said. Supervision is something that social workers have, but it's not a concept in medicine at all. I think it would be a great idea. It's an opportunity to share some of that emotional burden and reflect on it, whereas what we do, and what we're trained to do, is to push it all away. That works for most of your career but if other pressures come along you don't have the resources then to keep on pushing it away. So supervision was one of the things that I thought would be helpful over the years in terms of prevention, particularly for those specialties like intensive care.

And would that be a consultant or someone in more of a counselling role or is it almost like a separate body that is doing that.

I don't know. In my previous job I think I wouldn't have burned out because the team would have noticed and supported me and I wouldn't have got as sick because of that. So there is an element of sharing with colleagues who are doing the same job as you, and having the time and opportunity to do that. I've been battling for that time in my current job for us as a group of intensive care consultants to sit down once a week and discuss cases. If you provide opportunity, although not everyone wants to share their emotional load, it is an opportunity to reflect and learn. We don't have any time for that. It is not built into job plans and it's not really encouraged. The Trust don't want to pay us to do that because it's not considered important, it's not direct clinical care, it's not delivering an anaesthetic or delivering care on an intensive care unit, so it's not valued. We're supported to do mortality and morbidity reviews but the meeting are squeezed in around operating lists. Those meeting have gone since COVID happened and there isn't any appetite from the Trust to reinstate them. It's probably even more important that we do them now because it's been such a stressful time and we've dealt with a new disease so there is a lot to learn.

I think there should be access to trained supervision for those that want it. That would be more about the emotional load. I would access something like that but maybe not all my colleagues would be interested. There is a culture of sport, high performance, and endurance sports in Intensive Care Medicine so reflection on the emotional load may not be for everyone. There's less people like me who think about the emotional impact, perhaps because of the fear of opening up the floodgates.

A colleague recently had an appraisal with a psychiatrist, his first appraisal outside of anaesthetics and it was life changing for him. He told me how valuable the opportunity it was, he'd had an opportunity to reflect on his practice and experience and some of the feelings around his work as well as plan for his future. It was a revelation to him; he was like a changed man. Appraisal might be an opportunity for supervision in those that don't want to access support elsewhere. It could be constructive rather than the tick box exercise that a lot of people think it is. But then you need someone like a psychiatrist or a GP to do that, and they've got to do their own appraisals so it's difficult to provide.

And some of those themes that you've said have come up in other spaces in terms of having a space to share and feedback. You spoke earlier that during the first peak you were able to almost silo to care for the patients. So what impact can burnout have on patients. And this is not just you individually, but when patients are being cared for other staff facing burnout. Or is there no impact on them.

I think they're the last to suffer. Part of the reason that we burnout is that we prioritise everyone other ourselves. That was my main lesson, I've really learned that I've got to put my own oxygen mask on before I treat anyone else. So that's both my family and patients. I have to be right before I care for them and that's something I've only just learned after all these years in medicine.

I do see people being short-tempered delivering everyday cares, but I have not seen that a lot in COVID, as there is such a barrier with the PPE that we wear anyway. Somehow the communication barrier of PPE makes us more empathic. I have witnessed nasty comments about patients over the years but its obvious its because the staff are stressed and its very rare. I've seen conflict between staff in front of patients more often which is probably not very reassuring. There's also the chance of error that goes with the cognitive effects of depression or burnout. For me I worried about errors to do with drugs or calculations, what we call slips. It's not really high-level decision making because you can use your years of experience to get beyond that, but you can still make simple, human errors. That's because you're exhausted, you're not sleeping at night, and your brain just doesn't function as it should. Combine that with some hormones as well and you can be in quite a bit of trouble. I compensated for that by getting people to check things, but then that knocks your confidence. As you get people to check everything you sound like you're not confident and then it's like a vicious circle, because the more you're under-confident and double checking your decisions the more people start to question them and then you start to question them yourself.

But I think you're right, that's some of the reason why you burn out is because you're putting on that public face, but behind the scenes might be different. This question you've touched on already but it's what support is available for staff who are experiencing burnout or suffering from stress and anxiety that may lead to burnout. And are there any barriers to accessing that support?

We had no support until just before COVID when a new psychologist started and was interested in supporting critical care staff. When COVID hit she did a lot of support and built some relationships with people and helped some people who are teetering on the edge of burnout through without medication and without them taking time off. She's still supporting those people, but there is a lot of unmet need in psychology in patients now as well because of the PTSD after COVID so she is unable to do what she did for staff. She used to come to the Intensive Care Unit and talk to the nurses because they wouldn't go and refer to her. It's a big step to admit you need help and it's really hard to do that for health workers because it's putting your needs first and nobody ever does that. People interestingly didn't self refer to her so she used to just come and facilitate a bit of a chat in the ward in a group, but it would be informal. She just doesn't have the resource to do as much of that now but at least we've got her to go to and she's still able to support some staff on a one to one basis.

We have counselling available from the employer but again it's quite hard to speak through some of this stuff with a lay person. So they might be good at counselling for bereavement or stress but the degree of horrific things that we're seeing it's quite difficult to share with them. Lots of staff have PTSD and they avoid reflecting on the trauma that caused it. Another barriers to seeking help is not wanting to inflict the trauma on other people. I think also there is a feeling that everyone is struggling, so why should I need extra support. Healthcare staff tend to be fairly altruistic, not all of them but most of them are, so they tend to think that everyone is having a tough time for whatever reason and this is our job, we just have to get on with it. Why is my need any greater than my patients or anyone else around me? It's a real struggle putting yourself first partly because we're trained not to do that. We're trained to put the patient first, perhaps that's wrong and we should put ourselves first. Really it should be self, family, patients because if you're not coming from a good place then you're not going to be able to do your job with empathy. The culture of the NHS is against you trying to seek help.

Is that culture because the NHS don't want to fund the counselling or because they want staff on the wards. Where does that culture come from?

I think a lot of it is perhaps a lack of staff. There is a reluctance to say I think you need some time off. I witnessed that recently with a nurse redeployed to critical care who gas been doing a fantastic job. We both dealt with a really nasty death and she clearly wasn't coping with it very well. She took all her PPE off in the dogging area and left it on the floor. I followed her out and saw all of that. She clearly needed a break away from the ICU but it took me ages to persuade her to take some time off. In the end she sent me a text message saying she had broken down in front of the Chief Exec so she got a week off. It was so hard to get her to accept that she needed some time off, and she wasn't going mad and she was going to be fine. I remember that fear; it's the fear that if you open the floodgates you are just going to get overwhelmed so you just keep pushing it away. Actually time off when it's needed might just prevent the tsunami. It could just be a week or two. Maybe if I'd had a week or two off when I was really struggling, I might have not had three months off later on. I had to really battle to get the day off to have the interview with the Practitioner Health Programme, and I feel like now that I had to scream to get that time off. I remember shouting, because I'd got so desperate, to the guy that was in charge of the rota 'I'm depressed, I need to see the doctor.' You shouldn't have to do that should you? But people that are on the same rota as you so they don't want you to go off and that's the trouble. If a nurse goes off sick their boss/colleague/friend has got to cover that shift. And when you go off you know that you are dumping one of your colleague in it. Team NHS can be good and bad for our mental health. I don't want to say that I can't cope because there aren't enough people to do the job anyway and I'll just make it worse for my colleagues.

So we're moving now into my last question, and you've touched on it in terms of supervision and going back to having those reflective sessions with your colleagues, but it's what more could be done to protect you and your colleagues from burnout?

I think some education about how treatable it is, and prevention would be really useful. It should be part of normal training to learn about burnout and how to recognise it. Perhaps a bit like the mental health training that I think Mind do for workplaces on mental health first aid is we can support each other. It's amazing how little doctors that aren't GPs or psychiatrists know about mental health. I didn't know much about it, I thought I did, but I only studied psychiatry at medical school, and that is a long time ago. I now understand the lived experience of it and I am learning a lot more through the curated resources in the NHS practitioner health app called 87%.

The manager that was really supportive and spotted my burnout and suggested I take time off, she's had burnout as well. There are people within the NHS, probably quite a lot of people, that could be mental health champions. I am acting as one of those champions now for my colleagues. I think some education and a bit more information about treatment might give hope. It isn't the end of the world or your career and accepting you need help is really ok.

I remember when I was sick, our caring chief exec saying 'it's ok not to be ok' in one of his weekly messages. It's not ok, it's really horrible to not be ok. Phrases like that wind you up when you aren't OK. I understand the ethos but if you have no staff to cover your ward it's not ok to be not ok is it? Staffing levels are underpinning all of this. If you had enough staff then you'd be able to look after your staff but we're not going to magic that out of nowhere, we've got big shortages and they take years to train. I think in the shorter term it's about awareness and perhaps pressuring Trusts to allow people paid time to reflect together making reflection and sharing part of the job. A Schwartz round isn't the only way of doing that but we should have them across the NHS.

I think you need to reflect as part of a team. In fact it's a team that will help you through and as I said I think if I'd been in my previous job, I probably wouldn't have got sick. I might have been under exactly the same pressures, but I had a supportive team. You can't build a supportive team if you never have any time together. That's going to cost money and take us away from the bedside - when you're short of people it's hard to make that happen but it is possible that would help.

That's all my questions but now there is a space for you if there are any points that you want to add or to clarify.

One of the features of burnout is wanting to kill yourself to escape and this has been shown as frighteningly common in intensive care staff surveys. I thought it was depression, but I think it was actually burnout, it's basically an escape route from intolerable stress. The Practitioner Health Programme was life saving for me, I think it's really important to get that across. I think it's more common in health care staff than we realise. It's already quite frightening how bad suicide rates are in healthcare staff and I worry what COVID is going to do to that with all the PTSD. It's a way out of a situation that people can't see a way out of and again it's education that I would hope would help prevent that. I think we will lose people and that's horrible. I've already lost several colleagues to suicide over the years, doctors and nurses.

I'm sorry to hear that. And that's why the Committee want to do that to ask the government to be doing more to support staff to bring those numbers down and prevent that. I know that today we've seen tough themes raised so thank you for sharing today.

That's ok. I'm better and I feel quite strongly that I want to share some of my story in the hope that it will stop someone else having the problems that I've had. When I first went back to work they would stop me in the corridor to say hello and welcome back. I told them I had been off with depression and then they would say 'I'm not feeling that great at the moment either.' To me that's brilliant as my experience can perhaps help others earlier than I got help. I will am open about my mental healthI but not every doctor wants to be due to the stigma and the fear of professional repercussions. I am open but I was still not brave enough to share my experience live on the Internet. Its's great to have this opportunity because it makes me feel like I can turn this horrible experience into something that might help others.

Transcript of interview conducted by the Select Committee Engagement Team and Participant C on Thursday 11th February 2021. Interview conducted as part of the House of Commons Health and Social Care Committee inquiry 'workforce burnout and resilience in the NHS and social care.'

To start today, are you able to give some background about your role and how long you've worked in the NHS?

I'm the senior PCN- or primary care network- pharmacist for a primary care network in the South West. I've been working for this group of practices for the last five years, but PCNs have only been going for the last 16 months or so. In terms of working for the NHS I've been contracted through primary care, or through general practices, for five years and prior to that I was working for community pharmacy, so I was a contracted pharmacist.

Thanks and thank you again for joining us today. My first question is around what burnout, and the idea of burnout, looks like for you and your colleagues. Now obviously we're currently in the middle of the COVID pandemic, and we understand that that has impacted burnout, but that question is also looking at the time before COVID.

I think it's reasonable to start with my immediate experiences during the COVID pandemic. I feel quite fortunate in primary care, for several reasons, but I think there are a lot of challenges. What burnout looks like for me; I think for me, I can always tell when I'm personally feeling like I'm approaching the point where there is too much going on because my sleep gets affected, and I start having funny dreams. Not too long ago I was dreaming that the guidance for our coronavirus vaccine delivery, the standard operating procedures, had changed and when I woke up in the morning I had to go and check that it hadn't changed because I was so convinced that it wasn't a dream, and it was real. When I start having funny work-related dreams, when I struggle to get to sleep because of work or I struggle to get up in the morning that tends to be when I know my mental health is fraying a bit and I'm not getting my balance of family and my work/life balance sorted. The feedback I have from my wife is also that I sort of go more into myself or my personality changes.

Within primary care we've had a difficult pandemic and initially I think the general public were quite well received of the challenges that we were under, and what we had to do, and were more understanding, and I think now, with lockdown three, there is a media promotion going on about how GP practices are still open- and that's absolutely right- but I think some patients expectations of the service that we can deliver are almost reverting to pre-pandemic. So, they're expecting that we'll be seeing patients face to face, even if it's not necessary. So, we're having to explain a lot more that we are using virtual consultations, we're doing things that don't need to do face to face on the phone, so that we're able to see patients face to face when we really need to, and when that risk/benefit ratio is fixed. I think that's causing, certainly receptionists, a lot of grief when patients are calling and putting in complaints about us not seeing people for routine things and they're not perhaps satisfied with online consultations. Compared to some of my colleagues in community pharmacies on the front line, or in hospitals, we've been relatively sheltered I think in primary care, with the ability to have access to using online tools and to protect ourselves well, thus far.

I think the difficulty around trying to not burnout is around how your employer is able to give you that flexibility to work in ways that can facilitate things. When I think of colleagues in primary care who are struggling, it tends to be around inflexibility of being able to change your workload or to support practices in ways that are safer. A lot of the issues that were raised initially around PPE and things have all be resolved and we're really grateful for that. I think the main issues are that, well the way that I feel at the moment, is very well supported and looked after by my employer, but what

they don't have control over is my family life, and the issue and stressors that are happening outside of work because of lockdown and because of coronavirus, with friends and family getting sick- that sort of thing. And for my team, a lot of them employed in primary care networks have to do some mandatory training and that hasn't been suspended, whereas I know a lot of university courses and things have had to find ways of working around things. They're still expected, because it's part of the funding that comes with us employing them, they're still expected to do their training component. While that is understandable, I've heard in other PCNs, employers not being as flexible and expecting them to do their current workload, to contribute extra work to the coronavirus vaccine hubs and working on those as well as then having to do their own training and academic work on top of that in their own personal working time. And I know that's adversely affecting a lot of my colleagues, and I've really tried to impress that on our clinical directors so that my team are given protected learning time despite the pressures, and what we're expecting them to deliver, because there are other people that can do what we do in the vaccine hubs and other services.

I think how that's changed from pre-COVID, the expectations previously were around trying to get the workload delivered within your contracted hours and expectations of trying to deliver that outside. Things like WhatsApp messages and emails over the weekend, personally I have quite flexible hours with my employer, and I do a lot of work outside of work, but I'm quite happy to do that and I don't claim extra duties or things like that. I'm very involved with a lot or organisations and do a lot of activities, but I use these as a release and is something that I'm interested in anyway, but I know certainly other people aren't built that way and don't work that way and like to switch off and be out of office. I think that was probably the main driver of issues for burnout in workforce for my colleagues. My GP colleagues certainly would be working early hours, their contracted hours and then staying late to try and get the day job done and that was the main complaint.

Thank you so much for sharing that and for covering both pre and during COVID. You mentioned patient expectations and that feeds into my next question which is the impact that burnout has on the people and patients you care for- if there is one- and again that's pre and during COVID.

I think if you're nearing burnout, or you're burnt out, then the biggest impact on patients is that you're not able to give them the best care that they deserve just because you're not in the right head space. One of the things that we were taught when we were starting to do consultations years ago, was that you would do your consultation, you speak to your patient and then you have some time in between patients to clear your head and prepare for the next one so you're not bringing emotional baggage from whatever consultation you've had into the next one. I think with burnout you tend to carry that with you, and you can't clear things down and your thought process can be affected in an adverse way. So, I think the biggest effects on patients of burnout is poor decision making, it's maybe not having the same compassion for patients and the ability to be resilient and adapt to them. Every healthcare professional wants to provide the best that they can for their patients…sorry can I hear the question again.

Yes sure. It was around the impact that burnout can have on patients and people that you care for and you've spoken about how you might not be able to give the compassion and the empathy that you might usually give or that the decision making might be impaired. I guess an extension to that is, has that been seen more during the COVID pandemic or is that something that is always seen with burnout.

I think that's always something that is seen with burnout. What's different with COVID is that the new ways that we can work means we can see more patients. It's multifaceted so in terms of seeing patients you can get through more and almost deliver care in a better and more efficient way. I think

if you are going to have burnout affecting you anyway, or any sort of incapacity, it would be along the same lines. I think the main thing with COVID is we're hearing these stories of being affected and dying…where we are in the country is quite rural and we weren't too badly affected and I remember one occasion when a really young family all came down with COVID, they just had standard symptoms, and then one of them got really breathless, was admitted to hospital and passed away. And I think that really brought it home. At the clinical meeting where we were discussing it a lot of clinicians said it really brought home the reality of how it can happen to someone in your age group and it's not just affecting people who are elderly with a lot of co-mobilities. I think it makes it more difficult to be objective about things and it makes you more cautious about the processes that you have and the reason that you're doing things the way that you are. It's hard to separate out, and I think this is the thing when you have patients who are dying and patients who are really unwell and you've got that continuity of care that we have in general practice, it can affect you emotionally on a deeper level. I don't mean to be patronising to people in the acute sector who see people who die daily, but they might not necessarily have that long-term relationship that we have with our patients that goes back a number of years. It's difficult for everyone, but I think this a big thing.

You were saying earlier about flexible and supportive managers and my next question is looking at how supportive the NHS is and what support is available for staff who may be experiencing burnout. Are you aware of any support that is available?

I've been asking around in advance of this just to try and get an idea. It has been well publicised throughout the pandemic, and I've offered it to my teams, there's a service available around coaching for resilience. I think I was a bit sceptical- or I am a bit sceptical- about how coaching might help to relieve some of the issues. I'm sure there are some things that are helpful but certainly for me when I get burnt-out it tends to be more that things are mounting up or things are affecting me emotionally and I kind of struggle to see how the coaching service might help. That's one thing that has been provided. I know a couple of colleagues have taken it up and they've said it's been helpful but there isn't too much else that I'm aware of that's available. There are pharmacy charities that deliver services for pharmacists, that existed before the pandemic, and during the pandemic they've stepped up by offering confidential helplines and things like that.

Thank you for that and the information that you're providing is really helpful, and it's interesting to know about the coaching and the helplines. I guess then the other side of that is do you think there are barriers and challenges to people accessing what is already out there.

Yes. I was speaking to one of our practice managers and they were saying that certainly the older members of the team are much more reluctant to accept help or seek help. Why that might be culturally; I could offer some suggestions, but it would be generalising. They were saying that the younger team members seem happier discussing their emotions, discussing their mental health and seeking support when it was available. I don't know whether I fit into that older group, in that if there's something wrong then you sort it out yourself or don't talk to other people about it. I've got my own avenues for discussing things personally to me within exterior networks so unless something was materially affecting me at work, I don't think I would take it to my line manager.

This inquiry recognises that different people may face different challenges and part of what they're looking at is the experience of staff from BAME backgrounds. From your experiences of what you've seen, and from talking to people in your network, do you think that in regard to burnout accessing support, are there further challenges for staff from a BAME background?

That's a complicated question. Most of our clinicians, we're in South West England and our population is 99% white British. I'm mixed race myself, and we've got a couple of clinicians who are black, a couple who are Asian, but I think within our organisation all of those people are of a professional level, so they are all pharmacists, doctors or nurses, and I don't think there are particular barriers for them or issues for them. I think what's been concerning for them is reading the, or hearing on the news, the inequalities around COVID, with family members and the Public Health England report that came out. My personal observation is that it's not genetically that your ethnicity increases your risk, that it tends to be more around social demographics and levels of deprivation, maybe a bit around culture. But these are all healthcare professionals so I don't think they're necessarily experiencing the same issues that you might have in members of those communities who are not healthcare professionals. Where I think it might be an issue is where you have people from a BAME background, who are not working in a professional level so if they are porters or cleaners, but as far as I'm aware all of our teams within all of our practices are all local and white British and don't seem to be affected.

Thank you. This is my last question, before I open it up and ask if there is anything more that you want to add, and it's what more can be done to support you and your colleagues to prevent you from burning out.

Specifically for pharmacists since the pandemic we've been included in the NHS support. It was only recently that Primary Care was included in the same support services that the Trusts have been able to access for quite a long time- I know the BMA was pushing for a while to get primary care recognised. And that was recently extended to pharmacy teams in the pandemic, but as far as I'm aware that's only a short-lived thing. I think we're able to continue to access support by virtue of working in primary care, but I know my colleagues in community pharmacy are worried that that support will be taken away after the pandemic. I think the biggest challenge going forward will be trying to deal with the fallout from the pandemic because a lot of my colleagues are throwing themselves into the vaccine delivery work, so they're doing their day job and volunteering for extra shifts and things. I've been really clear with my team that I'm really concerned about burnout. With the vaccine clinics, I think we're already planning through to next year for how we're going to be delivering them and it's going to be massive marathon, not a sprint, to try and get as many people done as possible. We can't just do all the hours available now, and then not have anything left to be able to deliver next week or the week after or the months after. I've got particular members on my team who are really keen to help out and they've been volunteering to work weekends, and there are some points where I've stopped asking them for extra duty because I'm concerned that they've got to have some family time, they've got to have some time to not just be giving all they can. It's a funny environment because the patients are really appreciative, it's a big national effort, it's something historic, I think there are lots of reasons that allow people to burn the candle at both ends and do crazy 70/80 hours a week. But there is a danger with that and it's not sustainable over the long term. Having to deliver and give more of yourself over a sustained period of time will affect people working within the NHS and I see that as being an issue as well as all of the things that you're exposed to and hearing about when talking to patients and hearing their experiences.

Transcript of follow up discussion with Participant C that was held on Tuesday 16th February 2021.

I thought if I just spoke a bit more around what burnout looks like. I spoke in the previous interview about burnout and I was talking about how it affects me personally and how I recognise some of the signs. On reflection I thought it might be a bit flippant coming and saying, this is what happens, and clearly the way if affects people is different. I thought it would be useful for me to share my personal experience of burnout, to provide some context on why I recognise those signs and symptoms in me

to try and then do something about it. If I go back to maybe 10 years ago, I'd taken on a role, I was working for a large community pharmacy business, and I tended to be parachuted into stores that were struggling, to fix them. I took on a store which was a hundred-hour contract, so they would open up from 8 in the morning until midnight, six days a week and then the statutory hours that you do on a Sunday. And within in that role we had a number of issues with personnel in terms of people who are off on long term sick, or people off on maternity leave. I think the difficulty with a hundred-hour pharmacy, and with pharmacy in general, is that you need a pharmacist on the site to be able to keep it open. So there would be days when I would be doing the morning shift, and the locum or the pharmacist that we'd booked to come in for the afternoon shift didn't show up and so I would then do an 8 till midnight shift and then be booked in the next day. And as the lead pharmacist, or the pharmacist manger, if something happened with that rota I would get called in to cover, and at the drop of a hat on your day off you might have to go in and do a shift to keep the store open. I think one of the difficult things with pharmacy is if you feel professionally that that pharmacy isn't safe to run then you've got to decide whether you choose to close this store. And then you've got to weigh up the pros and cons of, if I take the decision that it's not safe to run this store, and I close it, what are the implications for the patients who are unable to collect their prescriptions from that store, and do you have sufficient procedures in place to ensure that they still are served properly. So it becomes a difficult decision to make. I was brought into that store and over the course of 6-8 months of turning it around, and one thing after another happened in terms of people not turning up. I had a pharmacist and a senior dispenser go on maternity leave as well as people on long term sick. I spoke to senior management, or the management in the store, about getting additional support and was told that you've already spent all your salary budget and there's nothing additional and there is no one on the relief team, and no other means of support or helping. I think things have turned around a lot in terms of whistleblowing, but this is going back 10 years, and it got to the point where I was doing pretty much 12 hour days, or even 14 hour days, working through lunch breaks, and was not conscious or recognising that I was burning myself out. It got to the point where I suffered from anxiety attacks when leaving the house, and I was thinking what is wrong with me, and I sought medical support from my GP who basically said what you're doing is not sustainable, you need to take sick leave. It took a lot to get through that and recognise that and I think subsequently that's why I recognise what the triggers are for me and how that manifests itself. And I think that the learning for me is around not just asking for help but demanding it. If you're not getting any joy by going up the chain, then by go straight over the head of your managers to more senior management and really kick up a bit of a fuss. There's got to be a point where you say, well actually it's not safe for my mental health as well as the health of my patients if I don't do something about it. It might be that you need to do something drastic like closing a store to make it visible to other people that it's not a safe place to work in. That's the context I wanted to give, which I didn't give before, and I thought that without that context it might be a less powerful testimony.

Thank you for sharing that and I think it is really useful for the Committee to hear about the long hours and the impact that that has, but also as you were saying the feeling that you were asking for help from the higher-ups and you wasn't getting it. To follow up on what you said about how you now know for yourself that you don't ask for help, you demand, do you think that is something that is felt by a lot of your colleagues or are people still hesitant to ask for help.

It depends on the person. I think it's a complicated issue because you might get somebody who is kicking up a fuss because that's the type of person they are but then you'll have legitimate concerns and it's assessing those on an individual basis. One of the questions was around what solutions there could be, and I certainly don't propose to have the answers, but I think that there is more of a clarity and more of a culture of being able to whistle blow and there are now hotlines that you can call if

you want to raise things. There will be a movement and a bit of a culture change but how can you bring that about any quicker, I'm not too sure.

Yeah, it's one of those things that have to evolve, but how quickly that evolution happens is interesting to see.

I think that it always starts with the leadership and with people recognising, and caring for, the people in their organisation. In that role that I was in, the priority was very much meeting targets, so it was how many prescriptions have you done, how much profit has the store turned over. It got to one point where we were told that we were so overspent on the consumerable budget, so we were told that we couldn't order anything else, even toilet paper, which was ridiculous. Having leaders with the strength of conviction to be able to stand up to senior management if that is the dictate that is coming through and call out silly things like that. It can start to build a culture of looking just at performance targets and money and not focussing on people's wellbeing.

I don't have any further questions, the main point- and you've touched on that- is looking forward and because the key part of the Committee's role is that they will highlight current problems but they will also make recommendations to the Government to say this is what we think needs to change to support staff and prevent burnout. My final point then would be is there any further things that you think could be done, or that they should recommend to the government, to prevent burnout. And I know that's a huge, blue-sky question.

COVID is this massive issue, which in some ways will be putting a lot of stress on people in their roles, but at the same time the amount of innovation that has taken place- having meetings over Teams, online booking of patients through apps and texting- this innovation that we've had in primary care I've not seen before. And that's in acute services as well. My wife recently gave birth to our son and she's had all of these follow up appointments with consultants virtually, whereas before she would have had to head to the hospital. Within this innovation and the new ways of working there are some things from that that we really want to keep, and we will be able to unleash so much capacity in the NHS and deliver things in a different way. But I said before the scars that will be left from the other things that are going on, and from the patients stories that you're hearing and exposed, to we will need some support and some way of addressing that. Certainly, I think that the thing that we struggle with a lot in Primary Care- and across the NHS as a whole- is bureaucracy for bureaucracy sake, and I think what's been brilliant about COVID and the vaccination programme is that you've got those safeguards for patient safety, and information governance and doing things in the right way but you've also been given quite a lot of freedom and autonomy to just go and deliver this and that's really important and really exciting for a lot of clinicians. The thing that I'm struggling with for my team at the moment, is that I'm trying to unleash them, and get them to be involved, because it's really exciting and a great thing to be involved in, but they're also some of them a danger to overcommitting to it, and not being able to have that self-awareness of if I keep doing this for the next few months I'm a risk of burning out. I think it's important to check in with them and for me as a manager to ask them how they're going and to have that focus not just on, we did this many jabs, and we're doing this many medicine reviews and we're doing this many MDTs, but how are they getting on, how are their families. Just taking a bit more of a personal approach, but how you do that on a larger scale I'm not 100% sure.

Transcript of interview conducted by the Select Committee Engagement Team and Participant D on Monday 22nd February 2021. Interview conducted as part of the House of Commons Health and Social Care Committee inquiry 'workforce burnout and resilience in the NHS and social care.'

To start, can I ask you for some background on your role and how long you've worked in the NHS?

I'm a community pharmacist, I'm based in a pharmacy in the South West and I've been a pharmacist now for 25 years. Most of that time I've worked in the UK, I say most of the time because I'm also a Canadian qualified pharmacist, so I went to Canada for a about a year. I also have other roles within the NHS. My roles in community pharmacy are leading the community pharmacy team, I'm also an independent prescriber and I'm also a PCN community pharmacy lead as well.

So, lots of hats that you wear in your role. The first question is on the idea of burnout, and its what burnout looks like to you and your colleagues, so what does that mean to you.

The way I like to think about it is that when you work in healthcare there is a bit about it, like in any other job, of you being aware of what is expected of you, and enjoying that but also having a great big motivation to want to care and want to make a difference. I think that means that you usually would never stick to the confines of the job specification, you never do the number of allocated hours, you want to do that. Burnout is really when those two things happen; when you no longer want to do what you're doing, but also when what you do is starting to have quite a detrimental impact on yourself. That tends to be where it surfaces the most. It's you not wanting to do it anymore, which is very strange because that's always been something that you've been drawn to and enjoyed. But what's even worse is that there is now evident; that what you have been doing has had this detrimental impact on you. And sometimes it can be very gradual; it can be almost latent, then you just fall into it. But it shows up in ill health, in physical and mental health presentations. Sometimes it's risky behaviour and people really go off the rails. But even worse is that it can also happen as a slow grind, where you just stop trying to do your best anymore and after a while you just don't want to do anything anymore. These are some of the ways that I would view that.

You kind of touched on it as you answered the last question, but it leads onto my next one which is what impact does burnout have on you and your colleagues?

I think for us, for community pharmacy, the impact of it is really quite severe. Firstly, when you start to get to that point you become a very unsafe practitioner and sometimes you yourself are in need to quite desperate help, support or assistance. Another bit of that is that it also impacts on your wider life. One of the particular challenges, though not unique to community pharmacy, is how our work-life balance is very poor. Over the last few years, we have done various surveys that ask questions about the impact of stress, work-life balance and job satisfaction and it's been a marked result from the survey how that continues to be more negative than positive. Particularly around the work-life balance- the wider impact of how our work impacts our relationships- because it really takes a toll, mostly on our mental health. What you then have is this pressure cooker environment all the time and at some point, you simply implode, but you implode in a way that is invisible. I think one of the things that it costs the wider NHS is on our patient care, because when you are at the point where you simply cannot sustain what you are meant to be doing. It also means that you are doing it in a somewhat detached way, or even worse you are simply running through the motions. So, there is no particular motivation or innovation there and I think that is really quite sad because it's actually a great form of absenteeism until you cannot sustain that anymore and then you actually have to be signed off, or you're away for a period of time to try and recuperate. Most people don't

come back, or if they come back from that experience, they're coming back less able to do what they used to do.

Thanks for that. So it's the idea that it can be quite a low build, but once it really starts to hit it can have a long-lasting impact and as say some people might not return. So obviously the idea of burnout is not new, it's a problem that the Committee and Government have been aware of, but we know that during the last 18 months burnout may have been more prevalent. What impact has the coronavirus had on burnout?

I think it certainly has exasperated that particular curve. I think at the beginning of the pandemic, and pretty much throughout most of the early part of the pandemic, we mustn't forget that community pharmacy kept on being open, kept on dealing with the pressures there and we kept on having longer hours. And that was ok, but at the same point we had an overwhelming sense of vulnerability, as we were asking for help, asking for PPE. To have that sense of responsibility forced on you, something you haven't invited but you are stepping up, saying 'this is my duty, my community and at the same time to also feel that sense of vulnerability and to think that nobody seems to care about us, and nobody is looking out for us. What is going on? And along the way there were some, most likely not deliberate, but insensitive little things would happen. When the list of healthcare professionals who could put their children back into school, pharmacy was not on it, so you were scrambling trying to sort that out. You were constantly looking to the Department of Health as you try to obtain funding for supplies, PPE and alongside all of this you are seeing a system that is not aligned or mindful enough to you or your role. And there was a sense that you always had to say "*I'm doing everything I can because I have no choice. My patients need me, I know them and I'm not just one of their options, I'm their only option, so I have to keep doing that. There is just no break for me."* At the same point you're then having to deal with the bureaucratic processes and how those bureaucratic processes somewhat do not seem to value or recognise your contribution, or your work, or when they do it's really very slow. But then at the same point you're having to sometimes look at how you innovate your practice and you're trying to protect your whole team. It's that fact that you're having to deal with all of those things at the same time. And one of the key things- which is still ongoing- is that for the whole sector, whether they are independent or multiple community pharmacies, individuals were investing a lot of their own resources to keep the care going, and they felt very disappointed that, even at the end, they're still having to negotiate, to say we had to buy things to protect our team. When are we going to get that money back? And even during the pandemic, getting emergency funding to sustain us, everything just seemed to take a long time. And I think the emotional trauma of that is really quite terrible, because not matter how exhausted you are the first thing, you're doing is watching the news; are we going to get funding to help us to cope. I think if you're in that place it is really quite draining. But what really lifted the spirits was watching the outpouring of support from the community that you're serving. But that is also very transient because people move on, we've gone through this peak of appreciation to frustration which is the human narrative. I think for myself; I've been a lot in front of that; during the pandemic I set up initiatives to support care delivery and other collective community efforts. But even through all of that it's still the fact that there's been no physical breaks, I haven't had a break since 2019. It's constant. It is this unhealthy balance of some choices that have been imposed on us, but also feeling disappointed with the system, or scared of the system, to think we'll just have to keep going and keep fighting, because I can't for a minute step away. I think these are some of the things, and you can imagine how emotionally and physically that is going to wipe people out.

Thank you for sharing that and I think that a lot of the issues that you raised are really important for the Committee to hear, and it's important to hear the views of those in the pharmacy sector.

You touched on some of this in your last answer, but my next question is how supportive you feel the NHS is as a body in supporting colleagues. How supported do you feel?

I think sadly very disappointed with it. Pharmacy works as part of the NHS contractor model and you sometimes think that people don't appreciate the fact that behind the contract model are individuals who are always delivering more than what the contract expects of them, because that's what the NHS always does, everybody in it does more. Everybody does that because that's the whole point of being in healthcare. And I think that sometimes that particular insensitivity means that even at times like this when people were under a lot of pressure, you didn't see the system remembering that we are not releasing funding to a business, we're releasing funding to help people get PPE or to allow people to continue to do what they're doing. The other thing that became very obvious during the pandemic was also how other parts of the NHS, other contractor models, seemed to have a certain amount of support, almost as though for some reason there is a prejudice against community pharmacy. I think a lot of pharmacists were aware of that and thinking other people are getting what we're asking for, why do we need to go through further avenues or why does support always have to come at the end. And I think this is almost the conversation to have with the NHS: what is your problem with community pharmacy? It's not surprising that one of the things that's been reported with many colleagues is that the experience of going through the pandemic has convinced many people that they don't want to be a community pharmacist anymore. But even at the point where we are delivering care that is most visible and universally appreciated, we still are not able to endear any support from NHS England, so you think what happens when we go back to the old ways. What is this seemingly embedded animosity that seems to express itself and it's a difficult one to understand. And I see that from somebody like me who sees the NHS with different lenses, who sees what happens in General Practice, or in acute hospitals, and you think well actually it's not the same. It's very demoralising and I think again it gives you that sense that you are really on your own. Where you have people that are already very strained, if you reinforce that sort of message then they keep on going because they think 'ok I've just got to keep going, I have no fallback, I have no support' and then they get even more burnt out, and even more frustrated. So, I don't think the care is there. Last year- and I know this predates the pandemic- when the NHS announced a package of support for mental health, pharmacy was campaigning to be part of that, and we never got to be part of it. And I think some of those things may look very small, but what does it say to think that the NHS is not able to open up the mental health support that's it's offering to other people. It's almost saying to you, you're expendable. Either we're part of it or we're not. But to say that we're part of it, but actually if you suffer any hardship, we're going to be there to support you it really feeds into the psyche of the whole profession and I think that's what's been happening.

The inquiry is looking at before and after the pandemic so that case you raised is important to hear. This inquiry is looking at burnout and resilience in the NHS and different people in the NHS have different experiences and part of what the Committee wasn't to understand is the different experiences faced by staff from BAME and other ethnic backgrounds. So, from your experience, and what you've observed, do you feel the NHS is supportive of staff from BAME backgrounds and do you feel that there are barriers for people from BAME backgrounds accessing support.

I think absolutely the support is not…. I can't give credit to the support. I will say that because there has been, over the last year, a real awakening because of the Black Lives Matter movement about the experiences of BAME colleagues within the NHS, but we mustn't forget that this is not new. We have the NHS People's Plan, but we are addressing things that have been visible for quite some time. The problem is that we now realise, because of COVID, more of the health impacts of the inequality that exists in the system, but those inequalities have always been there and addressing them should

always have been a priority. Yes, it's great that we're waking up to it, but what about all the people who have lived with that inequality, that's their lived experience. While COVID has woken up the system to say this is something we can not tolerate anymore, for those people it has never been bearable. I think there is a point of looking back and thinking yes, COVID has exposed us, has increased our awareness, but the first point is that actually we are really sorry, we're sorry for all of these years, we never took this as a priority. That has always meant to people that actually your experience, you pain, your injustice just never mattered then, and I think that is important. We do know that historical and even current data tells us that people from a minority background in the NHS are less likely to seek support that is available to the whole organisation. Why? Because if you are in a place where you feel need to prove yourself every day, if you start feeling vulnerable the last thing you want to do is go to the people who make you feel that way, when have to tell every day that I'm up to this, I can do it. And then we have the evidence of the microaggressions and that is detrimental to health, including how the evidence tells us that being exposed to microaggressions is bad for your cardiovascular health. So, you can then start to see this whole picture emerging of thinking '*this is what we've done, this is what we've allowed to exist*.' While yes, it's improving, or there is now a policy to address some of those things, I think there has got to be some accountability that really comes in and says, "*what where we doing all this time*?" because I think if we do that then it brings out….in the future where we have leadership in position they will know that they will be held accountable. It cannot be that the point where we start to hold the NHS accountable just from the People Plan because in a way that almost says well what stopped actions before now? You had the Five-Year Plan, you had other plans, why was it that there was no prominence in these?

All of the statistics that are now helping us to shape the plans are not new, the only one sadly is the deaths from COVID, but the statistics about discrimination, lack of progression, these are statistics that have always been there. I think there is some sense now of also saying that, and to remember that a lot of people from those communities, like myself, you're not thinking '*oh everything is changed.*' No actually, you're thinking ok the system is more awake to this but actually accountability is needed to achieve anything. So, the system has to respond, and it has responded, but is that really going to change anything? No, not until the accountability structures in the system change.

Thank you. I recognise that this next question is a big question, and it might not be something that you can answer, but what steps can managers, trust leaders and policy makers take to ensure that staff from BAME backgrounds feel better supported in the NHS?

I think the first thing is to say is that each organisation should do an audit of where their current position is, which should be publicly available. For it to have a sense of accountability it needs to be transparent. Your staff who are from minority origin must tell you how they feel about your organisation, because you will feel ashamed if you find out that say 80% of them think that this is an organisation that they don't feel supported in, or valued in. I think that's the first thing. I also think that every NHS organisation needs to submit a Parliamentary report every year, a declaration of their performance. If we let it be something that has high visibility it will create a determination to say that we needs to addressed, because it is seen somewhere outside. If it has low visibility, it inadvertently becomes low priority. The second thing is that we need to address the things that we know statistically already exist, part of that is some of the things which are already in the NHS People's Plan- which I must say is a good plan. One of the things that I think too many times- and I think the NHS Peoples Plan in fairness addresses some of this- what happens is that you have a Five-year plan with no benchmarks along the way for their performance. You have a Five-year plan and say we want to see 100% in 5 years, well why don't we say for the first year we want to see a 30%

change, and then another 30% in the second year, so actually the closer you get to the target the more time we give to you because we know that you've made progress. Otherwise, what happens is that things don't change because people are juggling lots of pressures. And the system when we come out of COVID, or when we look at how we're going to come out of COVID, is going to be under tremendous pressure which means that some of the things we're talking about now, about staff welfare, about experiences of minority groups, is not going to be the big news. The big news is going to be how do we deal with the mental health crisis, how do we deal with the waiting lists. If we do not create statutory instruments that looks at these things, they will move down the list because our priorities will move on. I think we therefore almost need to create vehicles that mean that in the statutory responsibilities of an organisation these themes are embedded into it, because if they are embedded into it, whether you like it or not, you have to do something about it. And that makes it constant, that makes it part of the juggling. If not, what then happens is it becomes a very good intention, but if people are trying their best, or they can't in the face of everything else, then it will be forgotten. Especially when you remember that some of the people groups, we're talking about are the least visible, they're not the most empowered or vocal so it's a convenient constituent to forget or put to the side, because they don't have a champion that will keep pushing for them.

We don't need champions; we need researched value shaped and legislative backed accountability. And when you think about it there are still some NHS trusts and boards that have never had a minority person on the board. That is the statistics, and it is a reality. If we don't create something from the top, that looks down and brings accountability, you can't believe that the organisation itself will have levers that will make that happen.

I think that there were some really interesting points raised for the Committee. So, my last question is back onto the idea of burnout and it's what more could be done to support you and your colleagues to avoid burning out.

I think there needs to be a fundamental culture change, and I think it needs to be a change that is much, much more aware of how it fails us all at the moment. I mean a culture change for example that asks during the pandemic how did it feel for you to be campaigning to get PPE? What does that say about your self-worth? What does that say about your sense of value? What does that say about being part of the NHS and the commitments that the NHS has to everybody in it? What does it say to you that you are campaigning to be part of the mental health support for NHS staff? I think up until somebody tells NHS England that that is actually a really terrible way to treat anybody, much less people that are a core part of our system. That (pharmacy) is the third largest healthcare group, this is the second largest healthcare outpost in the NHS? These are important, as well as seeing that all this is mentally traumatic. The other bit about it I think is how do we change the relationship between the contractor model community pharmacists work under? In which it has the sense of the mutual appreciation of the pressures, bearing in mind that as a contractor you are simply responding to their timeline. How do we create a work balance and a way or working that is much more empathetic and that is much kinder? I guess the difference with this setting is that you have very little leverage. You have a whole ton of activity to do, to maybe get to a particular payment or renumeration window and it's overwhelming, but then you go onto the next one again. And I think they have created something that is not very sustainable but the people who are engaging in it, they have no choice. So, we need to almost get to the point where we do look at what we're doing and think what our indirect impact on people is; is this a realistic model, is this right to expect for those people to do. Because if we don't start to actually step back and say actually '*no we're not going to do this because this is unkind or unfair*'… we will keep driving things in a way that is very performance based, forgetting the people dealing with this. They are individuals who are also taking

care of people. So, what happens is that if you do that to them, they will have to make some compromises on what they're going to do, and many times what happens is that they don't take care of themselves. So, they expand themselves to meet this unattainable, unsustainable model that we've created and that creates burnout. We need to accept the fact that this is happening daily and while I don't think that it's only NHS England which is responsible for this, I think we need to see it as a crisis, as a wellbeing crisis, within Community Pharmacy part of the NHS. When we look at pharmacy, we may be surprised to find that pharmacy's one of the worst places for this. And what do we do about it? Because it's the public purse that is likely responsible for training pharmacists, most of them work in the NHS, or for the NHS, because it's almost 98% of pharmacists working for the NHS- there is no private pharmacy model in the UK. So, if they get burnt out, it is the system that helped to train them, and we are losing out on that expertise. So, there is a very direct consequence to this before we talk of the personal relationships, the family consequences, for that individual also. So, the system has a statistical reason to think we don't want this to happen because actually we all lose out.

My last thing is then to give you space for any final comments that you want to make for the Committee's inquiry into NHS resilience and burnout.

One of the things that I want to raise to you is you asked how I feel about how the NHS supports their minority colleagues and it is one thing that is very topical. In pharmacy itself, if you can imagine that you are already in a position like the one, I painted to you, you can then imagine what it feels like to then be a minority person in pharmacy. If this is a profession that feels marginalised, that doesn't get all the support, a minority person will feel even more marginalised. You're the worst in the worst situation in that sense. I think it's important to say this because the danger is that we're going to fix everything in a gradual /slow process, or we're going to deal with one thing at a time. We need to create a sense of urgency, accountability and voice for those people. Everything I've said today is coming from me who feels in a relatively privileged position, but for many it's worse, and their burnout, their self-confidence is worse. I think it's also worth thinking if this is the bad picture of what community pharmacy looks like or feels like, that means for those people it's actually quite a tragic situation, that there is a certain urgency about it and again it's how do we create that change. I think that's the way the NHS really needs to own it and where the NHS need to look at it. For example, there are some good things in the NHS People Plan so how will it apply to pharmacy? How do we not let it be that it is left to the good intentions of people to bring it about. So, the same things I've said about creating structures of accountability that are visible applies. I will say that for some of my colleagues who are currently experiencing some of the worst experiences, and outcomes because of their minority identities, they need the NHS to bring about change. It must itself be an organisation that is able to create this. At the moment it's actually driving a negative agenda with its relationship with Community Pharmacy, so it now needs to come in and start to drive more of the positive. Hold the different constituencies to account, including the contractor model, because I feel that one of the gaps that exists in the NHS People's Plan is how does it fit into the contractor model.

Transcript of interview conducted by the Select Committee Engagement Team and Participant E on Monday 1st March 2021. Interview conducted as part of the House of Commons Health and Social Care Committee inquiry "workforce burnout and resilience in the NHS and social care."

My first question is quite an open, general question just asking for some background on your role and maybe how long you've worked in the NHS or in your role.

I've been the practice manager in my practice for 26 years. I've been a partner for the last 15 years, before that I was an employed practice manager. Prior to that I worked for accountants and solicitors – this has been my only role in the NHS.

It sounds like you've got a lot of experience that would be really great for the committee to hear about. Are you able to give a really brief summary of your 'day-to-day,' or what the main part of your role consists of?

Gosh, that's really difficult. I suppose it's human resources, HR management; it's IT management, it's obviously all the financial management, finances, payrolls and those sorts of things; it's dealing with anything that comes in in terms of information, governance, confidentiality, complaints, security; and the building, building management and maintenance issues… it could be any of those things and all of those things.

That's great, thank you. It really helps to provide context to the committee, then they can hear the background of the people that we're speaking to. My first question is: what does burnout look like for you and your colleagues? What does it mean to you?

I think to me burnout means getting to the stage where you just don't see that you could ever catch up with the workload, that it actually becomes totally unachievable.

What impact does that have on you and your colleagues when people reach that point? Or even when they're not quite there but reaching that stage of burnout, what impact can that have?

I think people can get very depressed, very down. Obviously, some people have already left the job because of the burnout. I think it affects family. I suppose if you were to read the blogs that I'm part of as a practice manager, the ones that really, really bring it home are the ones where '*it's 2 o'clock in the morning, I can't sleep, I'm worried about going to work*,' or, '*I'm on holiday this week but I'm so stressed because I know I'm going to go back to work next week and it's just going to be absolutely awful*.' So it's constant. It's that all the time for people, I think more than it's ever been. It's always been a stressful job but it's an insanely stressful job now.

I can say I imagine but it's something that we almost can't imagine, you know, that it's been really busy. As someone in your position, as you said you deal with the HR, you deal with the governance, what challenges does it present if you have someone in your staff or even several colleagues within your team who are experiencing burnout?

It's very difficult because I think for general practice there isn't very much structured support for people who are going through… well there probably is a bit more now, having said that. I think there

are some more resilience tools that people can tap in to. But it [burnout] just impacts on the whole team… we're a good team and we support each other, and we manage to get all of us through it. But it's becoming harder and harder.

Is that since Covid, or was it becoming harder even before Covid took hold?

I think it was becoming a bit harder before Covid, but since Covid it's relentless I suppose, and there's no getting away from it. There is always somebody who is in tears, or stressed, or crying, or having a really bad day, or wanting to leave, or wanting to walk out. That's a daily occurrence now, whereas that never used to happen. We weren't in that situation before.

I can imagine that has an impact on the rest of the staff as well. Seeing their colleagues in that position is another thing for staff to have to deal with.

And also because we're so socially distanced at work now, because we reorganised all of our workspace to divide ourselves into two teams so that we would always have the possibility of one team. We no longer sit and have coffee together, we don't have lunch together, we can't actually mix. We haven't had any of our social events that we normally have – at least two or three big staff social events throughout the year. We usually have a Christmas party in March, so we didn't have a Christmas party this year, and we haven't had a summer barbeque. I think people are just missing out on the sort of support you get from things like that.

I think that's really interesting and actually something we've not heard before, but you are right that the thing with Covid is that with social distancing – a lot of the support that you might have had, the more physical presence and the more social side is missing, and that's actually quite important in a team; that social support can be really important. I think that's a really interesting point. I guess it also helps with team building as well, and that's been something that hasn't been able to happen. In terms of the staff, if they are experiencing burnout, does that have an impact on the patients and the people you care for? How does staff burnout affect the patients, if it does?

I don't think at the moment it really does affect the patients because not everybody experiences burnout all together and we do support each other, so I think we can still protect the patients from the effects of this at the moment. If somebody is really falling off their perch, then we just take them out of patient contact and that workload is taken over by someone else. But obviously that does then impact on the amount of work that everybody else has to do.

Yeah, you take it from somewhere and it builds up somewhere else… One of the things we've heard in other interviews is the idea that the patients, because they're the priority a lot of the time, staff are so focused on that and the patients are the last to know that burnout is happening, but that also has an effect on staff. Is that something you've found in your practice?

Yes, I think that's true actually. It is all about the patients all of the time. I suppose the thing about general practices, we're never too busy, we can never be too busy and we can never turn anything away because we're kind of the last resort for everything. So there's always the feeling that we have to deal with it no matter what it is, whereas I think in other services, you know, they write to us and say '*we've got a lot of people sick so we're just calling in our service and you won't be able to refer to us anymore*,' and we can't do that because we just have to carry on.

That's definitely interesting from that perspective, the idea that you can't just shut your doors, you always have to be open and you always have to be there for the patients and that will have an impact on burnout. That leads on to my next question: Coronavirus has been around for a year, what impact has that had on your services and in turn the impact that has then had on levels of burnout within your services?

Obviously we do a lot less face-to-face work now, but we actually have a lot more patient contact. We worked out we probably have 50% more patient contact than we had before. It may be done by telephone, but there is still far more of it. Also I think it's far more… because the patients are so worried and themselves so stressed and depressed, it's far more draining on the staff. The patient contacts are exhausting in some cases because you're trying to support people who are really in a very bad way. We've definitely never worked so hard in our lives as we've worked in the last year. It's been relentless.

Hopefully you'll get a bit of a respite soon, hopefully it's not too early to say that… I can imagine that, as you said, if it is relentless and it hasn't stopped then breaks and stuff like that become less of a thing you're able to get. Just in terms of that then, and you kind of spoke about it in one of your earlier questions - if someone is experiencing burnout, what support is available to staff who are experiencing it, or are in the early stages of burnout.

There is support from our local medical committee, so you can have one-to-one counselling from somebody who will help you with resilience, which I think quite a few people in my practice have done and they've found it really useful. I think that's probably the primary… but mostly we support each other, mostly we will all rally round and help our colleagues just because that's the way we've always worked.

What you said back then sounds great, but it seems that it's quite local. Are you aware of any national, England wide support that's available, or is it just not there do you feel?

It probably is there but it's not come across my radar, so I couldn't honestly say that I was aware of it. Perhaps if I went looking for it, I might find it.

That's interesting in itself, the idea people are not quite sure what is available is obviously something the committee would like to know. This is something that's come up in other sessions: do you think that staff are aware of burnout? Do you think colleagues are able to really spot when they're experiencing burnout?

I think probably in the last few months I would say people have suddenly become more aware of burnout, and it's become more of a worry for people. I think because everybody is so tired after a whole year of this, and now we see that the period ahead is even busier potentially than the period that's just gone – although there's light at the end of the tunnel – now I think that people are becoming more aware and more concerned about burnout because they just feel that, you know, they might just be tipping over the edge. I think we all feel like that now. I think that one of the big worries we have when we talk about it is how tired and how frazzled everybody is, and how much everybody needs a break. But you can't really take a break because that just makes things worse for everybody who's left. And then when you come back it's even worse. I personally haven't had a week off for a year, or any time off – just because that's the way it's panned out, and I feel now if I took time out of the practice, what I'd come back to would be so horrific I probably wouldn't be able to come back.

I think that's always tough, the idea of taking time off work, what you come back to and also the effect it has on colleagues. I think that's always something that people feel more acutely in other sectors. As people are more able to spot that they're having burnout, has that meant they're also more likely to seek support than they ever were before?

Yes, I think that's true. I think there are more people who are going to take up this counselling offer and seek support. People who perhaps I would have been very surprised would have done that in the past are now seriously considering it.

There's two sides to that but it's good that people are now more willing to seek support. From that, if you're aware that more colleagues are going to seek support, is there more that should be done to support you and your colleagues? What more could be done?

That's a difficult question. I suppose it's just about making people more aware of what is available, because if you don't know about it you're not going to access it. I think when you're in the midst of something like that you're not always necessarily thinking clearly, so you're not really… you almost need to have it there so you can access it really easily without having to go looking for it, and I think that people don't know enough about it. I's just not part of what we hear.

My follow up then would be: how would we make people more aware of what's on offer? What avenues do you think the government should go down of making people more aware?

Well, I would say probably the thing not to do is send me an email because I get about 700 a week. Sending out emails to GP practice managers in the expectation that it's going to find its target is a bit silly these days because with the best will in the world you're going to pick out the things that you have to literally do and pass on, and other things get left. So I don't know, maybe a media campaign or radio campaign? Something that would actually get to peoples' consciousness without it coming to the practice.

So just being more vocal. I think that's interesting what you said, not just going to one person to pass it on but how it can be more national. My final question, and I apologise that this is quite a blue sky question or a big question… the committee's role is looking at this issue of workforce burnout, what it is, what it means for people that experience it, but they will now also go on to ask the government to make changes to support colleagues working in the NHS and health and social care – is there anything else you want to tell the committee about burnout or resilience in the NHS that they could then pass on to the government when they're making their report and recommendations? It can be about burnout or about other things as well.

I think that the thing that would probably have the biggest impact on general practice is to somehow stop the negativity that seems to surround everything that comes from the government in terms of general practice. It's almost like they reinforce the idea that we've sat at home for a whole year and done nothing, and that is so thoroughly demoralising. Every time we hear it from yet another source: that GPs aren't really doing any work, and they're not working hard when they're working harder than they've ever worked in their lives and are all on the edge – that is the thing I think would make a big difference. We need positivity about general practice, and we need that to come from on high.

Is there any final comment that you would want to make to the committee or just for the inquiry?

The one other thing that I would really like to see is that we would be told first before something new comes out, instead of having to watch it on the BBC like everybody else, because that is also soul destroying. You know, you watch television in the morning and find out something that you

should know, that you know hundreds of people are going to phone up about during the day, and it's news to us. That creates workload in itself, that's huge additional workload.

I can imagine. Is that so people will ring you for clarity and you've maybe not been able to see it first. I can imagine that would create extra work and pressure for you, especially if you don't have the answers at that point.

Well, things like when they add new groups to the Covid priority groups, which is great but please tell us about it first so it's not announced on the BBC, and then we get all the phone calls. That definitely fills you with horror sometimes, when you see it and you just know what you're going to go in and face.

In the last 20 minutes or so you've spoken about – just to summarise and see if there's anything further you want to add – the idea that burnout has increased over the last few months, that at the same time that's mainly because you're busier than ever, and that unlike other services you haven't been able to close down over the last 12 months, you're almost the last point so you have to remain open and that has ultimately had an effect on burnout, and it has maybe made people more aware of burnout than they maybe would have been 12 months ago, and one of the biggest changes you'd like to see is around messaging, so the idea that messaging around support should become more national and not just focused on sending you an email – because I can imagine you're getting quite a few, even without Covid but especially now – but also just ensuring that you are kept up to date with messaging before it goes public so you have to time to let staff know and to be able to respond to questions and to prepare. Are they kind of the main points?

I mean, a really good example of that was the shielding letters that went out, because they went out to all of the patients and we hadn't even seen them before. So then we have patients phoning with questions on something we hadn't even seen, and that is very stressful, it's very difficult to answer questions on something you've not even seen. And it also makes us look a bit stupid, really.

Yeah, I guess you don't want that from patients, to feel that you're behind.

No. Well it doesn't give them much confidence in you, does it? If they thought you didn't know what you're talking about.

Transcript of interview conducted by the Select Committee Engagement Team and Participant F on Thursday 4th March 2021. Interview conducted as part of the House of Commons Health and Social Care Committee inquiry "workforce burnout and resilience in the NHS and social care."

To begin with, would you mind just talking a little bit about your role and how long you've done it for?

Well, we've got lots of different titles in my role but ultimately it's a practice manager role. I've worked in the NHS for 10 years, and before that I was working in retail banking. I had a big sort-of corporate career beforehand which I burnt out on. But that was a different burnout. I moved careers when that happened, I moved into the NHS and flourished in this career as well. I essentially started as an assistant practice manager, just thinking it sounded interesting, and within 2 or 3 years the practice manager retired and is was natural for me to step into their shoes and take over the running of the practice. It's a very reactive business, we're obviously very heavily driven by decisions that are made in parliament and in particular the government – they say jump and we say, 'how high do we have to jump?' And we have to jump. So it's very much driven from the outside, which is probably one of the biggest issues with it.

Obviously funding across the NHS has reduced in real terms over the years, particularly over the past 10 years. When I joined, things were still fairly okay, but I have seen a dramatic change in the resources that we have to provide our service over the past 10 years, and I've also seen a significant increase in the demands placed on us. I think – again I can't speak for the rest of the NHS, but certainly in primary care – we're kind of at the bottom of the line. So everything stops at primary care, everything's passed down to us or delegated to us, and we have nowhere to go with that. Everything that lands at our door we have to deal with. As other parts of the NHS have been squeezed and squeezed, they've been trying to move their work on and it's moved from one person down to another person. But unfortunately being at the end of the line it stops with us, and as much as we try to push back we continue to get an avalanche of work coming our way.

What I've noticed is the more the technology has increased, that has actually had the impact of pushing more work out. We've seen lots of different organisations that we've generally worked successfully with over the years have adopted new IT software suites or online portals, etc., and that's had the result of making things easier for them, because it automates it all, but it's meant that we have to put in all the legwork to put stuff into that portal, whereas we would have just sent information through to them before. They now expect us to upload the information. I have several pages of A4 log-ins – I can't possibly remember them all; I have to have it down in a secure environment. That's not an exaggeration by the way.

So technology… don't get me wrong, I'm a real advocate for IT making things better. But IT doesn't make things better all of the time. It can have the impact of shifting the work elsewhere, and I don't think enough thought is put into that. It's not until it actually lands that we realise the impact of it, and by then it's too late, it's in place, it's been tested, it's been rolled out and paid for. So by the

time it hits us it's too late for us to say, 'hang on a minute, this is causing us additional work; it might be saving you guys, which is all well and good, but when it's effectively pushing work onto us, that's not good.' We've only got a certain amount of plates that we can keep spinning at the same time before they start to drop. That's the big issue that I think we have in primary care, and it's an issue for everyone that works in primary care: GP partners, salaried GPs. Practice managers take the brunt of it to be honest with you, because we're the conduit between all other organisations and our practices. It's always been our job to sort-of shield the GP partners so that they can get on with their clinical work. We can keep running, but as practice mangers it's just been absolutely relentless. This is before Covid, you know. It's been absolutely relentless. It doesn't take long for a single straw to break the camel's back, and that's what we're finding more and more now.

I belong to a Social Media based forum of 3,700 practices managers belonging to that group, and we keep the group as secure as we possibly can so that we can be very open and honest and rant at each other, get frustrations out and that kind of stuff. It's been a real eye-opener, but it's been good. It's been good for everybody because we know that we're not alone, and often the practice manager's job is a very lonely job because we haven't got peers working in the same building as us that we can go and have a chat with. Other practice managers are miles away – some areas are better than others by having local support, but we're very fortunate in our area having the practice managers' forum that meets up once a month and which predates my time in primary care, and I've got a good few connections there locally. However, that's been broken up a little with the advent of PTNs. With practices going off in different groups it's tended to have an impact on the overall forum that we all run, so everyone's kind of gone off in their own groups and they are becoming smaller and smaller. It is a concern that those local relationships are being split up, but it has bounced back a little bit since Covid, to be fair, so that's had a positive effect in bringing this forum back together. There was a stage where we had 38 practices in the area. We used to meet up monthly, and virtually everybody would come. We would have at least 20 or 30 people in the same room – we'd have a great afternoon just being able to chat with people which was significantly good. That dropped off with this fragmentation, so we now only get around 10 a month if we're lucky. That's really disappointing. But I have to say since Covid hit, and now obviously taking that online, everybody seems to have come back to that forum now, attracted back to each other because of the pandemic that we're all having to deal with. So it's had a positive effect on that, and I hope it will continue. So that's kind-of what's hit practices really. We're the end of the line; we genuinely don't have much option but just to do it; we just take on more and more and more and we're at the stage now where we're creaking, and if things don't change quickly… it's close to breaking.

It's good to have you explain it so clearly and to go through how we get to this point. I wondered whether you would mind just talking a little bit about what burnout looks like for people, and in teams?

You can't really explain it when you're going through it. It's only afterwards when you've kind-of recovered and you can look back and reflect on it. I've been through it twice in my previous career, but also in the NHS about 2 years ago. Again, because it is relentless, you're just taking on more and more. Because of staff resourcing not being great, everyone is busy; everyone has constantly got stuff to do and there's no capacity to delegate. That's what happened to me. I was taking on more and more, and I felt I couldn't delegate to anyone because everyone else was up to their eyeballs in it. I want to protect my team, for the team to function. But I forgot about protecting myself.

Now the difficulty in primary care is that they tend to be businesses run by partnerships, so they're independent contractors ran by local GPs and ran by us. The GPs ultimately have decision-making ability for spending, etc., and the profits of the business are their wages, so there's a big conflict of

interest there with regards to how they're paid, and with resourcing their staff and managers adequately so that they don't burn out. I think we've reached the crux now where, generally speaking, the income in primary care has stagnated over the last few years – with a few exceptions, obviously – and that's meant that the GPs are effectively seeing pay drops in real terms, only giving the minimum pay to staff and managers which is affecting morale, and it's a bit of a downward spiral… sorry, going back to burnout. I've gone off on a tangent there…

It's the relentless addition of more and more work. Eventually it got to the point where I was really struggling, there wasn't any… I did try to get a PA, an assistant, but I was told no. If you've got very supportive partners you will be helped, because they would see that as an investment for the future, but when you've got partners who are very money driven, which many of them but not all are, it will restrict the amount of resources you can get to help. That's what happened with me. I feel, dare I say it, that I was bullied for about 9 months. I felt bullied, I should say. There was one partner that none of the other partners were sort-of strong enough to stand up to. I felt I was treated badly over a number of months, and that's what broke me ultimately. It's not the workload – the workload got me to the cliff edge – but it was the behaviour and the way I was treated that pushed me over that edge. Whether or not that was deliberate is arguable, but I went off sick for probably 3 months and then returned on a staggered basis. But the behaviour towards me by this one particular person continued, and it got to the stage where I couldn't live with it anymore, I couldn't cope with the demands of the job and the behaviour towards me. As luck would have it I got to another practice, as somebody there was leaving. I came along at exactly the right time. I had a chat with them; they wanted me and I handed my notice in. I wouldn't say it's been easy since then, because I've gone from one practice where I knew absolutely everything to a practice where I knew nothing: a huge practice, about 6 times bigger; a very different environment. But probably about 18 months on I feel I'm at home. I'm doing well. I've got a very supportive group of partners, but there are still a few partners there that question the value of their managers, and I think this has highlighted for me – and I have heard it from other people in the forum as well – is that I think there's quite a lot of time when practice managers have felt that they are being questioned with, '*well, why have we got a practice manager? What do they actually do all day?*' And it's very, very hard to justify ourselves when we're asked, because we deal with anything and everything all of the time. Often it's just random things that come in that you have to deal with as a one-off.

So I think the 2 things are: the amount of work that's falling on us with nowhere else for it to go; but also the way that we are treated, the behaviour that we see. Also the recognition for what we do isn't there, and I don't think it's very well understood. That causes problems because if we have issues then we're seen as a failure, rather than for the help we give generally. Knowing that there are some GPs, even in this practice, I mean there have only been a few that I know of who have been grumbling, but they're asking, '*well, what does he do? We're paying him £xx,xxx a year, what does he do?*' And I can't put into words very easily what I do on a day-to-day basis. I just know I'm extremely busy all the time… and I never miss a deadline, and I always make sure everything is done on time.

I'm sorry to hear about some of those negative issues you raised there, they're difficult things to talk about.

It's about mental health, ultimately. You get to a point where you cannot see a way out and it starts to affect your health. That's the point where you have to get out. I'm seeing it happen to more and more people on a day-to-day basis on the group online. We're holding on by our fingernails most of the time.

My next question was going to be about the impact of burnout on your colleagues. I think you've mentioned it a fair bit already – is there anything you wanted to add about impact on colleagues?

Burnout affects everybody. If we're not functioning properly it affects the day-to-day functioning of the practice straight away; it affects the business as a whole and the impact of that can be a high cost to partners. If they haven't got somebody on the ball running the practice then it will cost more to run the practice, it's as simple as that. So they take a very short-sighted view, those that are looking at money. You need to invest in your staff, you need to provide staff support, and you need to recognise that they're doing a really difficult job. Unfortunately GPs – and this is very much a generalisation because they're not all like that – but many GPs can be quite selfish in what they want to happen in the practice. They want to make sure it benefits them at the end of the day, and they do take a short-sighted view. GP partners don't get any training – no GPs ever get training in people management, occupational health issues like mental health or burnout or anything like that. Personally I think they need to be made more aware of it. But being small partnerships and small businesses, there's no overarching NHS control over it. They're independent, and by that very nature it's difficult to write messages to reach them forcefully, unless they choose to listen. I think that's an issue.

Thank you for sharing that. We've talked about the impact of burnout on yourself and your colleagues, and about where it comes from. The next question is about the impact on patients that staff burnout might have.

It's probably not an immediate effect; it will be an effect that kicks in 2 or 3 months afterwards. But ultimately general practice is a well-oiled machine. It runs smoothly, and it's my job as a practice manager to make sure all the cogs are working, well-oiled and maintained. When that job is taken away, over time that oil will become sludgy, the parts will start to wear and creak, and eventually it will seize up unless someone else comes in to maintain it. So I think most people see practice managers as being fairly indispensable, but at my last practice it was made very clear to me that we're all replaceable, and that was a bit of a kick in the teeth when you're working so hard to basically keep their earnings up. Being told that everyone's replaceable doesn't exactly motivate you very much to carry on working as hard as you are. Again, we're moving more on to the solutions now of what needs to be done to help practice management. I'm not sure if you're looking at primary care specifically or the NHS overall… it's definitely not one size fits all. It's broken up into lots of different organisations now, and every organisation has their own challenges. Primary care is a huge part of the NHS, we deal with 90% of the contacts of the NHS overall, we're the gatekeeper to everything else. If primary care fails, the NHS fails, and that's no exaggeration. We're often forgotten about, everything's focused on big, shiny hospitals. Yes, we are independent, small contractors, small businesses effectively, but we do hold up the NHS. I genuinely believe that.

We've heard from other people that we've spoken to that the patients of course come first, and the patients have to be shielded, that work can't be turned down. I'm going to move on to another question in a moment but I wondered if there was anything else you wanted to add around the impact on patients?

Yes, sorry. I was going to say that the effect it has on patients is not immediate, but it does have an impact because the level of service will gradually deteriorate if the person leaving that service is not able to function properly. Lots of work piles up on their desks, get forgotten about because that's the practice manager's job; things won't get done; deadlines would get missed and therefore we would miss out on funding coming in, the result of that is less money to provide the service. When things start to go wrong it can snowball very quickly and have a big effect over another month or

two. I didn't keep in contact with any of the managers from my previous practice because I needed to get out and put that behind me, but since then I have spoken to people and it did [the previous practice] start to break down. They didn't replace the practice manager, they thought they could get away with something cheaper and so the way it runs has deteriorated a bit since then. So yeah, again they thought they could save money by getting cheaper people in, but people weren't doing the same level of work. On patients – they are important, we always look to maintain the level of service we provide. But it will deteriorate if all the cogs deteriorate, and patients are the last thing to be affected in all honesty.

Thank you. I want to talk a little bit about Covid-19 now and the effect that's had on levels of burnout in the NHS and social care, and maybe comparing more generally how things were before and how things have changed.

Yeah, obviously it has been a huge change. We've been able to change the way we do things quite rapidly, so a lot of the things that I had in mind were just sort-of from the technology point of view… We have pulled together as a team, but the biggest problem has been information flow. We've got information late, and still we hear about things in the news before we hear about it through the right channels. We've had patients calling us and telling us something and it's the first we've heard of it – that's a horrible position to be in. For that to still be happening a year on is very, very disappointing to be honest. I wouldn't put the blame entirely on the government, but the majority of it probably… in terms of the impact, we're just playing catch-up all of the time. We're having to react; we're having to make huge changes that would normally take months to prepare for, literally in some cases overnight. We're good at that in general practice. We're good at reacting, we're good at finding solutions and putting them into place – that's why we work so well. But it's been incredibly challenging. We have had a lot of work taken away, probably paperwork taken away, but we've had more challenges to replace that. It's new to everybody, so obviously it's very well saying in hindsight '*you could have done this or that*.' But I think the biggest problem has been information, keeping everyone up to date, and involving people in decisions. Decisions have been made at high levels, clearly without any thought about how it affects everyone on the front line, and that's been extremely demoralising. They need to be speaking to people on the front line to say, '*we think they're doing this, do you see any problems with it?*' Certainly as practice managers we're perfectly placed to do that. I've done that on behalf of our CCG locally, I've been an active member there, and they'll tell me, '*we're planning to do this*,' and I can give them a list of 10 things it will impact on off the top of my head that they're going to have to work through the solutions to. Whereas locally it's easier to manage that, national decisions are being made that we should have been consulted on at the front line first.

Thank you. The next thing I wanted to talk about and hear your opinion on is what support is available. It was interesting to hear about the Facebook group you help run, but I wondered if you could talk more generally across the service? What support is available, and are people using it?

To be fair there have been a lot of details sent to us about this support number, that support number… there's a lot of stuff there, and we do obviously try and let our staff know about it as much as possible. If there's anyone we've noticed with an individual problem we'll let them know there is a helpline. I've not used any of it myself, I haven't felt the need to. I don't know if anyone else has, that's confidential to them if they have… So there is the support there. It's all online or on the phone which is obviously necessary because of Covid. But it's made me think we needed this anyway. We don't need it because of Covid, we needed this beforehand, we needed this a few years ago in all honesty. But I think Covid has brought it to the fore, that NHS staff do need support, and not just because of Covid. Before Covid was even a word, we needed this support in place to go to. I needed

it when I burned out. I had to use local support services with an online program. I didn't even get to speak to someone over the phone. Mental health services are really awful at the moment. There's been an increase in what's available in mental health services… that needs to continue, but that should have been done much earlier before Covid.

There's obviously a problem here and things have been difficult. What support could there be? What could be done to help people?

I think perhaps more.. it is difficult… The working conditions need to be improved for one thing. It was relentless before Covid came along, and that goes for every part of the NHS but particularly primary care. The trouble with support is that it has to be cleared with every individual practice, it's got to be both wanted and invited by the GP partners at the end of the day. Again, I think more education to GP partners about what they need to be thinking about for their staff, particularly their managers because they do tend to take flack coming from below and from above, so we've got nowhere to share it. Some partners are better than others, but there needs to be a concerted effort to educate GP partners in managing teams and being aware of HR issues, being aware of burnout, being aware of the signs of burnout, and to give them the resources to be able to offer actual, real support to people when they need it, and also to make them aware that people aren't failing when they're burning out, they just need support. If you support them through that period, and see them through to the other end, you're going to have a loyal member of staff for the rest of their working life. It's making them realise what the benefits are of investing in their staffs' wellbeing. That's the key. It's education and being able to provide resource… It's the same in the business world: it's cheaper for you to retain your staff and their experience than it is to find new people. That's a basic premise of business, I think it needs to be clearer for partners. They're very money driven but that's because they haven't been trained or learned anything else.

Thank you. Do you have any final thoughts you would like to share with the committee?

I think we've pretty much covered everything I see as the main issues. It's more from a practice manager's point of view, that's who I feel I'm representing… it's close to my heart and I've seen so many other people open up in the Facebook group with their concerns, worries, and day to day problems.

Transcript of interview conducted by the Select Committee Engagement Team and Participant G on Thursday 25th March. Interview conducted as part of the House of Commons Health and Social Care Committee inquiry "Workforce burnout and resilience in the NHS and Social Care."

To start today, are you able to give some background about your role; so what your everyday role entails, and how long you've worked in the role and within the NHS.

I've been in my current role as a ward sister for three years. As a ward sister I oversee the shift and ensure patient and staff safety during my shift. I also coordinate care with the multi-disciplinary team during my shift. There are some management elements to what I do everyday such as returning people from sickness absence, answering safeguarding concerns, dealing with incident reports and also doing management meetings in the absence of the manager. Recently, I have a dual role, so I'm not just a ward sister. The ward sister role is 15 hours and I've got a research role for 22.5 hours a week and in that role, I am helping to develop a research project. So there is less of a front-line element to that especially the part that I am on which is development, so we will be patient facing when it comes to implementation. I've been in the NHS for 20 years, I started in June 2000. At the time there was no OSCE exams to take, it was a six-month adaption period. We were paid as healthcare assistant roles for that adaptation period until we were registered with the NNC. I have also taken CNS roles in my previous employment history with the NHS.

That sounds great and the project sounds really interesting, so I hope that goes well. The inquiry is around this idea of burnout, so my first question is what burnout means to you, and what does it look like to you.

Recently, I have been vocal about burnout and I have come to the matron level saying I need to do something else because I am burnt out. I am somebody who is forwards with their development and I've really learned the role, so at the workplace I am somebody who is reliable when it comes to clinical workload. I can teach and I can carry out the clinical workload no problem and in fact I am someone who is approached most by people who get stuck, so I troubleshoot clinical issues. Apart from that I do everything else that a nurse in charge would do. But because I am approachable and my clinical skills are highly valued, I am stopped more than the people who should be doing the teaching, the clinical nurse and educators. And that burns me out because I end up doing their job as well as doing mine in the timeframe that I need to do it. But I always think of the patients and if the educators cannot come and troubleshoot the situation I will have to because there is a patient at the end of the situation, and they don't deserve to be left in limbo. So that is me, I am very patient centred, and the patients are the reason I come to work because I end up going home and thinking 'I've helped someone today.' Along the path I do other supervision and teaching as well, that's also part of my nurse in charge role, and part of being a registered nurse. So burnout is when everyone just shouts my name because I'm just the person they want everywhere else. There have been times when I handover a task to the next shift, but I come back and they are waiting for me to do it. That contributes to my burnout and that's a chronic occurrence. It's so difficult for me to finish work in the timeframe and I end up staying at the workplace well over the time that I am supposed to be there because I get so overwhelmed with work.

The thing that suffers is documentation. I can deal with all the clinical workload, I can deal with the facilitating, but it is the sitting down quietly and documenting what I've done that I struggle with, because I get disturbed again. Even if I say can I please just have half an hour of quiet to write I hear my name again and most often I think of the patients again and say ok I just need to get up and do it. But that again contribute to my feeling burnout. Also, despite being a role model and despite being really highly skilled in the work that I do I get passed over in promotions and that again contributes to my burnout. I'm not clear on the reasons for that, I think my interview skills have been very poor, I must admit I have to really work hard to get some interview skills in me and practice them.

During this pandemic, we have daily briefings and they can occur anytime during the shift and that's run by the matrons and the managers, but they tend to say to me please stay with the patients while we attend the briefing, and some of these are one-to-one, so I tend to be the nurse to go to the bedside and deal with patients while everyone else goes to the briefing. To me, the briefings seem to go on forever and when I ask them what was discussed, I get one line and I'm like 'really, all that time for just that.' And that seems to be a chronic thing. Sometimes I volunteer, I must admit, but then it became my reputation 'oh she's there, we can go for a briefing' Then when I say I would like to go to a briefing today actually, would you mind staying with the patients they say 'no way'. Again I think of the patients, that I shouldn't leave them in this situation, so I end up doing it. And that actually makes me feel devalued, especially because I don't get someone coming to me and saying this is what happened, this is what was discussed. In the same way with training sessions, I tend to give in and say go to your training sessions, I'll go to the next one and then when it's my time to go I find that they've all gone for lunch or breaks so I just keep missing out. Also recently there have been issues with some personal issues, in a way that when I apply for academic or leadership courses I am not at the top of the line. Three years ago when I joined the team one of the things I had mentioned to management is that I would like to take some leadership courses, I know they are offered here locally and are promoted by the Trust, and I would really like to take part. Three years later it's still not my turn and I know two of my colleagues who have taken part and have since left the trust, yet it is not my turn. I seem to have to consistently ask for these things, like CPD and academic leadership, and am not put on them automatically. That leads to my feelings of being burnt out.

Thank you for that. There is a lot there but thank you for sharing and for letting us know the things that lead to burnout. We appreciate that it's a really difficult time with the pandemic. You talked about documentation, and how you don't have a chance to do that side but are there any further challenges that burnout presents. And that's not just burnout that's experienced by yourself but also burnout that's experienced by your colleagues. So what impact and challenges does overall burnout on your team present.

There is consistency with what I said, and some of my colleagues are in the same boat. We go the extra mile to finish the job because we want to have days off and we don't want to be disturbed when we have days off. So you come back do that again, and come back, and you hold out for as long as possible. The personal impact on me is I am scared of complacency. I've always been a high standards person, I strive towards the highest standard, even when there is so much pressure I do not give in, patients do not deserve less than the standards we give. But I'm afraid that burnout will make me go towards that complacency, when I'm no longer feeling at my best I will make an error and I will drop my standards. In January of this year I was close to that, I was close to no longer performing at my best because circumstances around me have been very difficult. But also, you feel very harassed, very discriminated against because when I felt like I could no longer continue I asked for help- because again I think of the patients they don't deserve me being in that state- I need help

and then you hear a lot of people saying you should be able to do that. I had to knock on offices in January because of my struggles running the ward and supervising people, and I said you're nurses as well please come out to the floor and help out, there is a long delay and they don't like it and they weren't very happy to see that reaction. However, when others asked for help the management are more ready, because the staff asking for help are a lot more junior, and they say 'ok they need help.' But when I ask for it, because I'm a more senior band, my shouts of help are less appreciated.

Thank you and some of that comes onto my next question and it's what support is available to staff experiencing burnout and what barriers are there to accessing it. You did cover some of that in your previous answer but if there is anything else that you want to add.

There are counselling services set-up and wellbeing services set-up, but I find that with burnout comes physical and mental exhaustion and it's almost a lot of effort again to sign up for these services because you just want to rest. And then when do I fit it in with what I'm doing is another question. Do I really have time to go to counselling, or do I have time to attend wellbeing sessions, because I just want to rest. I work so hard when I am at work so that I can get a good rest. Because what can happen, and I experienced this with my other colleagues, is that you get contacted on your days off and on your annual leave because you didn't seem to have finished the job, or documentation is not clear, that you get contacted about what you have done. I acknowledge that the services are available, but I struggle to fit it in my schedule. I don't want to do them while I'm resting. I must admit that I haven't had the chance to use the services because of that.

Interesting points there about the practicalities of the support. It's there but at what times do you access it; is it during the working day or during your own time. That's an interesting point so thank you for raising it. Obviously, this year has been, in many ways, an unprecedented time for the NHS and the Committee recognises that and the Committee recognises that burnout existed before Coronavirus but that it might have been exasperated by Coronavirus. So my next question is what impact has coronavirus had on burnout in the NHS?

It's highlighted it. It's enhanced it. Everything is a lot more difficult to do, and it takes a lot more time to do, because of the infection control practices. Now you have to put on PPE before you attend to patients, which is correct, but in the past you didn't have to think about that too much, handwashing was enough. It slows you down, but it's necessary to make the practise safer. The only positive thing with the coronavirus I suppose is the convenience of learning in a virtual way, however that relies again on a good internet connection. So you don't wait around for someone to arrive, you can just log onto a computer that's the one positive thing, but it relies on good working equipment to be successful. There is also the increased pressure because coronavirus has made a lot of people ill and you then have to double up on what you're already doing. Apart from being an educator and a mentor, nurse in charge and manager you then have to really be at the forefront with the patients, with your staff. It is physically draining, emotionally draining, and in the back of your mind you think have I done enough to keep myself safe? And breaks and lunches and all that suffer with the coronavirus, during the worst of it anyway. A lot of people who are in the offices came down to help facilitate, giving out drinks and to help with processing. A lot of people gave food actually, which is nice. There was more community spirit, which was really good. That's another good thing that came out of the peak of the pandemic. But you do end up teaching more because there was a lot of help, but they don't know what to do. It takes up a lot of your time again, but because the willingness is there it's amazing. I've met a lot of amazing people during the peak especially. The willingness is there so even though you are busy you really provide the time because you don't want that enthusiasm and spirit to die down immediately. You give them time to be nice and be kind and it

really is a lot of effort when you're under pressure to stay calm and to stay kind. It is a lot but that is being resilient. You just have to.

In your first answer you said that for you the patients are always at the front of your mind and we've heard something similar in the other interviews that we've done for this inquiry; that for those who work in the NHS the patient is key and always at the forefront of their mind. So my next question then is do you think the patients feel the effect of staff experiencing burnout. Does burnout affect patients or are they the last to know what is happening.

I work in a rehabilitation unit, so patients are long term and they do feel the difference in you. They will say 'oh you're grumpier today' or 'you're not smiling today' and it's very difficult to respond to that. I can't tell them how I'm feeling because that's not productive or helpful in a patient/nurse relationship. So I can say, and I've learnt to say, I am having a busy day yes. So in my line of work they do feel it, in fact they are the first one sometimes to notice it. Lots of them are just respectful, they will just take what you say. Actually observations like that from the patients help me re-focus, and think am I doing this too much now, is the pressure really showing in me today, so I quickly have to act on that. But yes, it does impact on them.

Yes, sometimes that third party perspective is quite useful isn't it as you take a step back and reflect. So part of this inquiry is looking at burnout and resilience, but also understanding that different people in the NHS have different experiences and my next question is do you feel that people from BAME, and other ethnic minorities, are more likely to experience burnout or to feel the impact of burnout. Is this something that you have observed or that you've experienced.

Yes and yes and yes. It seems to happen a lot more with people like myself and my black colleagues. We tend to have the front-line roles, the patient facing roles. A lot of our colleague who are in management positions are our white colleague and a lot of what they do isn't patient facing. That for me is a very sad occurrence and it does need to improve, and I believe there are now strategies to improve that, but yes we seem to be the ones who do more. At my level, and the ones below me, we have to work harder for things we want as well to help us refocus our work ethics. Like I said earlier I need to push for some academic and leadership qualifications, it just doesn't come easy for me. My example would be in my previous role as a ward sister, in my current trust, I had been a ward sister for ten years- I was the only band 6 nurse and there was a band 7 line manager and for many years we worked as a manager and a deputy manager. And then there was a need for another band 6- according to the trust-so this new person came in as a band 6 and in the first three months of his role he was offered leadership course. I said to the band 7 I've been here 10 years and you've never offered me a leadership course and she said 'have I not?' and I said no you haven't, there is a management course that I did 5 years ago and nothing after that, and whenever I come to you with you say 'I've already done the TNA and I haven't included your request'. But three months after this person started, he is offered a course and I just felt hurt, very very hurt. And this new band 6 is a white person. Also you don't want to think of it as race related but it makes you feel like it is, and I don't know if it is but it is but it just keeps happening to me.

So it feels like a pattern.

Yes. And I have to work extra hard to get what I want and to get what I require.

Thank you for sharing that and I think that experiences like that are really important for the committee to hear to help formulate their report. Are there any further barriers for staff from BAME and other ethnic minority backgrounds to access support?

One of the barriers that I've encountered myself is applying for National Leadership Courses, like the Mary Seacole courses. These are national grants but it's really difficult to apply and I say that because the application form is too exhaustive, and it discourages people. I've heard a lot of my colleagues say I've tried but the application form is too exhaustive, and it's asking too much, and so they get really disappointed. Sometimes there is just semantics, it's the language. You feel like you don't qualify when you're reading the programme, and you're reading through what is required of you, you don't feel like this is for me even when everyone else says that it is. So that needs to change I think, it needs to be a lot simpler for people who are wanting to get through it. Even at the level of a band 5 nurse, the staff nurses, the language used isn't really a par on what they're doing. So they have to escalate the application form so that they can fill it in properly. And sometimes they don't want to do that, so they just forget it. But also there are elements maybe like a support group, if there is something like interview skills training, or any other development training, that could help with assertiveness and can increase skills and it can be targeted to the ethnic minority groups. In my twenty years in the NHS I have not been in a room where I could fully share myself, because there have been a lot of strong characters, and it deters me from sharing. I haven't been in a room where it is all ethnic minorities, I don't know if I will feel safer to share in a room like that, I feel like I will but I don't know because in 20 years I have not had that chance. I'm always looking for opportunities to share, but I haven't found a room where it is all ethnic minorities and I could just freely get to the table what I want to say because it always feel like this person is too strong. And maybe that is my problem, I recognise it as such, because it shouldn't be a barrier. But I have to work on that.

Thank you and as I say I think it's always important for the Committee to hear the different experiences so thank you for sharing and I think the points that were raised were really interesting and insightful. My last question is around how we can move forward into the future. What measures do you think should be introduced to support staff who are experiencing burnout or even preventing burnout.

I think there should be, like with the peak of the pandemic, the easily accessible redeployment programmes. If you just want to have a bit of a rest from what you're doing, because your concentration is dwindling and your patients may suffer from that, then there should be that easy arrangement within trusts to see if you can help somewhere else, where you can learn new things and get a fresh start in many ways-even as a secondment. That's what I did for myself. I entered into research as a secondment initially and loved it, so it gave me a fresh new feeling, of learning again. But a lot more coaching and mentoring. I had coaching awareness sessions, but they were not personal coaching sessions, it was just on knowing what coaching is and all that. I think in every hospital there should be a pool of coaches and then you can choose which one or try to put yourself out there and they can say 'I'll take you on, no problem.' But there isn't one where I am. Like the counselling there is coaching out there for everyone to use, but I really like to see who can coach me. I think it is a very personal thing and I want to choose who can coach me or who I'd like to see coach me. And then the acceptance from management that if people do avail of this coaching that they are given the time for it because sometimes that is the difficulty.