HEE Workforce Strategy

Consultation submission by HCSA

April 2018

Question One

Do you support the six principles proposed to support better workforce planning; and in particular will the principals lead to better alignment of financial, policy, and service planning and represent best practice in the future?

The six principles are:

- Securing the Supply of Staff
- Training, Educating, and Investing
- Careers, Not Jobs
- Widening Participation in NHS Jobs
- Creating 'Model Modern Employers'
- Creating a 'Joined-Up' Workforce

HCSA response

Whilst the six principles are desirable, they involve many challenges that need to be acknowledged and considered at length at the planning stage. Below we outline our response to each in brief.

Securing the Supply of Staff

To secure the future supply of staff there needs to be considerable forward planning. Staffing requirements need to be projected 10-15 years in advance with a measure of leeway/excess. This will require greater insight and assessment of the demographic trends at play, and the medical and social care demands that this will involve. It should be said, however, predicting future population levels, particularly the older, more healthcare-intensive segment of the population, while not an exact science is a realistic ambition. From this, by harnessing existing knowledge of the care needs of a given segment of the population, an approximation of the staffing need can be extrapolated. There are of course uncertain variables which cut across this relatively clear picture – not least the uncertainty of staff emigration and immigration, those leaving the NHS because of factors such as poor pay and disillusionment, to other jobs or as early retirement. Greater government investment and consideration of these factors will also be necessary in order to secure the supply of staff.

A future workforce strategy need to address the historical reliance of the NHS on a considerable proportion of its recruits from overseas and Europe (10 per cent of hospital doctors and 7 per cent of nurses) and the closing off of these sources arising from Brexit and the rapid economic development of South Asian economies. It will be necessary to develop the means of balancing overseas supply with indigenously produced supply in the short- and mid-term.

Retention and returner programmes require increased and imaginative development and roll out in a future of increasing feminisation of the NHS professions. The perverse conspiracy of factors which cause early retirement of skilled professional and reduce the opportunity for return should be identified and eliminated.

Training, Educating, and Investing

Investment in the education and training of new staff is to be encouraged. In several areas this has already happened. For example, cardiac perfusionists, diabetic nurse specialists, and infection control nurse specialists. These roles are focused with specific needs and functions. However, extending the roles of certain professions or trades is only reasonable when the underlying rationale is clinically motivated, rather than administratively or financially driven. Developing and extending roles should be driven by clinical need and not an attempt to re-create a service for less money. In this case there is a risk of creating an environment where roles and functions are undertaken by staff only able to provide a limited 'cut-down' version of the real thing. And of course, while the consultation document avoids mention of this, there must be appropriate investment in education and training in order for it to truly effect positive change.

Careers, Not Jobs

The opportunity to increase skills and experience is to be encouraged and supported. However, progression between the different professions is not always appropriate. Often retraining rather than progression would be required in order for an individual to enter another professional group. Of course, some crossover skills and experience would assist in this process. Within more closely aligned professions, creating pathways to allow individuals from one staff group to progress to a higher staff group, via a transitional training process, is sensible. For example, those employed as a medical laboratory assistant could undertake significant extra learning and training to then become a biomedical scientist. Indeed, this is what many individuals have done in the past. Similarly, State Enrolled Nurses (SENS), trained and competent at all aspects of patient nursing on the ward or clinic, could undertake extra tuition and training to convert to a State Registered Nurses (SRN), who take on managerial and greater pastoral functions amongst other extra duties. HCSA supports the principle of career progression and transition, but it needs to be approached with caution and with medical expertise and training needs at its core.

Widening Participation in NHS Jobs

We acknowledge the need for widening participation to bring underrepresented groups into the NHS. However, this must be weighed against the need to employ the most qualified individuals. "Quick fixes" such as quotas and positive discrimination have a role to play where two or more candidates of equal skill are involved. However, when it comes to medical grades in particular, the issues affecting in particular any socio-economic imbalance in the intake are well beyond the remit of the NHS – the factors are societal. It should be noted that women medical students outnumber men, and have done for some time. We should ensure that this trend is monitored and that as these intakes progress, a similar balance becomes apparent at higher grades. Steps to mitigate the impact of part-time working during childcare or once child-caring responsibilities have lessened – additional training or other assistance upon return, as well as more family-friendly conditions will undoubtedly assist in ensuring this is the case. However, where it is not, and in particular within specific specialties or geographies, it is not sufficient to sit back. A clear, ongoing monitoring framework should be maintained to assess variance in progression and the health professional associations/trade unions should have a reserved high-level role in maintaining this structure, along the principles of partnership working.

Creating 'Model Modern Employers'

We would welcome an emphasis on creating better employers – the current culture leaves much to be desired. The current environment can be described as being a 'culture of blame', bullying and harassment, demands on 'performance', excessive managerial control, excessive paperwork with micromanagement, and overburdening over-regulation and scrutiny. Addressing these issues is essential for recruitment and retention, staff well-being and morale, and patient safety. The NHS needs to focus on creating an environment that supports rather than undermines its workforce. We present several recommendations, setting out what reforms and changes are needed in order for the NHS to become a 'Model Modern Employer'.

Creating a 'Joined-Up' System

We support the principle of creating a 'joined-up' system. We see the benefit of service, financial and workforce planning being intertwined and guaranteeing that significant policy change which has workforce implications is thought through and tested. However, we are concerned with the approach currently taken. A reduction in the qualification and expertise of the workforce to the minimal level may enable management to provide a cheaper service, but this will be to the detriment of patient care. Cost should not automatically trump expertise.

What data do we need to ensure we can plan effectively, and how do we align across workforce, finance and service planning?

Current Workforce Challenges, Future Workforce Challenges

We need far better-quality data to be able to assess all the factors and trends within the NHS workforce. With regards the medical workforce, it has been startling to see how little central data is currently being collated to assess, for instance, the true level of vacancies or the trends and drivers around retirement. While at one extreme statistical monitoring can become a pointless tick box exercise that serves little purpose other than frustrating the individuals concerned, a well-planned and focused set of assessment criteria that encompasses all Trusts is necessary in order to be able to establish a true picture of the current situation before even moving forward to looking at the future situation. Whilst the collection of data in needed to ensure effective planning, we also need to move beyond data collection and revise current systems. The focus needs to move beyond simply collecting data that illuminates a problem, and instead action is needed to improve systems and tackle workforce issues.

In terms of data there is a clear need to establish a baseline assessment of 'service demand' versus 'available service supply'. The approach within STPs, for instance, where budgets are set and then services are drawn up to fit makes little sense and risks higher costs as, if service assumptions are wrong, ultimately more will be spent on stop-gap emergency staffing or patients will be allowed to worsen to a point at which cases become more acute and take up greater NHS resources in the long term.

We already have some measure of patient demand, on the one hand, in the form of elective waiting lists and A&E statistics. Each NHS provider should make a detailed service demand data collection, with central assistance to help with accurate modelling, and relate that to workforce demand.

In order to establish a baseline on the workforce demand side, we need to measure the requirements of the service to meet a given level of care versus actual available number of staff. This will reveal the

real current staffing shortfall, therefore allowing a clearer picture when drawing up a longer-term strategy. For instance, for hospital anaesthetists it is possible to calculate the number of sessions a week that is required to cover all service sites. It is possible to calculate how many Direct Clinical Care PAs are required. Weighed against this is the calculation of how many DCC are actually available from the Consultant and SAS pool, taking into account sickness, maternity leave, study leave and other forms of leave – such leave amounts to a significant additional staffing need, which in turn should be modelled to reach an accurate value. This could be as high as 25 per cent in additional staffing requirement.

Such data would need to be regularly reviewed, and trends drawn from this that would assist in future planning.

Placing a requirement on Trusts to calculate and report this measure would give a far clearer indication of current available staffing and future staffing need than a count of the number of vacancies advertised, or the total bank or agency staff bill. It would create a proper baseline which, dovetailed with known and relatively predictable demographic trends, will give a broad indication of workforce needs over coming decades.

Work should also be undertaken to model and support Trusts in understanding shared experience on workforce needs of changes to care provision, in order to assist Trusts in making a full impact assessment of decisions – such an assessment should be compulsory and is essential in order to ensure that there are not unforeseen consequences on staffing and workforce demand. The alteration or expansion of one service naturally increases demand on other support services. This needs to be fully considered and planned for. For example, a HCSA member reported an incident where a radiology department developed a new screening service but did not consider the workload implications on anaesthetists that were needed to sedate the patients. This led to requests for anaesthetic cover which had then to be provided as the service had already begun to operate, an increased demand which had not be planned for.

Questions Two & Six

2. What measures are needed to secure the staff the system needs for the future?
6. What does being a 'modern, model employer' mean to you and how can we ensure the NHS meets those ambitions?

Below we outline some of the measures that are needed both to secure the staff the system needs to the future, and to move the NHS towards being a modern, model employer. We believe that these issues are entwined and can be tackled through the same set of reforms.

HCSA response

Pay Needs to Be Appropriate

Pay and Pension

Pay awards need to be fair. They need to reflect the wider economy, in particular to maintain a rough parity of reward with those professions which compete for the same quality of talent and rise in line with inflation. In real terms doctors have seen their pay shrink, whilst at they say time they are being

asked to work harder and get more done. Pay has not kept pace with other sectors but eroded over the last decade. **Pay needs to consistently rise with inflation.**

Net pay has been shaved over the past decade in various discreet ways. Increases in pension contribution, changes to the definition of normal working hours, and a loss of personal allowance on taxable income over £100,000 have all impacted upon recruitment and retention. For example, retiring doctors have been disincentivised from returning to part-time work due to pension and salary placing them into the 70 per cent tax band. Pay has led to many doctors retiring early and leaving the NHS to work abroad. **There needs to be a consistent, predictable and assured pension scheme.**

Make Doctors Feel Valued

Engage Doctors in Decision Making, and Listen to What They Have to Say

Engaging staff is not an optional extra, but essential in making successful change and improvement happen. Staff that are engaged feel respected, empowered, and feel able to influence the decision-making process in a positive way. However, staff who are not engaged feel disillusioned, detached, and removed from the running of the organisation. This leads to low morale and motivation. Currently, NHS staff continue to report feeling ignored, silenced, and distant from the decision-making process, staff also report low motivation and morale. The benefits of staff engagement are powerful. An engaged staff body benefits patient safety, improves productivity, creates a decision-making process that is based on expertise, and creates a workforce that feels valued, respected and supported. Therefore, the NHS needs to fully embed a system and culture of staff engagement.

Research has found that organisations with engaged staff deliver a better patient experience, and performances and productivity increases. For example, a study by Laschinger and Leiter (2006) of more than 8,000 hospital nurses found that higher engagement was linked to safer patient care. Reinforcing this finding, Prins et al (2010), in a study of hospital doctors in the Netherlands, found that those who felt more engaged were significantly less likely to make mistakes. Looking particularly at the UK, West and Dawson (2012) compared engagement scores in the NHS staff survey with a wide range of outcome data. They showed that trusts with lower infection rates have more staff who feel engaged and able to contribute towards improvements.

Hospital doctors report feeling excluded from decision-making and disempowered. This needs to change. Those with medical expertise need to be engaged in the running of the NHS. Currently, doctors may have little or no budget, no status to alter the running of the administration, and little influence over the organisation's goals. Decisions are being made that have a profound impact on patients and the quality of care, yet are done with little or no clinical engagement.

The engagement and consultation process can be described as broken for many reasons.

First, information distribution and engagement are poor. This often leads to medical staff feeling alienated and removed from the process, and unable to contribute. Many clinicians have not been properly informed why plans are being produced or introduced or what 'problem(s)' they are attempting to solve. This was certainly evident with the introduction of STPs: many HCSA members felt that they did not have the necessary information to fully engage in a meaningful way.

Second, **many medics are unaware how their views and expertise can be threaded into the process.** Our work on STPs discovered that 86 per cent did not know how to engage with their local STP and 93 per cent were not involved in producing their local STP.

Third, **workload pressure on clinicians in many parts of the country makes consultation difficult even in areas where opinions are sought.**

Fourth, **when doctors do engage with the process it appears meaningless.** Frequently, opinions, views and expertise are ignored or dismissed. Where doctors are eager to engage with the process they do not feel as if their input has been fully considered, frequently it will not be reflected in the outcome. This discourages future engagement and undermines the process, turning it into nothing more than a box-ticking exercise.

Action is needed to develop a system and culture of engagement. This will require altering the mind set of managers and policy-makers. It means going further than having an engagement strategy that often fails to fully engage, listen and reflect. It will require the development of a system that is based on expertise and engagement, one that allocates doctors with the time that is needed for effective engagement.

There needs to be a Shift in Tone and Approach towards Doctors

The current public tone and approach towards doctors by the Department of Health and Social Care is harmful and needs to change. The public message that is currently being sent out is often very hostile, and this is reinforcing the 'blame game' culture that has developed.

The apex of the problem is the way that the Secretary of State role is now positioned as the guardian of 'patient safety' rather than the individual ultimately responsible for the NHS. Whilst hospital doctors of course acknowledge the importance of patient safety, and indeed we put it at the core of what we do each day, this approach has naturally introduced an adversarial 'them and us' dimension which needs to be addressed. Currently, doctors feel they are constantly under examination and there is almost a presumption wrong-doing. We need to move beyond this counterproductive blame game culture, as it is leading to several problems. Firstly, it is forcing doctors to doctors feel uneasy and uncertain about the potential medico-legal risks they face in discharging their duty to the health service, which in turn is eroding confidence and workplace well-being. Secondly, it is having an impact upon patient expectations, often creating unrealistic expectations that cannot be met due to resources and circumstances. Thirdly, it is draining money from the NHS. It has created an environment where each thing needs to be reviewed and assessed. The cost implications need to be fully examined and accounted for.

Instead of a creating and reinforcing an unproductive blame culture, there needs to be a campaign to express appreciation for hospital doctors, as well as other NHS staff, fully supporting and celebrating their contribution to society. This is not a vanity issue, but is about perception, morale and confidence. It would go some way towards restoring confidence and recreating the appropriate environment.

Give Doctors What They Need to Do the Job

Provide the Beds Needed

The daily problem for doctors (and other staffs) is the inadequate provision of hospital beds. Delays in commencing theatre lists and in settled admissions to acute wards stem from the inadequacy of the bed base. The ridiculous daily scramble to find a bed for the patient whether post theatre or admission (elective) has characterised the service for too long and is a major factor in static and declining productivity.

Improve and Invest in Technology

The NHS needs to update it computer equipment and software. Our members have frequently highlighted that their computer equipment is out of date and problematic, resulting in poor integration, increased workloads, and in some incidences rendering them unable to do their job. This needs to be addressed.

Computer systems across the NHS are poor. Many Trusts across the UK are running Windows XP, an operating system what was released in 2001, and a system which Microsoft stopped supporting in 2014. This means that the computer systems are outdated, slow, inefficient, and often insecure. Ineffective and problematic IT also causes day-to-day inefficiencies. For example, it is often the case that referrals take longer than necessary, letters fail to get sent, and waiting times generated are often greater than necessary. The introduction of up-to-date computer software and tech invocations across the NHS could lead to a better experience from both staff and patients. The NHS needs to face outwards, to go with this tide of innovation, instead of seeking to stand in its way.

Currently our workforce is ill-equipped for the job. We need to urgently improve the digital readiness of current staff within the NHS and ensure that the new and current staff have the tools and training needed. Currently there is fragmentation of the record systems, often even within the same organisation. The comprehensive National Patient record system that was attempted never emerged. Frequently, services are dependent on commercial providers for their record and reporting package. This means that a commercial company will host the software and the data. Often the clinical functionality is poor and does not allow for access to other services within organisations. This means that communication across services is frequently time-consuming and ineffective as electronic data sharing is not being well utilised or integrated into the system.

In the wake of the failure to implement a central IT system, there has been an understandable rowing back towards a far more localised approach to commissioning. However, Trusts and NHS providers locally often lack the wherewithal to assess and monitor the quality of such projects. There is a role here for, at the very least, a set of national standards or detailed specifications and reporting requirements that would police the development of an ecosystem of software, and also enforce the accurate implementation of common interface or API requirements to allow the distinct elements of an emerging national IT system to integrate in a secure way.

We have also to question whether the reliance on Windows ecosystems is the most cost-effective approach for the NHS to adopt. Alternatives such as Linux should be considered in order to reduce reliance on a single company and the need for inevitable costly upgrades and expensive contracts for after-life servicing.

The argument for improvements to NHS computer systems runs deeper than simply operational annoyances or security. Reports from several Computer Science academics have claimed that poor NHS computer systems are resulting in patient deaths. Several have identified problematic IT programmes which fail to detect risks of lethal errors, such as fatal drug dosing errors, which are resulting in avoidable patient deaths.

Professor Martyn Thomas and Professor Harold Thimbley in a working paper entitled *Computer Bugs in Hospitals: A New Killer*, highlighted the danger with the current NHS computer systems[1]. They state: 'Our own very conservative estimate is that 1,000 deaths per year are caused in the English NHS by unnecessary bugs in computer systems'. They go on to highlight that this is considerably more than the 167 deaths in the 1988 Piper Alpha disaster or than the 31 deaths in the Ladbroke Grove rail crash, both which led to the launch of public inquiries and major safety changes.

Their research highlights the impact of a recent crypto-locker ransomware attack: '37 hospital trusts were infected and locked out of devices, almost 20,000 hospital patient appointments were cancelled, 44 hospital trusts were not infected but experienced disruption, 21 trusts and 71 GP practices had systems trying to contact the WannaCry command server (but were not locked out of devices), 595 GP practices were infected and locked out of devices, plus there was an unknown amount of further NHS disruption'. They claim that these actions could have led to patient deaths.

The research also shows that daily the failure of computer systems in the NHS to spot basic errors - such as drug overdoses - was likely to be causing significant harm to patients. The report also stated that a 'significant proportion' of clinical negligence claims in the NHS are due to 'bad computer systems, buggy computer systems, leading professionals to make mistakes. And then the professionals get blamed for it'. They added: 'Badly designed computer systems can be at the heart of, can trigger or contribute to, all the causes of harm that are reported as serious adverse events'. Their research calls for better regulation of healthcare computers and more research into the implications of errors.

It is essential that the computer systems and software across the NHS is able to perform the tasks needed at speed and to a high standard. Staff should be provided with the technology needed, and technology should enhance the safety and efficiency of patient care, not endanger it. We acknowledge the review into computer systems by Professor Bob Wachter, but we urge that review result in concrete changes across then NHS, with computers and software updated.

Move Away from Pagers and an Increased Use of 'Bleep Screening'

The NHS strives for efficiency and productivity. However, the 'bleep' system can cause inefficiency and negatively impact upon patient care. Problems with the current standard bleep system continue to go ignored or unnoticed, and familiarity with the bleep system is allowing an outdated system to continue.

This system allows for doctors to be contacted across the hospital site. However, there are many practical difficulties associated with the 'bleep' system that need to be reviewed. Frequently they result in delays and mis-prioritised treatment. Responding to a 'bleep' will require interrupting workflow, accessing a hospital telephone, and calling the displayed extension number. This system can create problems, and hinder patient safety. There have been reported incidences of hospital doctors receiving a 'bleep' to re-write a drug chart whilst attending a cardiac arrest.

Nurses paging doctors do not receive confirmation of whether their messages have been received, and signal blackspots can lead to a communication failure. Bleepers also have an incredibly limited memory, meaning that messages can quickly get removed from the device and missed by the doctor.

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[1] *Thomas, M. and Thimbley, H. 2018 'Computer Bugs in Hospitals: An Unnoticed Killer' Available at: www.harold.thimbleby.net/cv/files/killer.pdf*

The bleeper system requires the doctor to respond to messages by directly contacting the nurse that initially paged them. However, in practice this causes difficulty. Often the nurse is busy, away from the desk and unavailable. The leads to increased delays in treatment, and affects patient safety.

The limited nature of paged communications also means that there is a lack of detail. This means that doctors are not given the information that they need to prioritise tasks. The system is also one-directional, so whilst the individual doctor contacted may not be able to respond, other doctors who are available to respond immediately are unaware of the call. Therefore, it does not allow the full workforce to be utilised. This fuels inefficiency, failure to maximise resources, and delays to patient care.

Increasing the use of 'bleep screening' by senior nurses who triage treatments and assign to appropriate staff members would be an effective step forward, but does not remove the other problems associated with bleep pagers. The pager-based system of communicating with medical staff is outdated and in need of replacement. There needs to be a move away from outdated and ineffective forms of communication, and an embrace on modern technology via handheld devices. A new system of call handling, task management and prioritisation needs to be explored. Hospitals rely upon effective communication, and the most popular form of communication in a hospital is a bleep pager, therefore it is important to replace this tool with something equally simple and effective.

Some Trusts have implemented a wireless system of task management. This has helped co-ordinated teams to manage clinical resources in a way that is effective and efficient. The use of workflow management software and mobile technology allows for nurses to feed tasks through a coordinator who provide a triage function to allocate clinical tasks. In hospitals where this system has been imposed there has been significant process in efficiency, productivity, and better working systems for staff and patients.

Increase the Use of Digital Health and Self-Care

As demand for healthcare grows we need to consider other means to monitor health and perform tasks. Increasing the use of digital health and self-care will free up resources, such as staff, appointments, and beds. We need to embrace technology and appreciate that the public's relationship with technology and their ability to monitor their health is advancing. Therefore, for long-term health conditions, the public can take responsibility for monitoring their needs, or wear an appropriate monitoring device that reports to a surgery or assessment unit, and flags a problem or the need for further assessment.

This will mean that highly skilled professionals are no longer undertaking tasks that could be performed at home. It could also help towards solving resolving the 'bed-blocking' issue, acknowledged as a significant problem for the NHS. It occurs when individuals are admitted to hospital due to an issue or concern, and whist that issue has been treated or resolved they are unable to be discharged as they require some care of monitoring. Therefore, they stay in hospital beyond the length of time appropriate, causing knock-on effects for the NHS and sometimes for their own health. An increased use of technology in the NHS could move towards solving this problem. For example, individuals could use wearable technology that monitors bloody sugar levels, or patients could use alarm pendants. This would allow patients to return to their own homes, accompanied with human intervention and support where necessary from appropriately trained care-givers. **Therefore, we support investment in and increased use of digital health care and self-service.**

Improve Resources, Equipment, and Medicines

There needs to be increased and long-term planned investment to support a rolling programme of equipment renewal and to increase access to medicines and treatments. In order for NHS staff to do their job to the best of their ability they need to be supported by the latest technology and equipment and have access to a fuller range of treatment and medicines. Patient care, and the ability for doctors to treat patients, is being held back by out-of-date equipment. For example, a report published by the Clinical Imaging Board (CIB) stated that more must be done to future proof the NHS's capacity to use magnetic resonance imaging (MRI) to scan patients[2].

The board — a collaboration between the Royal College of Radiologists, the Society and College of Radiographers, and the Institute of Physics and Engineering in Medicine — conducted a survey of UK radiology teams to measure the state of MRI equipment. They found that there was wide variation in equipment ages, with 29 per cent being over 10 years old, and only 44 per cent five or fewer years old. The report goes on to state that this compares unfavourably with other European countries. **Action is needed to ensure better access to equipment within the NHS.**

Similarly, in terms of access to medicines and treatments, the NHS has fallen behind other European countries. For example, a report by leading charities Breast Cancer Now and Prostate Cancer UK shows NHS cancer patients in the UK are missing out on innovative treatments being made available in some comparable countries of similar wealth. **Action is needed to ensure better access to treatments.**

There needs to be a full audit and review of the current medical technology development projects, for example, developments in robotics. From this we need to extrapolate, and predict and plan for its impact on the workforce, such as the level of training that will be required.

Create a Better Working Condition and Environment for Staff

Ensure Access to Appropriate Rest Facilities

Night shifts can often last for 12 hours and run to up to four consecutive days. Whilst NHS Employers recommended that those on night shifts 'take 20 to 45-minute naps to counteract fatigue'[3], there is often no rest facility available. When rest facilities are available they are often inappropriate, cold, uncomfortable, and lacking privacy. This frequently leaves doctors fatigued and exhausted. This not only impacts upon well-being, morale and motivation but it endangers the life of doctors, leaving many exhausted during their drive home.

A 2017 study by The Association of Anaesthetists found that 50 per cent NHS junior doctors who responded to a survey experienced an accident or near miss when driving home after a night shift. The study also went on to state how many trainees had described falling asleep at the wheel, being

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[2] *Clinical Imaging Board, 2017, Available at: https://www.rcr.ac.uk/sites/default/files/cib_mri_equipment_report.pdf*

[3] *NHS Employers, Unsocial Hours and Nigh Working Advice Sheet, Available at: http://www.nhsemployers.org/~/media/Employers/Publications/Unsocial%20hours%20and%20night%20working.pdf*

woken by rumble strips, having minor bumps, and having 'microsleeps' while driving[4]. Therefore, appropriate rest facilities should be available to help staff avoid dangerous fatigue.

There also needs to be an information and advice distributed to staff on how to take effective short naps, the importance of breaks, and the use of rooms after a night shift if staff feel tired and unable to drive home safely. **Trusts should be made responsible for providing rest facilities and for running campaigns around the benefits of using them.**

Sickness Absence Policy

Sickness Absence Procedures have become perversely punitive in the hands of performance output motivated managers. HCSA members have reported going into work although unwell because they were made to feel guilty, or bullied by management. In a National Health Service with an aging workforce, the management of staff sickness needs to be exemplary. We urge a change in culture and approach towards sickness policy.

Create a Healthy Workplace

The employer needs to ensure they are providing a working environment that encourages health and wellbeing. Currently many employers are not providing this. The unsuitable working environments that hospital doctors are often expected to work in is an underappreciated cause of workplace stress and poor well-being. For example, our members have reported not being able to access hot, fresh and healthy food during their shifts. This is unacceptable. The NHS not only has a duty to its employees, it also has the duty to act as a good example to the public, encouraging an active and health lifestyle.

Another key area for improving health and well-being for staff is providing access to facilities and schemes that promote physical activity. Trusts should provide sporting and recreational activities on site, as well as access to mental health support, rapid access to physiotherapy, and weight management support. The benefits of workplace health promotion include increased productivity, reduced absenteeism, improved staff morale and increased retention of staff[5]. **Therefore, we call for a full analysis of the conditions throughout the UK, and a series of recommendations for improvements to be made.**

Encourage and Support Those Returning to Practice After A Period of Absence

There needs to be a drive to attract people back to work, and support provided to enable them to do so. Individuals take periods of absence and career breaks for numerous reasons. However, returning to practice can often be a challenging process.

Returning to Work After Maternity Leave

Similarly, more should be done to support women returning to work following maternity leave. Returning to work after a period of maternity leave can often appear daunting. Therefore, more needs to be done to support the individual. For instance, employees could put on a 'back to work' or 'taster session', whereby the returning member of staff shadows another doctor.

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[4] *The Association of Anaesthetists, June 2017, Available at: https://www.aagbi.org/news/trainee-doctors-risking-lives-car-accidents-after-night-shifts-survey-reveals*

[5] *European Agency for Occupational Safety at Health, 2015*

Better Work-Life Balance and Flexible, Family Friendly Hours

More needs to be done to improve the work-life balance of staff. It needs to be recognised that to attract and maintain the workforce the NHS needs, and to be considered a 'modern, model employer' the NHS must invest in family-friendly policies. This includes introducing term-time only contracts, job shares, flexible hours, as well as supporting and facilitating home working for administration and essential training.

Employers also need to make changes to the current culture, and instead showcase the NHS as a family-friendly employer. This could be done through things such as family invites to employer events. Events like these not only display the NHS as a family-friendly employer, but also help workplace morale and well-being, and create a sense of 'belonging' which has arguably become lost in the NHS.

Question Three

How can we ensure the system more effectively trains, educates and invests in the new and current workforce?

The below section sets out how we can ensure that the system trains, educates and invests in the new and current workforce.

Create a Better Experience for Junior Doctors

Locally implemented changes could help to improve the morale of today's workforce, retention and productivity, and, in turn, patient safety. There are several ways at local level to enact improvements to junior doctors' working lives, for example:

Effective Rota Planning

Whilst in principle work schedules should be devised and released six to eight weeks in advance, in practice they are often late, subject to last-minute change, and inaccurate. This results in employees attempting to solve rota issues by swapping shifts with colleagues. There are also last-minute changes which means doctors are swapped onto night shifts without much notice or called back into work without warning. This creates additional stress for some employees, hinders well-being, and impacts upon work-life balance.

There needs to be a far better system of rota planning, whereby there is effective prior planning and dialogue between the doctor and the rota co-ordinator, whereby the co-ordinator can resolve any issue rather than it becoming the responsibility of the individual doctor. For example, employees are often required to rely upon swapping swifts with colleagues to guarantee leave rather than this being secured via a work schedule. Schedules also need to be devised on time, six to eight weeks in advance, as this would allow the employee to effectively plan family and personal commitments.

Debriefs

Junior Doctors frequently work with multiple on-call teams, and rotations are often short. This means that Junior Doctors often struggle to feel integrated within the team. Junior Doctors working 11-hour night shifts often report feeling mentally and physically drained, and as a result unable to rest and get sufficient sleep before returning to work for their next shift. One way to improve

integration, and to create an opportunity for teams and individuals to wind down, reflect, and to air anxieties, is to hold informal breakfast de-briefs. This not only helps create a more communicative team, but it also creates an appropriate environment and moment where the junior doctors can calm concerns before 'switching off'.

Induction

Junior Doctors can often feel isolated, unsupported, and unprepared. Junior Doctors have reported starting a first shift in a new environment not knowing where things are, who people are, and how to perform certain functions, such as ordering tests. Whilst support is often available, contact information for who can provide support or assistance is often not distributed.

Therefore, there needs to be a mandatory, embedded, clinically focused induction that is arranged at the start of each new rotation. This should also be supported by an 'induction pack' which outlines key contacts, key information about the department, the staff, the facilities, and technology and computer systems, and must be distributed in advance. Whilst we acknowledge that is some departments and some trusts induction is effective and embedded into the starting process, in others the process is ad hoc. This often causes undue stress.

Ensure Effective Supervision and Mentoring

The first years of training and practice are crucial. Therefore, good supervision, mentoring, and support during placements is vital to ensure that staff are supported and mentored to obtain the expertise and skills necessary. These schemes also allow for staff to develop effective relationships that are necessary for workplace well-being. However, the current system does not allow for this. Senior staff are not being designated the appropriate time and training needed to provide this level of support. As a result, supervision and mentoring is often ad hoc and ineffective. This is frustrating for both the junior staff member and senior members who want to contribute to this process but are unable to properly undertake these duties as they are not give the preparation time or resources. Therefore, time and training need to be granted across all trusts to ensure that supervision and mentoring is properly embedded in the system, and not an afterthought.

Placements Need to be Longer

Placements are often too short and carried out mainly in silos. This prevents effective learning and engagement. Individuals need the time to learn how to work within in a team. However, the way doctors are currently trained results in them moving from place to place, a system that can prevent a sense of belonging to a particular group or Trust. This makes it difficult for inter-professional staff and teams to develop team rapport and trust which is essential to team work and patient safety. A degree of continuity is needed to allow for effective learning and working.

Trainees Need to be Truly Supernumerary

If trainees, at least in their initial training years, were fully supernumerary, and 'workforce need' calculations were based only on permanent staff, it would allow for a more accurate calculation of demand. It would also mean that trainees could dedicate time (outside on-call duties) to learning the relevant skills which are needed. This would go some way towards reducing the burden upon trainees and making the posts more attractive.

Smaller Regional Rotation Areas

Currently trainee rotation areas area too large. The geographical area that trainees are expected to travel within needs to be more family friendly.

Invest and Think About Continued Training and Development

Continuing Professional Development is Essential and Needs to be Properly Funded and Embedded

Continuing Professional Development is essential, but it is frequently the victim of underinvestment. It is important that staff can take time out to increase their skills and ensure that that skills are up to date. Frequently, staff do not have the time to focus on their CPD. Understandably, in a stretched and understaffed workforce protecting time for CPD is often very difficult. Frequently, therefore, medical staff attend training course in their spare time, as they are unable to secure this time within their work plan. Trusts, and service level managers, are often an obstacle to CPD days, as they are prioritising short-term service needs over the long-term skills and career development of staff.

We need to ensure that CPD is properly costed and funded, and measured as an essential part of the job, and not a 'possible extra'. There need to be better, and more, training opportunities and an increased budget for development.

Introduce an International Exchange Programme and Improve Sabbatical Opportunities

Serious consideration must be given to introducing an international exchange programme that hospitals doctors can access. This will not only contribute to individuals' training and development, it will also provide an international learning transfer process that could benefit the NHS.

Sabbaticals also need to be improved. One way to do that is to establish a centre which coordinates national and international sabbatical opportunities through which consultants can apply for, and which provides a replacement sabbatical person into gaps to ensure trusts or service provider is unaffected and not left with unfilled rota or workload gaps.

Invest in the Development of 'Physician Leaders'

Typically, the chief executive officer (CEO) or leader of a Trust is more likely to be a non-clinically trained professional manager instead of a doctor. However, more needs to be done to draw doctors into leadership and management. One way to encourage this is to develop new educational opportunities that equip doctors with the management and leadership skills they need.

This should be encouraged as research shows that where leaders have expertise in the area they are leading or managing the organisation performs at a higher level[6]. Research has found that where leaders have an expert background there are high levels of employee job satisfaction[7]. Looking specifically at a healthcare setting, research has also found that a 'physician leader' improves productivity, satisfaction and well-being among team members[8].

Physician leaders who have successfully evolved into leadership roles in healthcare organisations not only provide the level of area expertise that is needed, they are also more likely to understand and relate to the issues of junior colleagues, and effectively engage with them with a shared vocabulary and understanding. However, the complexity of healthcare service delivery and management in the

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[6] *See for example: Goodall A, Stoller JK. BMJ Leader 2017; 0:1–4; Sarto F, Veronesi G. Clinical leadership and hospital performance: assessing the evidence base.*

[7] *Artz B, Goodall AH, Oswald AJ. Boss competence and worker well-being. Industrial and Labor Relations Review, published online, 2016*

[8] *Shanafelt TD, Gorringe G, Menaker R, et al. Impact of organizational leadership on physician burnout and satisfaction. Proc 2015; 90:432–40.*

current environment needs to be acknowledged. Leaders are required to balance quality against cost, technology against humanity. These challenges require extradentary leadership. More needs to be done to provide the learning opportunities for doctors to equip themselves with the skills they need to be effective leaders. Greater emphasis and weight should be placed on taking the time to assist physicians with an aptitude for leadership to acquire the skills to do so at a senior level in our Trusts, which is a somewhat more realistic goal than asking professional managers with little or no health experience to learn to become well-versed in clinical matters.

Introduce a System of 'Long Term Service Leave'

In an acknowledgement of the pressures placed on individuals within the NHS, and in order to aid well-being and therefore retention rates, the NHS should consider introducing a system of long-term service leave allowance in addition to annual leave allowance. For example:

- At 10 year service - 1 month paid long term service break
- At 15 year service - 2 month paid long term service break
- At 20 year service - 3 months paid long term service break
- Or the capacity to carry breaks over to accumulate so at 20 years an individual could take a 6 month break in addition to annual leave allowances.

Training and Recruitment

Below we explore some ways to attract more people to work in the NHS, and possibilities around career transition within the NHS. However, while transferable qualifications will be important to some individuals, it should be emphasised that to improve recruitment and retention, the many factors detailed elsewhere in this submission need to be addressed, otherwise the issues that are impact upon the current workforce will simply continue to have an adverse and unpredictable impact on a new and changing workforce.

Career Transitions, Not Career Paths

We need to move away from the view that an individual decides upon a career path in their early twenties and sticks firmly to it. Instead we need to introduce job path flexibility so that doctors can re-focus their area of speciality. Rather than focus solely on extremely restrictive career paths, consideration should be given as to how the focus can be placed on career transitions, supporting individuals to make decisions that keep them in medicine. Postgraduate training for doctors centres on the idea of working towards a defined and specialised career goal, and that can be a real barrier for people who change their mind, change direction or want to take a break from medicine. Skills mix and flexibility to move and cross the professional boundary is needed, but it needs to be clinically driven, monitored, and approved. This will help to retain the NHS workforce.

Better Inter-Disciplinary and Multi-Professional Learning

There needs to be greater emphasis on multi-professional inter-disciplinary learning and teaching. When appropriate, doctors, nurses, and applied health professionals should be training and learning together. This has the potential to play a key role as we strive to achieve integrated care systems across physical and mental health. The chance to develop close working relationships with others, giving insights into other roles and specialist skills, improves communication and allows teams to develop together with a shared ethos and shared learning. Whilst there are different curriculums and different learning outcomes, there needs to be a way to bring these multi-professional groups

together during learning. This will require an assessment of the current formal curricula to see how initiatives that enhance teamwork and collaboration between can be introduced. Developing a more integrated system would help to break down traditional silos in healthcare organisation.

Introduction/Increased Spread of Interrelated Degrees That Give Doctors Management and Business Skills

Some medical schools allow interrelated degrees. Most of these are science-related but, for example, the University of Leeds offers an MBA in healthcare. This training and formal learning would be useful to most doctors. It would allow doctors to be better managers, and bring their skills and experience to parts of the NHS that are currently the preserve of those with business and management experience but no medical knowledge. Encouraging and promoting this route for doctors would allow many to develop the skills and knowledge to take more of a role, confidently and effectively, in this aspect of the NHS. This, in turn, would be extremely beneficial in creating a new dimension in decision-making that combines business goals and patient care.

Credentialing

Credentialing could be transformative for Trusts and help develop the skilled workforce that is needed. As retirement ages continue to increase, individuals leaving university today are likely to spend the next 50 years within a job. Therefore, we need to address the detrimental impact of locking an individual into a narrow set of professional options. The choices that individuals make at 18 should not restrict their future carer development. Instead we need to invest in ways that will help people get the skills that they need to retrain and develop the skills that they need, regardless of their professional background. Through developing the appropriate credentialing systems, we could work towards tackling the issues of staff and skills shortages. Whilst there are concerns regarding movement towards the credentialing route, these concerns could be removed through the development of an effective system and process. Through the development of a system that is trusted, recognised, and accurately measures and records credits, we could develop a system that is effective, professional, and ensures the continuation of high standards and high quality of care. This system needs to be developed with professional bodies and regulators.

Focusing on Education Prior to University and Raising Awareness of Types/Range of Careers

More needs to be done to raise awareness of NHS careers, and to celebrate the NHS as a place to work. We need to do more to engage and inspire young people into working in healthcare. We need to do more to attract students from a young age, to inspire them to consider a career in medicine or healthcare. One way to do this is to incorporate first aid into the school curriculum. This would provide students with an applied understanding and experience. Biology and science curricula should be examined to see how they can more effectively link what they are being taught or what they are reading in text books to the work of various professions in the NHS.

Universities also have a responsibility to undertake more effective outreach and recruitment events. This includes inviting students to lectures, providing talks at schools, as well as holding open days. This could be a route to increase awareness of other healthcare professions, and to show students the diversity of roles within the NHS.

Other routes to medicine and health care also need to be fully utilised. Organisation like St Johns Ambulance and Cadets play an important role in recruiting individuals into the NHS. Their contribution needs to be fully acknowledged and supported, and they need to be incorporated into a recruitment strategy. TV advertisement also needs to be explored. This source of marketing and promotion is embedded in recruitment strategies for the armed forces, and can be a powerful recruitment tool.