

This is a transcript from a conference on 26 January 2017, about patient safety, at which Henrietta Hughes was a speaker.

The conference organisers advise:

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‘The role of the National Guardian’ Dr Henrietta Hughes, National Guardian (Freedom to Speak Up)

Thank you so much for the introduction and I’m really delighted to be here today.

So as was said I started this role in October last year and I’ve learnt so much over the past few months about the experiences that staff have had and how things have really got to change going forward. I think this morning has been a really interesting experience because almost everything that needs to be said has already been said by the previous speakers. So we heard about staff feeling that they would be less defensive if they didn’t think they were going to have their neck on the line. We heard about staff not feeling supported and not having their emotional needs met and that if they did have the right environment that they would feel more happy about speaking up, not only after the event but also before the event and how important prevention is as part of that.

We also heard about hospital acquired infections and one of the things that I found from my experience as a commissioner was that although trusts have brought the number of infections right down, when it comes to the actual meeting where they’re being held to account, the key thing they wanted to do was pass the attribution of the blame onto somebody else and I think that was a real essence of the feelings and the culture in the NHS

as it stands at the moment, but I think there is good news and that's what I'm going to talk about in terms of the work that is happening so far.

So as is clear my role was set up following the Francis Report and the Freedom to Speak Up Report which had key recommendations, one of which was to have an independent national officer as a National Guardian but also a Freedom to Speak Up guardian in every Trust and Foundation Trust in the country.

And what I've put on this slide is just some of the organisations that I'm working with. So... I'm just going to see if I've got a pointer. I'm sponsored by NHS England, the Care Quality Commission and NHS Improvement with accountability up into the Department of Health but also working with a host of other organisations, I didn't have room on the slide to put everyone but I've just put Health Education England, NHS Employers and NHS Providers who are all providing a huge amount of support to my team but I'm also working in partnership with the NHS Leadership Academy, I'm going to be having conversations with all different parts of the NHS and organisations which surround it.

I'll talk a bit more about the governance but we have an accountability and liaison board which consists of a non-exec director, or an executive from the three sponsoring organisations and I'll talk a bit more about the advisory group which is in development at the moment.

So it's absolutely clear that there's a link between staff experience and patient experience and I just want to actually talk about something else that was mentioned earlier this morning. It's more than just staff experience and patient experience; we know that patient safety can also be linked to this although it doesn't have such a big evidence base. So one of the things that was talked about this morning was washing hands and about patients being confident that staff have washed their hands but also what happens if, you know, why don't patient's also wash their hands in the same way; and one of the things that was mentioned to me is if there aren't enough sinks in the department for patients to wash their hands. So I would see that as something that is a concern that could be raised by a member of staff which is something that gets in the way of them being able to deliver the great care that they want to deliver. And that could be something, you know, which might seem quite small but being able to talk about that and raise that concern in your department, it all depends on the environment and the culture that exists in that hospital or in that department where staff feel safe that they can actually raise that concern without thinking it's going to come back on themselves.

So the Freedom to Speak Up Guardians have been appointed in the majority of Trusts. In some Trusts they have one person fulfilling the role and in others it makes much more practical sense to have a host of people. So for example in the community and mental health Trusts which are spread over a very large geography, it wouldn't be practical to have one person doing that role.

And what's really interesting is that they're coming from a wide range of different backgrounds clinical and non clinical and at a different grades and seniorities and it's a really interesting group of people who, in fact we have one here, and you know, because it's

something which is a very different approach, how it's done in the Trust is very much within the gift of that Trust but in terms of what we're concerned about, it's about that establishment meets the needs of the staff in that Trust.

And I've put up some of the features about the Freedom to Speak Up Guardians that's really important and I think independence is a really important part of this that the staff do not feel that the Guardian is working for the board or the board don't feel that the Guardian is working against them or for the staff, it's really about an independent and impartial role where every member of staff can expect to receive the same level of support from their Guardian.

So these slides had to be submitted last Thursday so my apologies for the fact that some of the numbers are out of date. We're now in communication with 100% of Trusts in England and 16 have yet to appoint but we've got an action plan for each of those so that we're aware of what stage they're at, some of them are going through elections, some of them are appointing, so we're wanting to make sure that every single Trust has a Freedom to Speak Up guardian in place so that their staff have got someone to go to.

We've been working with the Guardians who've been appointed in terms of training which has been put on but also in terms of resources and materials for them and bringing them together so that they can actually learn and share from each other. We've also done workshops for non-executive directors and for directors of HR and that's because the Trusts need to understand what they're going to expect from having somebody in this role and to see the benefit that it can bring the organisation.

And in October last year we had an event for over 130 Freedom to Speak Up Guardians attended by Sir Robert Francis and for many it was the first time that they'd actually met each other and it was fantastic to see how immediately everybody gelled and at that point we launched a national network which was based on the clinical senate footprint but it also coincides with the footprint of the social partnership forum as well. And we're having regional meetings which are chaired by Freedom to Speak Up Guardians, members of my team or myself are attending those meetings so that we can give an update on what's happening across the country but also we can get feedback on the local priorities as well.

The feedback from the Freedom to Speak Up Guardians is so important because that's what will actually shape our priorities going forward and particularly in terms of the training needs and any issues that they're encountering.

What's really been fantastic is that this group is working in a very unusual way for the NHS because we talk about siloed working and impermeable boundaries between organisations, but the Freedom to Speak Up Guardians are learning and sharing from each other automatically, there is no 'not invented here' or 'that won't work for me'; and in fact as well as the regional networks there are also other networks which are springing up such as the community and mental health network because they've discovered that the things that are important for them transcend the region, it's what the particular features that they have in their Trust, so for example they have sometimes very small teams where they are fearful about completing the staff survey because they feel that they'll automatically be identified

and it's that type of learning and sharing which they're looking to see how they can overcome some of those barriers.

So in terms of measuring impact, this is a really interesting question. We know that the staff survey has got some questions about speaking up and about how valued people feel and how much they believe that an organisation will act on the concerns that they raise, but we're also looking at quantitative data in terms of publicly available information so that we can look at the hotspots of where there might be concerns, and that will include, for example, aspects about culture but also patient safety information.

But there's also qualitative information that's coming out, case studies that the Freedom to Speak Up Guardians are collecting where members of staff have come to them, raised a concern that they've then had action that's been taken as a result and feedback has been given to the members of staff and we're really interested in how the Freedom to Speak Up Guardians are gathering feedback on the work that they're doing from their clients, from the staff who are speaking to them.

So I think it was about ten days ago now I published a report on my first 100 days which covers an awful lot of the stuff that I've been talking about this morning and I've put the link on, these slides will be sent out as part of the delegate pack, so you'll be able to access the link all through the web pages that we have on the CQC website, but our future priorities are about gathering this information, measuring the impact. This is new information and it will help to take the temperature of the NHS, organisation by organisation. I think it's really going to be interesting to see whether certain staff groups are more interested in talking to Freedom to Speak Up Guardians and how Trusts deal with situations where no one is coming to talk to them. How are they going to adapt and amend their systems so that they are able to gather the information and help support staff to make the changes that they need to make.

We're also interested in where things aren't going so well and there's a process of case review which at the moment is open where we're gathering information from a wide range of different individuals and organisations.

So the Advisory Group is something we feel is really important. The thing that's difficult is to understand how we can gather the right information in what different ways and it's likely that there will be a number of different ways that we will do that, by talking to individuals, by talking to organisations and also by having more digital online ways of actually gathering feedback and queries from individuals. Some people aren't able to self-identify as whistleblowers, they have got confidentiality clauses which prevent them from actually saying they're a whistleblower so it's impractical to say, 'come to a meeting' and there have got to be ways that everyone can put their own thoughts and ideas and suggestions in to help support our work.

So I've put our contact details on there and there are, as I said, there are opportunities for people to talk about how we could be doing case reviews but also in terms of the advisory group. People are also contacting us directly with cases that they would like to look at, at the moment we haven't decided the inclusion or exclusion criteria. At the moment, we're

covering secondary care, not primary care or social care, but I think this is a really interesting and rapidly expanding area and there will be a lot more to say when I've been in post for a bit longer. Thank you very much.

Henrietta Hughes' PowerPoint presentation can be downloaded from the following link:

http://www.westminsterforumprojects.co.uk/forums/slides/Henrietta_Hughes_Patient_Safety.pdf

Henrietta Hughes' answers to questions from the floor

Anita Higham: This time I'm wearing the hat of being a publicly elected governor of a Foundation Trust, the Oxford University Hospital Trust, and I noticed that you said you've had training for NEDs and I'm sure you're well aware of the statutory duty of governing councils to hold their NEDs to account; are you offering training for governors because I think that would be really valuable?

Dr Henrietta Hughes: Thanks very much, that's a really good point and we've actually got some Trusts who've appointed their governors as their Freedom to Speak Up Guardians but I think that's something that we will definitely take back to make sure that governors have the opportunity as well to learn about the Freedom to Speak Up.

Chris Ward: From Patient's Voice. I've just recently put a question to our CCG about who is our Freedom to Speak Up Guardian of which I've had no response from yet, but however, our organisation actually now tends to act as an advocate for whistleblowers because patients, carers, people in residential homes are fearful of telling what they know because of the repercussions of it. So is there any plans to roll... because your Freedom to Speak Up policy is really for staff as opposed for patients and carers and relatives of those, is there any plans for this to be rolled out, so the public if you will, can have a more protected role in whistleblowing?

Dr Henrietta Hughes: So one of the things which is really important is for all people to be able to feedback about their experience, whether their experience is as a worker or their experience as a patient or a member of the public. And I think that for organisations we know that the ones who are genuinely interested in hearing feedback from their staff and their patients are the ones who are more likely to make the safety improvements that we have been talking about this morning. So in terms of how those things can be fed back it's certainly the case that some people feel that if they make a complaint or if they raise a concern about something that's happening in their care or that of one of their relatives, that they're fearful that it might have implications on them and how that might impact on the care that they receive. And that's where I think organisations such as Healthwatch and Patients Associations are really important in terms of capturing some of those ideas and that feedback. And we've been encouraging the Freedom to Speak Up Guardians in the Trust to have really good connection with other people who are working as part of that organisation including Healthwatch, including staff side, the Dignity at Work Ambassadors,

people who are working on the WRES because it's by getting that whole feedback from a wide range of different sources that the improvements that need to be made will be made.

David Rowland: From the General Optical Council. This is a question to Anna; first of all to say thanks very much for the presentation and for the learning that you have gained from the work that you have done around whistleblowing and for the approach that you've taken; and I think there's a lot within that that other regulators can apply as well. I guess the question that I've got is that when you've gone through the investigation process and you've identified that a complaint has been made against an individual in a way which is intended, in a sense, to silence a whistleblower, so there's no evidential basis to take forward a complaint. What do you then do with that information, do you then go back to the referring organisation and make them aware that this complaint has been made; do you consider taking action against any individuals who have raised a concern in a potentially vindictive way? It's just following on that loop really as to once you've reached that point with the investigation, if that makes sense.

Dr Henrietta Hughes: I think also what the new system does is enable us to identify where it may not be that there's something malicious but just that the procedures locally for responding to whistleblowing are poor and as a result of that someone is genuinely seen as a problem when actually if you look through another filter they were trying to do the right thing but the culture is such that others who are trying to do their job have started to see them as a problem. So I think also that the new arrangements around the form enable us to then... we do ask in the form what did you do about the whistleblowing and how did you respond to it and I think if we identify poor practice we do reflect that back through our connection between the employer liaison service and ROs and also using second tier ROs if that's appropriate.

Rosie Cooper MP: If I may abuse my position as Chair, may I just say to you that in places like Liverpool Community Trust, nurses who voiced concerns or didn't do what they were told were given the alternative of going through a disciplinary procedure where they would be found guilty and would be reported to the NMC or to retire and resign. My response to that is not at all, I don't think you'll find it surprising in that now we've got to this point I have reported the Chief Nurse to the NMC and she is currently suspended and we await what will happen. So that procedure she applied to those who were subordinate to her is now being applied to her and I think that's the route, you can't have... I don't... and forgive me, I'm not one of these people who do no blame, what I believe is in fair blame, we all just do it and get on with it, if it's wrong, put it right, move on but there are consequences on both sides for those things that you do do, so that's me being very naughty as Chair. The gentleman there.

Noel Finn: Yes okay. Henrietta, in regards to being a whistleblower myself, as you're aware I did a presentation last month, over the course of ten years I have been raising concerns, I was never branded a whistleblower, it was my duty of care to raise concerns under the code of conduct. I was only branded a whistleblower when I went outside the organisations but I did try to resolve the issues. What I have found with the National Guardian role is that they've bolted on the jobs onto extra jobs for National Guardians and they're not

standalone jobs themselves to ensure quality and to ensure that selfimpartiality as well. What I found in local Trust was that the Director of Nursing was the National Guardian which I felt was a bit of a conflict of interest. And there seems to be a disjointed, through my eyes, there seems to be a disjointedness with the National Guardian role in Trusts and that will confuse, I believe, whistleblowers are people who are raising concerns as it is their duty and because if the Director of Nursing was sitting as an Executive Director who has a voting card under directorship and is also a National Guardian lead, that's going to be a conflict in interest.

Dr Henrietta Hughes: I think what you're saying is a really valid point because different Trusts have approached this in widely different ways. In some Trusts, existing members of staff have either had time put aside for this role as part of a clinical role and for others it's a voluntary role and in some Trusts, they've gone outside the organisation and contracted with an independent organisation. And I see there are strengths and weaknesses in all of these different models. For some organisations having that visibility of somebody that they know and who they've had long established relationships makes a massive difference, certainly in terms of being able to access all different parts of the organisation is key; and for some clinical staff particularly there are certain groups like radiographers and anaesthetists who do know the entire organisation, they get everywhere in the organisation and for others their experience is more limited. So we haven't been prescriptive in saying this is how you have to do it, the bottom line is does the way that the organisation has set this up meet the needs of their staff and so we're encouraging the Guardians to go and do pulse surveys and actually find out from staff is this working for them? And you know, in some organisations they really didn't know quite how to establish the role in the best way and so somebody has been put in almost as a placeholder and we accept that that was a nomination needed to be in by the 1st October and that's how they addressed it. But going forward it may be that an executive director or a nonexecutive director is not the best person to do that role and we're looking to see how Trusts will take that feedback on board and actually by doing, not just reactive by listening to staff who are coming to them, but pro-active and actually going out and asking staff, sitting in staff meetings, going walking the wards and meeting all of the different groups of staff, maybe being at the staff inductions, and having many different ways to be contacted anonymously, confidentially and happy to share their details, that that will be the test of the role. And so we're going to be doing some research where we're going to look at how the roles have been established, who's doing it, how many hours they've got, do they feel supported and then we'll be able to, from that, say yes this organisation you seem to be getting it right, this one doesn't seem to be meeting the needs of your staff, you need to go back and rethink it. So I do think it's an evolution, I wouldn't expect every organisation to get it right spot on first time because this is brand new, it's not like we can go and say we're going to take the Swedish model or the airline model or any other model and apply it, this is a very new way of working and I think what we have to do and it was said earlier this morning is we need to learn from the best, when we learn who is getting it right we can then go to other organisations and say we can put you in touch, we can buddy you with that organisation because they're really getting it right and you've got a lot to learn from them.

Baroness Masham of Ilton: House of Lords There have been some tragic cases in maternity and a local case to me was a woman transferred from a midwife only unit to a large hospital up north on a Saturday afternoon, she needed a caesarean, she was sent home, things went wrong, the next day the baby was born by caesarean and very badly damaged, died five days later. The enquiry seemed to take so long on these terrible cases and the one thing is to put the thing right so it doesn't happen again. Why wasn't she sent to yet another hospital?

Dr Henrietta Hughes: I think we've heard a lot this morning about how organisations try and put things right but we don't always get that learning shared across the NHS and I can give another example where a freezer that was being used to store stem cells broke and the patients who were expecting their transplant died. And then ten years later another hospital a mile down the road had exactly the same incident and in my view that's just iniquitous because if we find that there's a problem which has an application to the whole of the NHS or to a particular area then there should be some kind of.... well I think we heard about Q earlier where there have been lots of initiatives to try and make sure that that learning gets shared. Because I've no doubt that there would have been another example of a similar tragedy which would have depended on, you know, the boundary between clinical teams which we know is such a big barrier in terms of the care of patient across the patient pathway. So I agree with you, we need to have systems where when lessons are learnt they're not just learnt for that organisation but they're learnt for the whole country.

Trevor Dale: Thank you very much, I'm getting a second bite as well, so I'm an External Training Provider of Human Factors Training to, amongst others dare I say, Northumbria although a while ago. A couple of comments first of all, I think one thing, I've got an aviation background, the biggest killer in aviation is complacency and that's I think just a general worry, you know it doesn't happen here we're fine. The second one is I've just come back from running a two day course for frontline teams at part of the Staffordshire Hospitals for a funny old thing, some of those people were working in Mid Staffs when that went on, the comment I got from the frontline staff who I found absolutely excellent, I also went into their unit and saw what they do and have to deal with, they said the biggest problem in their opinion was senior management not walking the talk; they talk the talk but they don't walk it. And the last one is a question to you really which is, it was so telling what Brian said just now, I think he said was I labelled as a whistleblower, do you think it's time we moved on from the term whistleblower, it's been used so many times this morning, does it not have, a leading question here, does it not have negative connotations, is there not something really bad about being a whistleblower? You know, if you are genuinely raising concerns about an unsafe organisation and maybe unsafe people, unsafe systems whatever it is, should that not be praised and welcomed and not have such a, if you like, a dreadfully negative name on it and should there be trumpet blowers or safety advocates, I mean what does the room think, I just think it's one of those things that's....

From the floor: Professionals.

Trevor Dale: Professionals yes, there you go, what does a professional mean; and just one more little comment which is, sorry I'm really taking it up here, is there's been a little bit of talk about learning from success this morning but an awful lot of talk about learning from

error. Now there are one or two Trusts, and there maybe some in this room, who are looking at learning from success because let's face it, most of the time people get it right, a lot of it's by luck and that's why this whole thing which we're here today for which is about learning, is about if people learn not just from when it goes wrong which obviously has the blame connotations but learning from when it went right, hey why did today go so well let's look at that. And it's one of the Birmingham hospitals, I hesitate to say which one because I can't remember, but they're doing a learning from success root cause analysis on successful interventions at the moment and what a way to go. Now that is a way to the future I think, so I'll shut up now, thank you.

Dr Henrietta Hughes: I'm happy to start, so I think the word whistleblower, different people use it in different connotations and in my view the normal state of affairs should be that if somebody spots something, not necessarily because there's been something that's gone wrong but a near miss or even something where they're looking at it, you know, objectively before there's a problem, in a normal state of affairs they should be able to talk to anyone, their line manager, their colleague, their mentor, their chief executive and the response should be, 'thank you so much for pointing that out, that's brilliant, we'll work it out and then we'll let you know how we got on' and in the vast majority of situations, you know, that's certainly been my experience in my career and I have raised all sorts of issues in the past and I'm astounded that I'm still you know able to carry on because some people have had terrible experiences when they've raised concerns. So the ideal thing is that Freedom to Speak Up Guardians won't be necessary, my job won't be necessary, this will be a, you know, a short lived experience and the culture in the NHS will improve. I've talked to a lot of pilots recently and I do think the NHS can learn an awful lot from aviation. I think civil aviation is different from let's say military aviation because, you know, in the RAF there's obviously the fact that its Government funded and that risk based activity has to be appropriate to the level of risk that's taken, so I think there's an awful lot of similarities in the way that the NHS works, we can't just ground the aircraft as it were and close the hospital because you know there's still the work to be done. So I agree with you, I think that the term whistleblower is one which I'm hoping that it won't have negative connotations, if somebody wants to call themselves a whistleblower, great, but if somebody also wants to say that they're raising a concern or speaking up safely, that's also great.

Sharon Brennan: I'm from the Health Service Journal. It's a question for Henrietta but, obviously, anyone can chip in. One of the concerns Trusts have raised is that because the Freedom to Speak Up Guardians will be employed by the Trust that they're meant to be helping staff raise concerns, that they themselves will worry about raising concerns on directors or chief executives who are allowing a bullying culture. Do you think in the future you would need any kind of legal clarifications over what Trusts can and can't do for their Freedom to Speak Up Guardians so they aren't retaliated against?

Dr Henrietta Hughes: I think that's a really good point and what we've found from Freedom to Speak Up Guardians that when they run into problems its sometimes when they want to raise a concern themselves and so who do they go to if they're the only one in the Trust. But also if concerns are raised by board members about board members or about, you know, from members of staff about executives or board members, what's the position of the Freedom to Speak Up Guardian in that? And in the first instance what we like to do is to put

a Freedom to Speak Up Guardian in touch with somebody in maybe in a neighbouring Trust who provides them with buddying and support but there's also something about the external view of the Trust and that's where the National Guardians Office can provide that level of top cover to the Freedom to Speak Up Guardians. When it comes to board members raising concerns about each other or staff raising concerns about board members, my advice to Freedom to Speak Up Guardians is to provide the same level of support to the board member as they would to any other member of staff. Now that obviously can be really challenging and I think that that's where we can also provide advice and support for them. When it comes to any detriment to the Freedom to Speak Up Guardian, I think that's where our office would also come into play. I think what's really significant is that looking at Freedom to Speak Up and the Freedom to Speak Up process will become part of the CQC well led inspection and we're going to be developing guidance with the CQC inspectors and also Freedom to Speak Up Guardians together so that it will become a really valuable part of understanding what's happening in the culture of the Trust. And obviously the more senior the members of staff are that are raising concerns, I think that also you know feeds into the leadership and the well led domain of the CQC inspection.

Judith Abel: All-Party Health Group. Just sort of again wondering are there too many routes into the complaint system, we've got PALS, I think PALS are still up and running, Healthwatch, then we've got the Freedom to Speak Up Guardians in other contexts and then we've got the Parliamentary Health Service Ombudsman investigating things at the end stage and we've heard some recent poor publicity about some of their investigations taking too long. So are there too many ways into this system?

Dr Henrietta Hughes: Can I just add something; I mean we're really interested to learn what speaking up looks like in different sectors. So the NHS is not one organisation, it's as sector of the economy but we're also speaking to people who are responsible for safe speaking up in the finance sector, in telecoms, in a whole range of different industries because I think that, you know, the NHS the way that it's being done and the Trusts is obviously very novel but we want to learn from everyone else in terms of the way that works really well for them, so you know for example with the Dodd-Frank Legislation in America, if you whistleblow in the finance industry, you get a percentage of the fine. Now I don't know what that would look like, you'd go home with a whole bunch of bandages or something but I think that there is something about that gratitude for somebody to speaking up, which is obviously in finance they can put that in money terms, but there's something about that same gratitude that we need to see when patients are helpfully giving feedback through PALS or through Healthwatch but also when staff are giving feedback so that they can deliver the care that they aspire to deliver and that's what it's all about.

Duncan Astill: This morning's session was obviously very much about, actually it's not about the individual, it's about the system. I'm a Regulatory Lawyer from Mills & Reeve and this morning's session I thought was very interesting about that it's not about the individual accountability, you know I spend a lot of time defending individuals in Criminal Courts and, you know, they are just like everyone else we've heard about, going in to work to do a good job and they're overwhelmed by the system and I think it's the same for senior managers, the system that they operate underneath the regulation, the department above them, as it is for individuals on the frontline within the department system that they operate in. So you

know, actually this culture change has to be led from the very top and that includes politicians and the department and the regulators.

Dr Henrietta Hughes: May I just make a comment? I think one of the things which is thought about when we talk about NHS staff, there's a sort of, we see you know the stock photos that go up on the slides, I'm guilty as charged and they show, you know, members of clinical staff delivering clinical care, but I think we have to think about every single person who works in the NHS, which includes porters, the hospitality staff, the, the people who are doing facilities management as well as the clinicians, also the middle managers who often are put into positions with no training, wouldn't know how to line manage, they've gone from being expert clinician to an unprepared manager; we also know that there's enormous pressure on Trust boards and on executives. So I see this as pressure at every point in the system and I think that in the same way that when we find that there are problems, we should look at the system first and before we then look at the individual. But there's also something about saying they might not be great in that job but they might be fine somewhere else but that would be the same for doctors, nurses and for all sorts of people. So I would really say let's think about the system first, let's look at the individual second but also think about the pressure that exists on all staff across every role in the NHS at the moment.