HOUSE OF COMMONS

# Health and Social Care Committee

## Oral evidence: Workforce burnout and resilience in the NHS and social care, HC 703

Tuesday 20 October 2020

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Watch the meeting

Members present: Jeremy Hunt (Chair); Paul Bristow; Rosie Cooper; Dr James Davies; Dr Luke Evans; Neale Hanvey; Barbara Keeley; Sarah Owen; Dean Russell.

Questions 1 - 70

### Witnesses

I: Bernie Miller, Discharge Lounge Clinical Lead, Lancashire Hospitals NHS Foundation Trust; and Jo Da Silva, Care Worker.

II: Professor Michael West, Senior Visiting Fellow, The King's Fund; Professor Martin Green OBE, Chief Executive, Care England; and Caroline Waterfield, Director of Development and Employment, NHS Employers (part of the NHS Confederation).

III: Prerana Issar, NHS Chief People Officer, NHS England and NHS Improvement; and Claire Murdoch, National Mental Health Director, NHS England and NHS Improvement.

# Examination of witnesses

Witnesses: Bernie Miller and Jo Da Silva.

**Chair:** Good morning and welcome to the House of Commons Health and Social Care Select Committee. Today, we are opening our inquiry into workforce burnout among NHS and care staff, following the many reports that we have heard about the pressures placed on frontline staff, both before and during the pandemic.

We have some expert witnesses today: Professor Michael West of the King's Fund; Professor Martin Green of Care England, representing many organisations that provide social care; Caroline Waterfield, the director of development and employment at NHS Employers; Prerana Issar, who is the NHS chief people officer; and Claire Murdoch, the head of mental health at NHS England.

Before we hear from those experts, we will hear from some people who have experienced themselves, or have seen other people who have had, burnout on the frontline, to understand their perspective.

First, we are going to hear from Bernie Miller, who works in the discharge lounge in a hospital in Preston. She has been a nurse for 40 years. We will also hear from Jo Da Silva, who is a home care worker from Dorset. We are very grateful to both of you for joining us this morning. Neale Hanvey, who is himself a cancer nurse, will ask Bernie some questions, and then Paul Bristow will ask Jo some questions.

Q1 **Neale Hanvey:** Good morning, Bernie. Thank you so much for coming along to speak to us today. I would like you to start, if you can, by telling us a bit about your experience of workforce burnout before the pandemic and your experiences in the pandemic. That would be enormously helpful. Obviously, your role as an RCN has given you insight into the concerns of others.

***Bernie Miller:*** Good morning. I am a nurse at the Royal Preston Hospital. I am the clinical lead for the discharge lounge, which was up and running before Covid hit us.

From a burnout point of view, we have been a very good team. We supported each other quite well during the Covid period. We ended up having to extend the fracture clinic that we share our area with. It moved to the Chorley site, so we were given an area where we accepted Covid patients who were being discharged from the hospital, to free the beds up and facilitate patient flow at the front entrance of the hospital as well.

From my point of view, I have a very small team, but we are very supportive of each other. We liaise with a lot of the other areas in the hospital, including the ward areas where patients are handed over to us. None of the staff has experienced any burnout personally, but we set up a good network in the team.

We developed a WhatsApp group. You have probably heard mention of areas that developed wobble rooms. I didn't have anywhere for a wobble room, so I developed a wobble book. Staff could put their experiences down there if they were experiencing a little bit of a wobble. They could discuss what they were feeling, any jokes that they wanted to put in or any experiences they had had with patients. They could anonymise it if they wanted to.

The trust as a whole has been absolutely amazing. They set up a wellbeing team, and there was the creation of the heroes hub as well, which provides essentials to both sites of the hospital, with toiletries and food for NHS staff. We are also looking at setting up some relaxation pods in another area of the hospital, where staff can go to chill and relax with colleagues.

As part of our developing the fracture clinic as the Covid area, we also ended up having to accept and welcome teams of redeployed staff from the outpatients department. Their working was different as well. Actually, they don't want to leave us now, which is a real positive.

One of the hardest things that can cause us to have a bit of a wobble is communication, especially communication with our patients when we are wearing masks and the patients are wearing masks as well. It can cause a little bit of miscommunication, especially if the patients are hard of hearing.

I have had fabulous support from my matron, my next line manager and all the rest of the team in the hospital, from the CEO and our director of nursing to the portering staff. They have been absolutely amazing. I think the trust has really worked well together to support each other.

Q2 **Neale Hanvey:** How does that contrast with the kind of support that was in place before the pandemic?

***Bernie Miller:*** Support has always been in place in the trust. This has made it more prominent. The CEO did a daily report; we got a Covid report on a daily basis, which I shared with my staff at my daily safety huddles, when we could discuss any concerns that we had.

Sarah Cullen, our director of nursing, has now set up a weekly podcast, which will probably continue post Covid but was not actually in place before Covid hit. All the things that we have developed from the CEO and from our director of nursing and the medical directors have been really helpful. Obviously, a lot of processes are going to change now for the better.

Q3 **Neale Hanvey:** Has funding been an issue in setting these things up or sustaining them for the future?

***Bernie Miller:*** Funding has not been an issue. If we needed gloves, masks, aprons or whatever, they have always been available for us. We have been able to go down to the stores and pick them up, or put an

order in, and it is waiting for us to pick up. Anything that has been needed with regard to things like scrubs for doctors and nursing staff has been put in place.

Q4 **Neale Hanvey:** Clearly, the focus of the whole hospital team has been on Covid during the pandemic, and many other specialties have either been working on reduced numbers or have not been offering treatment. What is the feeling on the ground as we move back to the more departmental pressures?

***Bernie Miller:*** In the discharge lounge, given the fact that the fracture clinic has moved back to us, with social distancing we now have half the amount of space we had, which we share with the fracture clinic. However, within our team, we have developed a waiting list. We try to prioritise any patients that need to come down. If I identify that there is a patient in A&E who needs a medical bed, and somebody is handed over to us from a medical ward, I can look at prioritising them. It is looking at that and putting patients at the heart of everything we do, while making sure that safety is of paramount importance.

Q5 **Neale Hanvey:** I have one last question, Bernie. It relates to some of the challenges that were experienced around the discharge of patients to care homes at the beginning of the pandemic. How did you and your team feel about that process?

***Bernie Miller:*** In the discharge lounge we also have the hospital at home team, which I managed for a few weeks at the beginning of the year and right at the beginning of Covid as well. Those were patients who were going home. We could check on our system that the patients had had their swabs done. It was the same for anybody being transferred to a nursing home. We were able to check as part of our handover process, to make sure that all the processes were in place and that the patients had had the swabs done and had the results back before they were transferred out of the trust. As far as I am aware, there weren't any issues. All the processes were put in place to make sure that the patient was safe.

**Chair:** Thank you very much indeed, Bernie. We often hear on this Committee from hospitals where things are going wrong, so it is very good to hear about a hospital where things are not going wrong and where it is obviously very well run. Thank you very much to you and all your team in the hospital, Bernie, for the extraordinary hard work during this pandemic year, which is enormously appreciated by everyone on the Committee and all MPs.

We now move to Jo Da Silva, who is a home care worker in Dorset, and also a carer herself. We are really grateful to you for joining us, Jo. Paul Bristow will ask you some questions.

Q6 **Paul Bristow:** Very sadly, my father died during lockdown, but his final few months were made so much easier by the care and the love he received from domiciliary care workers during that difficult time, so I

want to thank you, Jo, and everyone else who works in that field.

How do you feel that your job changed during lockdown?

***Jo Da Silva:*** I am sorry; I am a little bit teary.

It changed dramatically in several ways. We have seen a massive increase in extra visits being put in place for our service users, for various reasons. There are health issues, and extra duties that we needed to take up due to family members being shielded. We have quite a variety of service users. Some are independent and some of them rely immensely on care staff. It changed in many ways.

For me personally, I witnessed a lot of our service users being very fearful, especially at the beginning when Covid came in. They were worried that we, ourselves, would not be able to work, so where were they going to get care? There was a lot of reassurance needed, and it still is needed on a regular basis.

Q7 **Paul Bristow:** Did you find that many service users were perhaps fearful of Covid and were reluctant to allow people into their homes to issue them the care that they so desperately needed during lockdown?

***Jo Da Silva:*** Yes, absolutely. That was very apparent. In the beginning, they were also worried that we were not going to go in. There was quite a mixed feeling. We certainly saw an increase in anxiety and health deterioration with regard to Covid hitting.

Q8 **Paul Bristow:** Jane Townson from the Homecare Association said to us in a previous session that she felt morale among domiciliary care workers had improved during the Covid pandemic because of the focus that was given to the sector. Is that your experience as well?

***Jo Da Silva:*** Yes, absolutely. I think it definitely did. There was a morale boost. Covid brought a lot of people together. There were positives and negatives. We supported each other. At the end of the day, in our line of work, we have a duty of care. It is our job and that is what we need to do, and should do.

Q9 **Paul Bristow:** Do you feel that the public have a greater appreciation of what you do as a result of the Covid pandemic?

***Jo Da Silva:*** Yes, for sure. It has certainly opened their eyes to what we actually do as care workers. It is not just personal care. A lot of our service users relied on us to take the role of some of their family members. We have been doing extra shopping and medication duties. I think overall there has been a good experience from the general public. We had really good care from Agincare as a whole throughout, and that continues. Yes; definitely.

Q10 **Paul Bristow:** Would you talk to us a little bit about how your employer has helped you during this difficult time?

***Jo Da Silva:*** We have been very lucky. Obviously, with Covid, things have had to change. We have received a consistent amount of emails and video links. We have received links with regard to our mental health and links with support—that sort of thing. We have had phone calls. Care workers have come together; we are like a little family. We have had little groups, where we have been able to offload.

Q11 **Paul Bristow:** Domiciliary home care is a bit of a focus for me, because of my recent experiences more than anything else. How would you feel that you can get better outcomes for your service users? Do you think the system where providers are paid on episodes of care really allows you to do what you would like to do for your service users, or do you think a focus on outcomes would be better?

***Jo Da Silva:*** Yes, definitely. Sorry, I have lost track of the question.

Q12 **Paul Bristow:** At the moment, your service providers are recompensed on episodic care—every 15 minutes or every period of care. That is how people are reimbursed. Do you feel it would be better if they were reimbursed on outcomes? For example, would the service user have a better outcome if they were able to make their own cup of tea or go out and see friends, and you were able to help them to do that sort of stuff? Would that be a better situation?

***Jo Da Silva:*** I think so, yes. I truly believe that. Service users are allocated a certain amount of time because that is what is paid for, but we find ourselves staying for much longer periods of time than is allocated, and especially more so during the Covid period. It was there before, but it has certainly increased during the Covid period. Like I said, we have obviously taken on extra duties as well.

**Paul Bristow:** Thank you very much, Jo. That was very powerful.

Q13 **Barbara Keeley:** I want to talk about the additional duties that you have just been talking about, Jo. I know that district nurses and GPs were not visiting and not able to take on those tasks. What impact do you think those additional duties have, and how should they be handled going forward? Should we look at the home care role and say that it can be expanded, because people coped with it?

***Jo Da Silva:*** Yes, I think so. It showed that we have taken on additional duties, as I said previously, and we have been able to manage them as an agency; we really have. We have taken on many extra duties. We are all well aware that it was difficult to get in contact with GPs and district nurses. We were asked at certain times to do certain tasks that required a district nurse.

It was across the board, even down to the extra shopping duties. Key workers were allocated a certain timeslot, but as domiciliary care that did not necessarily work for all of us. We were having to juggle our own work schedule, sometimes working outside our hours to do a service user's

shopping because they were either shielding or had no family members. The increase in our workload was exacerbated massively, but we did it.

Q14 **Dr Evans:** Jo, given all the experience that you have seen, what would you like to see come down from the top? Is there something that you think would make a real difference to try to prevent burnout, be it a policy or something you had asked for? If I were to sit you in front of Matt Hancock and say to you, "What would you like to see to stop burnout?", is there something that springs to mind from your personal experience of your sector, or from speaking to your friends and family, that would make a big difference?

***Jo Da Silva:*** In my personal opinion, and that of a lot of my colleagues and my friends who work in different areas of the sector, the main thing that has been discussed is about being recognised. That has come up time and time again. I feel that we have done above and beyond what our job should entail. We had to because of the Covid situation. To be on a par with other people means more than anything. Yes, it would be nice to get a little bit of a pay rise for what we do. We have done things that are on a par with other medical professions, if I am honest. That is absolutely fine because we have a duty to care, and we do the job for a reason. I think the main thing is to be recognised.

Q15 **Dr Evans:** That is a really important point. It has come up time and time again for us. Is there something specific in terms of that recognition? It is anything from the badges that have been put out to say there is a care sector out there, to the pay, which you mentioned. There is also parity in terms of education. Is there something specific?

I am mindful that we are trying to make recommendations. It is key to make sure that there is a balance between it not seeming to be tokenism but not going completely over the top and swamping it. Is there something that the sector, even from your personal experience, would feel is right in terms of that recognition? If you cannot answer that question, I understand that. We are just trying to feel out the best way of getting that across to Government.

***Jo Da Silva:*** The only thing I could think of is that we are not just perceived as care workers. I do not know how to word this other than saying that we are just seen to do the personal care side of things, but it entails so much more than that. I would like the whole care sector to be more highlighted and positive. There are negatives to it—of course there are—but there is a whole load of positives in the job as well. That needs to be highlighted.

Q16 **Dean Russell:** Jo, thank you for your testimony today as a witness; it has been really enlightening. My question is about looking forward. It has obviously been an incredibly intense time in the past few months with Covid, and the social care sector has done an incredible job with home care, social care and the many unpaid carers out there.

What would you say we should be putting in place for the next six

months or a year to make sure that there isn't burnout, moving forward? I would also like to get your thoughts on career pathways for carers. One of the things that has come out in previous testimony, and from what I have heard on the frontline, is, where do people go once they have become a carer? Do you think there should be better ways for careers, long term, to flip between the NHS and social care? I am interested in your views as somebody in that space.

***Jo Da Silva:*** Obviously, funding is a big issue. I know it has been discussed, but it is a big issue. There is the availability of PPE with regard to that, also. What was the next question? Sorry.

Q17 **Dean Russell:** Looking around career pathways, I was interested in your view on whether you feel that once you have become a carer there are other options within the care system to be able to have long-term employment but also build a career.

***Jo Da Silva:*** I think so. There are many options out there, certainly within the agency I work for. There are other options and a career path. You could go on to do anything you want to do. It depends how you view it. For me, personally, I love the job and I am happy in what I do as a care worker. Some people could use it as a stepping stone to go on to nursing. There are many avenues for people to review and go down in care sector work.

Q18 **Chair:** Jo, if you can bear it, there are a final couple of questions from me. I want to ask you about testing. Are you tested for Covid on a regular basis?

***Jo Da Silva:*** No.

Q19 **Chair:** Do you think you should be?

***Jo Da Silva:*** Yes, I do. For sure, that would lessen a lot of the anxiety among care workers. Most definitely.

Q20 **Chair:** Could you explain how that anxiety works for you?

***Jo Da Silva:*** The guidelines are changing all the time on the symptoms. Obviously, we are well aware of the symptoms in our line of work, so we are always looking for symptoms. Sometimes even the slightest symptom could be Covid related and then the anxiety sets in. Our immediate thought as care workers is that we would like to go and get tested there and then, not only for ourselves and our own family but to protect our service users.

Q21 **Chair:** I know that you are a carer yourself. You have to look after your son. You talked earlier about having to work longer hours to give your service users additional care during the pandemic. How have you juggled your family responsibilities with your professional ones?

***Jo Da Silva:*** I have been quite lucky in the sense that I have a partner, and a very long-term friend who has known my son since he was little. She has always been there, and I have been able to use her, so I have

been quite lucky but I know that other people have not been. It has been very stressful; I am not going to say that because I have had support it has necessarily been any less, because it absolutely has not. My son is literally obsessed with Covid at the minute in quite a negative way.

**Chair:** Thank you very much for joining us. It is fascinating testimony. Thank you, Bernie, as well for joining us. We really appreciate it. It has created an excellent context for this morning's session. You are welcome to carry on tuning in, or you can watch it on TV. We appreciate you answering our questions this morning.

## Examination of witnesses

Witnesses: Professor West, Professor Green and Caroline Waterfield.

Q22 **Chair:** We now move to our second panel. I welcome Professor Michael West of the King's Fund, Professor Martin Green of Care England and Caroline Waterfield, director of development and employment at NHS Employers. Thank you all for joining us.

Professor West, what is your reaction to what you heard from Jo Da Silva about some of the pressures of knocking door to door for service users on the frontline?

***Professor West:*** First is a sense of huge admiration and gratitude for the compassion and professionalism during what has clearly been a very difficult time. My sense, Jo, is that you were rather understating the difficulties you faced with the problems of managing childcare and the additional demands on you. There was a sense of how colleagues have been a mainstay and compassionate in supporting each other in what has been a very demanding time, as well as a sense of the need for recognition nationally in terms of support for the social care sector, not just recognising that it is important but providing practical support for all the organisations that are delivering social care. Overall, there is a real thank you for the inspiration and compassion in what you have said.

Q23 **Chair:** I think we all echo that. You have done a lot of work on the issue of burnout for the King's Fund, and a lot of thinking about it. Can you define burnout? Can you tell us whether it is something that predates the pandemic, or whether it has become a big issue during the pandemic?

***Professor West:*** Very simply, stress and burnout at work are when the demands on us exceed the resources that we have; the level of work demands is very high and the resources we have to respond are not sometimes adequate, whether to do with our own personal resources, such as lack of skills, lack of training, lack of equipment, or the resources in our teams or organisations such as staff shortages, lack of PPE equipment, inadequate technologies or, more broadly, lack of the training and skills needed.

The other point to make about burnout is that the term is often used to describe a constellation of three factors. One is emotional exhaustion.

The second is a sense of what is sometimes called depersonalisation: cynicism or detachment, with people finding it difficult to relate to the people they are caring for. The third is a sense of lack of personal accomplishment—that they are not really making a difference. Sometimes it is called moral distress, the feeling that "I am not providing the quality of care that I should be providing for the people I am offering services for."

Back in January, stress levels in the NHS were at their highest since we began recording stress levels in the current way. We know that around 50% more staff in the NHS report debilitating levels of work stress compared with the general working population as a whole. In 2019, 41% of NHS staff in the national staff survey reported that they had been unwell as a result of work stress during the previous year. For nurses, it was 44%; for midwives it was 51%. Those were the highest levels that we have recorded.

Q24 **Chair:** When did you start recording in that way?

***Professor West:*** The staff survey was begun in 2003, but the change in the specific items occurred around 2009. This is the highest level in the last 11 years. My sense is that over that entire period there has been overall an increase in stress levels.

We see, for example, similar pressures in primary care. GPs reported their highest levels of stress in the national GP worklife survey in 2017. Those were the highest levels since 1998. That is mirrored by the data we have on the intention of GPs to quit direct face-to-face patient care in the next five years, which at 39% is its highest level.

The General Medical Council national training survey goes out to tens of thousands of trainees and doctors. In 2019, they used a standardised international measure called the Copenhagen burnout inventory. The data that came back to the GMC indicated that something like 44% of trainers and 49% of trainees had moderate or high levels of burnout.

Overall, the picture that we had was of very high stress levels, and then the pandemic struck.

Q25 **Chair:** You have seen the NHS people plan that was published in June last year. In your view, what are the strengths of it and what are the gaps?

***Professor West:*** The strengths are that it is beginning to identify some of the key factors that impact wellbeing and intrinsic motivation at work, to do with giving people more voice and influence, and it addresses issues to do with creating cultures that are focused more on learning, fairness and openness than on fear and blame. It strongly addresses issues of discrimination against, for example, minority ethnic groups, which have been thrown into sharp relief during the pandemic.

The people plan is focused on the importance of building more effective teamworking, compassionate leadership and compassionate cultures, and to some extent it focuses on the core issue of chronic excessive workload. That needs a much stronger focus. There is some focus on better supervision for staff, and training and development. All of those are welcome.

The gaps are that we do not yet have a detailed thought-through workforce strategy for the future. In a sense, the people plan is like a very smart looking car but we do not yet have the engine of a detailed workforce strategy. What skills are we going to need to meet the demands of our health and care systems in the future? What skill mix are we going to need? What new roles need to be developed? How are we going to work with community services? How are we going to integrate with social care services?

It does not provide detail on how many of the recommendations and prescriptions in the people plan can be implemented by integrated care systems at regional or local level, and how individual trusts will be supported to implement the recommendations. The direction of travel is excellent, but we need a lot more detail, particularly around workforce strategy.

Q26 **Chair:** It does not answer one very simple question, which is how many doctors and nurses the NHS is going to need in 10 years' time, and are we training enough? Is that something that needs to be thought about if we are thinking about chronic excessive workload?

***Professor West:*** It needs to be thought about very deeply. We had a staff shortage of 100,000 at the beginning of the pandemic back in January. That is something like one in 10 or one in 12 staff across the NHS. It places enormous pressure on existing staff and contributes to the problem of chronic excessive workload.

I want to be clear about the issue of excessive workload. The danger is that we do not see it. It is like the pattern on the wallpaper that we no longer see, but it is the No. 1 predictor of staff stress and staff intention to quit. It is also the No. 1 predictor of patient dissatisfaction. It is highly associated with the level of errors.

Staff shortages are clearly the most important factor in determining chronic excessive workload. Unless we have a well worked-out plan for how we can fill all the vacancies and reduce the attrition rate of staff in the NHS—a hugely important point—we are going to be in trouble. The fact that one in four nurses and health visitors leaves the NHS within three years of joining it is deeply concerning. The fact that so many doctors are intending to quit the NHS, some to go abroad and some to quit medical practice altogether, is also deeply concerning. These issues are not confined to nurses, midwives and doctors, but relate to groups of staff across the NHS. A well- worked-out, thought-through strategy, based on a vision of the kind of health and care we want to be providing

in 10 years' time, is fundamental to our ability to plan for the numbers that we will need over that period.

Q27 **Chair:** Thank you very much. Professor Green, how do you define burnout in the social care system? Can you quantify in the way that Professor West just has the numbers of people affected?

***Professor Green:*** On what burnout means in the social care sector, I think it is very similar to what Professor West said. It is about people feeling that they cannot do the job they want to do. It is about people feeling that they are completely pressurised, that the workload is unmanageable and that they cannot deliver what they want to deliver to the people they support.

Unlike Professor West though, unfortunately the problem in social care is that we do not have comprehensive datasets. We do not have things like the staff survey in a uniform way, although there is some work being done by Skills for Care to try to make sure that we have some understanding of what is going on in social care. One of our challenges is that it is a very fragmented system.

Professor West is fortunate to be able to talk about things like the people plan. We have been waiting for a long-term strategy on the social care workforce for a long time. It would be really helpful if we could have a plan, but of course the reality is that, although there is endless discussion about integrated services, one of the things that we need is a clear and integrated plan. If we are to meet the challenges of the future, we have to make sure that we have enough staff. Currently, the silo approach is not going to work. We need people who can move across systems, just as citizens do. There are some big deficits in social care, and we are running to catch up with the NHS.

Q28 **Chair:** One solution is a workforce plan. Are there any other key solutions in your mind?

***Professor Green:*** I think we need a 10-year plan for social care, just as we have a 10-year plan for the NHS. Those plans should be aligned on every level. We should look to the workforce issues. We should look to the outcomes we want to require. We should look also at the issues of skills mix. Jo Da Silva made some really important points about how the pandemic had shown that people were able to step up and do things they were not doing in the past. We need a very clear vision for what an integrated system will look like, how we support staff and how we make sure that we retain as well as recruit the right people. Some of that needs to be based on values.

Professor West spoke about concerns around recruitment and retention. We have similar concerns in social care, but probably worse than in the NHS, both on people coming into the system and going out again and on burnout issues.

Q29 **Chair:** We will come back to you very soon, Professor Green, but I want

to ask Caroline Waterfield a question before I bring in my colleagues. Thank you so much for joining us. You are from NHS Employers, which negotiates the terms and conditions for NHS staff.

We just heard Professor West say that to publish a people plan without detailed projections of the skill mix, the skills and the numbers of doctors and nurses that you will need in the future is like having a car without an engine. Would you agree with that?

***Caroline Waterfield:*** From an NHS Employers and NHS Confederation perspective, we were keen to see the people plan published over the summer. We were supportive of the things in the remit that could be set out at that point in time, accepting that it could not cover everything that it needed to cover. It set out some of the long-term plans that required additional and fairly substantial funding attached to them. There was a risk by not publishing the people plan as it exists at the end of July and beginning of August that the absence of the plan itself became bigger than not having a part plan.

What we have experienced and what we have seen over the summer sets out what we have learnt through the pandemic, and what we can take in terms of the previous evidence, to do what we can to support improving staff experience. We also said though, similarly to Professor West, that it was light, and it did not cover some of the longer-term aspects that our employers were keen to see and the funding that needed to go behind that.

We would fully support the focus on addressing vacancies, not just within the NHS acute provider sector. It needs to look at the wider health sector and social care. For us, it needs to look beyond the numbers of doctors and nurses, which can be high volume, and say that if we are to deliver care differently and transform our services, and have a more integrated approach to delivering that care, we need to pay significant attention to some of the smaller professions, such as our allied health professions and our healthcare scientists, and to the role of pharmacists and where they are based and placed in and across our communities. If we do not do that, we will fail to deliver things like diagnostic workforce and diagnostic service transformation in the way that it needs to be geared up to deliver the care needed for our patient population.

It is yes and no. I agree with Professor West that a whole lot of work still needs to be done, and we must have a medium to longer-term view and the funding behind it, but there is also some value in the things that were published this summer around placing real focus on what we can do to improve the experience of staff with the evidence we have.

Q30 **Barbara Keeley:** My first question is to Martin Green. Professor West has identified autonomy and the ability to deliver high-quality services as central to avoiding burnout among health staff. Given what we know about the strain on the social sector, do you think social care staff were being given autonomy and the ability to deliver high-quality services?

You commented on how social care staff stepped up during the pandemic. Do you think that contributed to burnout, or is it a sense of pride and people being pleased that their responsibilities have expanded?

***Professor Green:*** I will answer the second question first, Barbara, if I may. I think throughout this pandemic staff were pleased that they were able to expand their role. In fact, they got a lot more autonomy through the pandemic because there was nobody in some of the support services, or indeed in commissioning, to say, "You can't do this."

One of the challenges, going back to your first question, is the way in which social care is commissioned. It is all commissioned on a process basis, particularly in domiciliary care, sometimes minute by minute. That does not allow for the professionalism of staff to make judgments about how they deliver care on a much more outcome-based framework.

One of the challenges is that the structure of the way social care is commissioned does not facilitate people having a much more autonomous role, although I think they showed during the pandemic that they were able to step up and do a whole raft of things. If you give them the confidence and the professional status, social care workers will be able to do those things, which are about delivering an outcome for the people they support.

Q31 **Barbara Keeley:** There has been mention of the people plan. Given that the social care workforce is clearly spread across thousands of independent organisations, what would a people plan for social care look like? What do you think are the immediate changes that should be made in order to support the workforce? Clearly, we have the second wave, and we have winter to work through. We are already identifying burnout. What would those two things look like: a people plan and the immediate changes that could be made?

***Professor Green:*** What a people plan would look like is, first of all, to start with a vision for social care. Too often, we begin discussions that are all about the nuts and bolts, but we need a clear vision about what social care delivers.

You would then say, "What are the requirements and what are the levels of skills and competencies? Indeed, what are some of the career escalators that people might put in place, to enable people to see this much more as a career?" What we have seen during Covid is the professionalism of the social care workforce, but it has never really been acknowledged by the rest of the system.

You are absolutely right. It is a fragmented system, but there are other fragmented systems where we have clear skills and competencies frameworks—for example, in the airline industry. There might be several airlines, but we have a clear understanding of what the level of competency is to fly a plane. We could have a really clear vision. We could identify a very clear skills and competency framework. We could

put in some career escalators. I think Jo said in her evidence that people use social care to go on to do nursing. We have seen some great examples of that with the nurse associate role. There is a real opportunity to have a very clear skills and competencies escalator.

In terms of what could be done immediately, one of the things we should acknowledge is how much money goes into training and development in the NHS. Health Education England's budget, at £4.9 billion, is enormous compared with social care's budget for training and development, though social care has more staff than the NHS.

One of the things that could happen is that we could open the training and development budget out to the whole system so that people could access some of that training and development. What that would do is two things. It would give a clear lot of skills and training to the social care workforce; it would also mean that the social care workforce was training alongside the NHS workforce, and that would enhance relationships and give better understanding of what each bit of the system does.

Q32 **Dr Evans:** My question is to Professor West, to begin with, and is about workload intensity. You gave intrinsic factors on burnout, as well as extrinsic factors. My experience, when I was on the wards in hospitals, was that with a cholecystectomy—removing a gall bladder—a patient would be in for seven days. They are now in and out within a day. In primary care, we give a lot of workload to nurses and allied professions, but that means you are dealing with complex patients every 10 minutes who have multiple comorbidities.

What evidence is there about that, and what thought has been put into dealing with work intensity for professionals? How much does that contribute? Anecdotally, from my point of view, and the people I know, that is one of the biggest drivers for the problems we face. People cannot deal with the intense workload repeatedly when they are seeing 40 patients a day.

***Professor West:*** That is absolutely right. What we have seen, particularly in general practice, is that there is much greater complexity of presenting problems, and it has increased the workload. We can distinguish between quantitative workload—the number of tasks I have to do—and qualitative workload, which is how intense it is. All of those demands have an impact on the individual's ability to respond effectively.

When we have episodic, transient demands on us, that's life; we can deal with that. It is when it is chronic that it is a problem. The evidence we have is that stress in healthcare tends to be chronic. If you measure stress at one point in time and then again six months later, it is usually at a similar level if it is high, for example. What is disturbing is that, whether it is intensification in terms of amount or quality, we know that that level of chronic work stress predicts cardiovascular disorders, cardiovascular disease, addictions, diabetes, cancer and depression.

There is a significantly increased likelihood of diagnosed illness when you have high levels of work demands, and also greater odds of early mortality. The paradox is that, in a system focused on promoting health and wellbeing, in the process we are damaging the health and wellbeing of a very large proportion of our population who work in health and care services.

Q33 **Dr Evans:** Have you seen any evidence, particularly for other countries, or indeed in your work across the UK, of how to de-intensify that or box it off to try to protect the staff?

***Professor West:*** Yes. What is striking about our system is that, when we look across the NHS in England, we see light spots and dark spots. We heard from the first witness from Royal Preston a light spot of good practice. We see light spots and dark spots, but even within the best organisations there are dark spots. In the worst organisations, there are light spots of good practice.

To take the example that you gave of primary care, at the Prince of Wales surgery in Leicester they were working under intense pressure, and the staff were collectively saying that they could not cope. Counter-intuitively, they introduced two team meetings every week and a partners' meeting that all staff could attend so that they could begin to address the question of workload and work intensification, and they have overcome many of the problems.

In St Austell in Cornwall, they brought in physiotherapists to deal with some of the musculoskeletal problems that were being presented to GPs. They brought in psychiatric nurses to work with people with mental health problems in the practice so that GPs were able to have more time to work with some of the most complex cases. It reduced the quantitative demands on them in order that they could deal with some of the qualitative demands. Across the country during Covid, we have seen many examples, as we heard from both of the first two witnesses, of teams coming together to review what they are trying to achieve, what they are faced with and how they are going about it. Through that review process, they come up with ideas for new and improved ways of delivering services.

We have seen innovation at a scale and at a pace that was unimaginable just a year ago. There is something about supporting local services and local teams to take time out to review and reflect on how they respond to those sorts of challenges.

Q34 **Dr Evans:** Professor Green mentioned the airline industry. Doctor colleagues and nurses often say to me, "Why doesn't the Government introduce a fixed number? You wouldn't allow a pilot to fly more than 12 hours. Why don't we fix the number of patients that a professional should see to box everything off?" Is that a view that you would take, and would it be a solution? Is there any evidence to back it up, or is there an alternative?

***Professor West:*** I think we need to gather evidence about the quantitative and qualitative demands on people. I want to give one example of why that is so important.

Many nurses want to work 12-hour shifts, for a variety of reasons; yet the evidence we have internationally is that 12-hour shifts put an enormous amount of pressure on nurses and to some extent can impair the quality and safety of care. The solution is not to say that we are going to get rid of 12-hour shifts. The solution is to say, let's look at the evidence and the factors that mitigate the impact of 12-hour shifts on people. Let's look at the idea of only having a 30-minute rest break in a 12-hour shift. Is that appropriate and is that right?

Rather than reaching for one lever and seeking a solution like saying it is the number of patients, we need to do much more to gather evidence. There is a lot of evidence internationally on how we can safely deliver high-quality care. We must adapt that to the local circumstances of the organisations that are delivering care. Simply imposing a template on local organisations like Royal Preston or a social care organisation without taking account of local context often creates more problems than it solves.

Q35 **Sarah Owen:** Professor West, you touched just a minute ago on black, Asian and minority ethnic healthcare workers and burnout. Could you give us a bit more information about that, and about some of the possible solutions to the very specific issues that our black, Asian and minority ethnic healthcare workforce are facing?

***Professor West:*** We are all aware that the pandemic has revealed the tragic disproportionate effect of the context of our society on people from minority ethnic group backgrounds, and the tragically high number of deaths among staff from minority ethnic groups. What that has done is shine a light on evidence we have been aware of for some years of how discrimination and racism in society generally takes a toll on the health and wellbeing of people from minority ethnic groups and, indeed, other groups that are discriminated against. The challenge for us is what we do about it.

We have some examples from across the NHS of trusts that have made significant progress. North East London NHS Foundation Trust has implemented both processes and structural changes to address the issue, focusing on reducing the disproportionate number of disciplinaries against staff from minority ethnic groups; looking at appointment and recruitment processes; looking at the role of leaders in bringing about change; and modelling a commitment to equity, equality and positive approaches to diversity and inclusiveness, as well as training all their leaders to understand the impact of discrimination on the wellbeing of staff from those groups and encouraging cultural changes. There is work going on across the whole of London at the moment, initially inspired by the workforce race equality standard work, to bring about a change in culture.

Our solutions have to be at three levels. We have to change the structures and processes in our organisations around disciplinaries. We have the example of Mersey Care, which introduced a restorative culture and focused on ensuring that the approach to supporting staff is based on support and learning rather than on fear and blame.

It is about making sure that we train leaders to lead their teams and the organisations in an inclusive way so that everyone feels included by their leadership. It is also making sure that everyone in organisations sees that they have a responsibility for creating inclusive and supportive cultures. After all, the NHS was built on the idea of providing compassionate care to everyone across our society, regardless of wealth, prestige, ethnicity or background. Those principles of inclusivity are a responsibility of all staff in the NHS, so we need action at all those levels. There are very good examples around the country where that is already occurring.

Q36 **Sarah Owen:** Thank you so much, Professor West. That was really useful and heartening to hear.

My second question is about staff from overseas. We know that overseas staff have made a massive difference in our fight against the pandemic. They have also paid, as you say, a tragic price. The first 10 doctors we lost during the pandemic were from overseas, and Filipino nurses have died in greater numbers in this country than they have in the entire Philippines. In looking at vacancies, are we going to need a different approach in how we attract and retain staff from overseas to this country?

***Professor West:*** The short answer is yes. We need to attract staff from other countries.

There is a critical period when they first arrive when they need to be supported with the practical details of beginning a new life, around housing and dealing with the day-to-day bureaucratic challenges, as well as integrating into a system that is often very different. There are again examples around the country where support is being put in place to achieve that. Tayside meets international recruitment colleagues from the plane and makes sure that they are provided accommodation. In the north-west, led by Wigan, a consortium of trusts has a scheme for supporting international medical graduates coming to work in this country. In some places, for example, they help with acculturation by making sure that a doctor doing a breast examination never does one without seeing it modelled by a doctor from the UK on a number of occasions first, so that people are supported to manage the process of integrating into the system.

We have to address those issues, but there is also the issue of retaining people. We have the example in the south-east, in Barking, Havering and Redbridge, of a preceptorship programme for new nurses joining the NHS from other countries. They are supported intensively during the first six

months of their service in the NHS and brought together in groups to provide each other with social support; and they get expert support from experienced, senior nurses to help them cope with challenges that they face both in the course of their work and in the course of their life in a new country. That scheme has led to a massive reduction in the attrition of international nurses from the trust.

We need to address three issues: how we attract people; how we manage the transition in the most supportive way to enable them to be effective practitioners; and how we retain them and create conditions in our organisations where people are not getting burned out, but are supported and valued and feel they are making a positive difference to patients and communities.

Q37 **Paul Bristow:** Professor West, the WHO does not classify burnout as a medical condition. Surveys can capture how some of those who work in our healthcare system are feeling at a particular time, or even over time, but without classificational criteria how can we determine with any degree of certainty, or in a quantitative sense, the extent of the problem in the NHS?

***Professor West:*** It is a really good question, and one that I have raised over the years a number of times. We need a consistent way of measuring stress in the NHS. We have a couple of questions in the national staff survey that focus on the second area there. They are not standardised questions but they correlate with some of the more robust measures that we know of.

The most robust study that was undertaken in the NHS used a measure called the general health questionnaire, which is well established as a measure of stress in the general population and which predicts mental health issues. It predicts physiological problems. In order to establish what was an appropriate cut-off, 600 clinical interviews were undertaken with staff and correlated with their scores on the general health questionnaire. That was a very precise way of establishing an appropriate cut-off and suggested that 27% of staff scored above the cut-off, indicating minor psychiatric morbidity, compared with 18% in the general working population as a whole.

We need to establish a single measure across our whole health and care system—Professor Green talked about the need for measurement in the social care system as well—which gives us a very clear and standardised indication of the extent of the problems. The General Medical Council has used the Copenhagen burnout inventory, which is well accepted internationally. I think that is a good step forward.

Q38 **Paul Bristow:** We now have below average hospital use. I heard a lot of what you said about chronic excessive workload before Covid, and during, but we now have below average hospital use. What is the effect of extra downtime and lower demand on staff? What effect is that having now?

***Professor West:*** Extra downtime and lower demand obviously has a beneficial effect on us. We know that when we go out into nature we feel better, and when we take time out to practise mindfulness or relax. Obviously, those things have a positive effect.

The problem at the moment is that we do not have sufficient data from the pandemic to indicate what impact the fear people have about contracting the virus has on their levels of stress; the fear that they will pass the virus on to colleagues and family members, and the general fear that exists in society. However, NHS England and Improvement set up support services for staff during this period. There have been half a million contacts with people seeking help from those services, which is an extraordinary figure. The indications from the few studies that have been done—it is important to say that they focus on particular groups of staff like ICU staff or nurses—suggest that there are significant impacts on wellbeing.

Q39 **Paul Bristow:** Let's hope that the downtime we have at the moment has helped. I am conscious of the time, and I have one final question. The King's Fund reported that NHS staff were 50% more likely to experience high levels of work-related stress compared with the general working population. Nursing and healthcare is obviously a stressful but very rewarding profession; you deal with emotional issues like life, death and illness. What is the equivalent position in the general working population that you are using for comparison?

***Professor West:*** I am not sure I understand the question, but the comparison was based on the—

Q40 **Paul Bristow:** If you are comparing what is a very stressful job, and that everyone would accept is a stressful job, emotionally, but it is also a rewarding job, and trying to create equivalence between that job and the general working population, I would think you would want to choose an equivalent position within the general working population. You cannot compare a nurse, for example, with somebody who works in a factory and does not have one-on-one emotional time with patients. How do you factor that into your comparisons?

***Professor West:*** The point to make is that, regardless of who you are comparing it with, the effects of stress on healthcare outcomes are dramatic. If you have high levels of stress, and the data from the survey that I described show that 27% of staff were scoring above a cut-off indicating higher psychiatric—

Q41 **Paul Bristow:** If I may, Professor West, it is a bit like saying that a soldier is likely to have more stress because they have a stressful job. A nurse is likely to have more stress because of the nature of that job. I just want to make sure that that is captured in your analysis. Just saying that 50% are more likely to be stressed is a shocking statistic but you have to take into account the nature of the job, as you would for someone who serves in our armed forces, for example.

***Professor West:*** Yes, and the nature of the job, if you sustain those demands over a period of time, will have an impact on the likelihood that you will be diagnosed with an illness, or that you will have early mortality. You will have cardiovascular disease or cardiovascular disorder. Whatever the occupation you work in, if you are subject to sustained levels of stress and high levels of chronic work demands, it will have a negative impact not only on your physical health but on your likelihood of making mistakes. We know that doctors subject to very high levels of work demands chronically are between 45% and 63% more likely to make a major medical error in the subsequent three months.

Q42 **Neale Hanvey:** I want to go back to establishment, if I may, particularly how we tracked and captured the baseline of staff prior to Covid, and look at where there was evidence of chronic excessive workload; the redeployment of staff when some services were not in place because of Covid; the additional skilling up of that workforce and expansion of the role; and how that translates to future planning for a minimum skill mix that enables the developments realised as part of Covid, and any additional support that was provided then, and prevents them from being lost.

In terms of the workforce planning aspect, would Caroline talk about the data capture—where we were, what happened in Covid and how we are using that information to plan the workforce for the future, bearing in mind that even after the second wave Covid will probably not be over? There is going to have to be some capacity to respond to a dynamic and shifting situation in the months and years ahead.

***Caroline Waterfield:*** You have touched on some of the things that our employers and staff experienced in the NHS through the pandemic to date. There was the redeployment and use of our student population. People who worked within local organisations offered to return to work. Existing staff who may not have been doing their normal day job, or whatever that was at that point in time, could be supported to upskill or reskill and be deployed to teams to support Covid patients through the pandemic to date.

What we have now is a restoration of services. A lot of the people who were repurposed and reskilled to support some of that are back doing their other job. Students have, quite rightly, gone back to their course, to resume their studies, because we absolutely need to make sure the priority is that they continue, complete and are available at the point when they were planned to be available to support the workforce as registered professionals.

While we might have people who are able to support some of the demands of dealing with Covid, they are being asked to do other things as well. There is a risk of multiple groups being called on multiple times. There is probably only one job that you can do at any one point in time, not standing down services to support that.

Q43 **Neale Hanvey:** I appreciate that. The word you used there, which is crucial, is that they "could" do other jobs. I am interested in what the plan is. What is the plan to capture that activity when people have expanded their roles, worked in different fields and been innovative? One of the key things that people have highlighted to us is that there has been innovation; barriers have broken down and bureaucracy in the service has been minimised. What is being done to capture the parts that have enabled the workforce to respond in such an impressive way?

***Caroline Waterfield:*** It is at multiple different levels. Local organisations have captured the things that they did differently with their own workforce. We have seen a real acceleration of partnership working across integrated care systems, and the development of some of the infrastructure there to look at how we managed some of that across a locality, accepting that there is still a fair way to go on some of the infrastructure that is needed across systems.

Regional teams have been looking at what people have done in a much broader patch around regions. We know, from our own point of view, that the NHS Confederation reset campaign has connected with members to pull out some of those innovations, whether around digital technology or use of different conversations and different teamworking across some of the traditional boundaries, to be able to play back to members through sharing good practice. We also have the NHS England and Improvement beneficial changes work.

Information is being gathered at a whole raft of different levels. We need to make sure that it is locked in and reflected on properly. I suppose there is a risk as we move into the heightened period of winter that it will be different. It is different. Some of that learning can be used and locked in, but some of it will need to adapt and change, and then we will have new learning. There is a real conundrum for all parts of the system to be able to do that, but there is willingness. We have seen the start of it over the last few months. We just need to make sure that there is some focus and that there are beneficial changes.

**Chair:** I need to move on to the next panel. We have a final brief question from Barbara Keeley.

Q44 **Barbara Keeley:** Over and above all the other stresses that you have talked about for staff is the additional worry with Covid that NHS and care staff might take the infection home to their own family members. How much is that additional stress a factor that you come across, and what measures are being taken, and could be taken, to help staff with that? I know of things like people living in flats or hotels so that they do not go home to their children or a vulnerable person, but how much is that recognised and being dealt with? Professor West, is it a stress that you came across?

***Professor West:*** The Samaritans helpline set up to support staff certainly reports that that was a key issue that was raised. Health

Education England's learning collaborative, which was also gathering data, reported a similar issue, so it is absolutely right to have that concern.

***Caroline Waterfield:*** I would agree. There are a number of other factors that we will need to keep an eye on as we move into the next stage, where increasing numbers of self-isolating issues that may appear from school closures might impact on the capacity of our staff to work, and increased levels of anxiety there. There is a raft of things to keep an eye on.

Perhaps I could take one moment to say that there are some practical solutions that can address some of the heightened levels of stress and pressure around jobs, which Professor West mentioned. These are difficult jobs for our people, whether they are in the NHS, wider healthcare or social care. It is about making sure that we give people breaks on shift and that they have somewhere to go or have somewhere to be able to check in and check out with their manager and their surrounding team. That makes a huge difference to their wellbeing at work. Good line management and supervision is absolutely critical, as well as the leadership of the organisation in which they are working.

Some of those things have an immediate productivity impact. If we do not do them, they have a longer-term disproportionate impact. The benefit of making sure that we have time at the beginning and end of shift to check in and check out is worth it longer term. The benefit of having somewhere where staff can go and have a break, meaning that those staff areas might not be patient areas or clinic areas, is really important. They are fairly practical things, but they are critical for us to hold on to.

Q45 **Chair:** Those are very important points to end with. Very briefly, Professor Green, and then we must move on.

***Professor Green:*** What has come across today is that we have exactly the same problems in social care as they do in the NHS, but we do not have the systematic response to them that the NHS has. We need to look at how we roll the responses that the NHS has into social care as well. The issues are the same and people are dealing with similarly complex cases. The impacts are the same in social care as they are in the NHS.

**Chair:** Thank you very much indeed. Professor Green, Professor West and Caroline Waterfield, thank you for your excellent and very informed evidence. It is very good to have Professor Green here and to hear the social care perspective. I think the things that you talk about are things that can be put right if we have that 10-year plan. Professor West, thank you too, and Caroline Waterfield, for your very thorough and thoughtful contributions.

Witnesses: Prerana Issar and Claire Murdoch.

Q46 **Chair:** For our final panel this morning, we are very pleased to welcome Prerana Issar, who is the NHS's first ever chief people officer, and Claire Murdoch, who is in charge of mental health for NHS England and a regular contributor to our Committee. Claire has a very important announcement about mental health, which I will ask her to talk to a little bit later, but I want to start by asking Prerana some questions.

Many congratulations on your appointment. This is a very simple question. Do you accept that shortages of doctors, nurses and other frontline workers contribute to burnout among staff?

***Prerana Issar:*** Yes. The short answer is yes. Let me expand on that a little more, but, first of all, good morning and thank you for the welcome, Chair.

Even before the pandemic, there were shortages and rising demands in services. The demand curve and the supply curve were both contributing to stress across the NHS. That was already reflected in the interim people plan that was published in summer 2019, in the service of delivering the long-term plan.

What the pandemic has shown us—a once in 100-year event—is that NHS staff are responding and pulling out all the stops. It has also shown us that the health and wellbeing of our staff and the numbers of our staff, as well as the environment in which they work, are three mutually reinforcing elements that determine how people respond to the pandemic.

I would like to say a few words about the people plan.

Q47 **Chair:** I absolutely want to talk about that, but, before we do, I want to talk about the numbers because I know that is one of your three key criteria. The plan published in July 2020 had no projections of the numbers of extra doctors and nurses the NHS would need. We were told that they would come after the spending review. When those numbers are published, will they be independent forecasts? Will they be what the NHS believes it needs, or will they be a number that is negotiated with the Treasury on the basis of cost?

***Prerana Issar:*** In the service of the lockdown plan, we have had work done, such as modelling and so on, with Health Education England on the projection for the numbers that we need in order to deliver the long-term plan. We have made recommendations to the Treasury for the comprehensive spending review. We will not be able to share in a public forum what those recommendations are; the decisions are for the Government to make, based on the choices that the Treasury and the Government have to make. The recommendations have been based on what staffing is required to deliver the long-term plan.

Q48 **Chair:** You have made those recommendations, and they are part of the

negotiations. I understand that you cannot publish them now because you are in the middle of those negotiations, but after the spending review is concluded will you publish those numbers?

***Prerana Issar:*** I am not able to say that now, not knowing what the outcome of the spending review will be.

Q49 **Chair:** That is a concern. What the NHS needs to know is that the Government are delivering the numbers of doctors and nurses that you personally say it needs and that the NHS says it needs. You are saying that you may not be able to share with us what the numbers of doctors, nurses and other frontline professionals are. Is that correct?

***Prerana Issar:*** The numbers required for the long-term plan are already in the public domain, and Health Education England is working on expanding that.

Q50 **Chair:** I am sorry; I didn't think they were in the public domain. Will you write to us after this Committee and tell us what the numbers are? Baroness Harding said that the numbers were not going to be published until after the spending review, but you say that they are in the public domain.

***Prerana Issar:*** I will write to you.

Q51 **Chair:** Will you publish what you are asking the Treasury for, what you say the NHS needs in terms of future doctors and nurses? I understand that you cannot do it until after the spending review. Let me, if I may, remind you that Baroness Harding has told another Committee that those numbers will be published after the spending review; she had the numbers but she could not publish until the spending review. It would be a very big thing if the NHS was now saying that it was not going to publish what it is asking the Treasury for. You will write to us and let us know whether you are going to publish them. Is that all right?

***Prerana Issar:*** Yes; absolutely.

Q52 **Chair:** I want to go back to something that Professor West said. He said that it is not just the overall numbers of doctors and nurses but it is the numbers by speciality: how many you are going to need in cancer, how many you are going to need in mental health, how many you are going to need in maternity and the skill mix you are going to need. He used a very striking analogy. He said that trying to do a workforce plan without those numbers is like having a car without an engine. Would you agree with that?

***Prerana Issar:*** I would not agree entirely. I will share why. We consulted over 350 stakeholder entities on agreeing the three priorities for the NHS workforce in order to deliver the long-term plan. Across the 350 stakeholders and tens of thousands of staff we engaged with during 18 months, the three priorities, which were of equal importance, were more staff; preventing them from leaving by working differently; and dealing with stress. Just having more staff will not solve the challenges,

because we have people leaving and we have people who are stressed, which is the focus of these discussions, so all of those things need to work hand in hand to be able to deliver the care that we need to deliver.

Q53 **Chair:** We all completely agree with that. Let's take a specific example: mental health. We are going to hear from Claire Murdoch in a moment. To deliver the very ambitious plans we have for mental health, we are going to need additional psychiatrists, therapists and mental health nurses across a whole range, and we are going to need to improve retention by looking after people better and creating a better work environment. But unless you have the numbers that you need over a five or 10-year period, and you are open about the fact that we need to recruit this many thousand extra people, you are not going to give confidence to people working in mental health that you have plans in place that mean that we have enough doctors and nurses to do that work. In turn, it will increase the stress and the risk of burnout if people think we do not have enough people in the pipeline to do the job. Is that not right?

***Prerana Issar:*** We need more people. That is absolutely a given. People have told us that they need all the three things to happen. Yes, we absolutely need the confidence that more people are going to be recruited, whether or not that is into the care path for people going forward; they need specialists in all those areas, whether cancer, mental health and so on, but they also need to feel on a daily basis that they have flexibility, that they have a sense of belonging, no matter what their ethnicity or sexual orientation, and that they are able to work differently with the innovation that we have seen during the pandemic over the last seven months.

Q54 **Chair:** Thank you. We are going to ask a lot about those other areas, but I wanted to be clear about the numbers. You are going to write to us and tell us about that.

I have a final question for you, if I may. Given the interdependence of the NHS and the social care system, do we need a people plan for the social care system as well?

***Prerana Issar:*** Yes. We do not have a remit in the NHS to do that, but, given that health outcomes depend so much on the interaction between health and social care, we need the same kind of focus for social care.

Q55 **Chair:** Thank you very much. We have lots of questions to ask you and we will come back to you.

I would like to turn to Claire Murdoch. Welcome back to our Committee, Claire. Thank you very much for joining us. Do you want to start with the announcement that you are making this morning?

***Claire Murdoch:*** Good morning, everybody. It is a huge pleasure to be here today, and to talk about staff wellbeing, emotional, psychological and physical.

I want to do two things immediately. First, I have to take this opportunity to say that, after 37 years of working in the NHS, many of them as a nurse, and now as a chief exec and the national director for mental health in this country, I have been simply in awe of the work of my colleagues right across the NHS, social care and other key worker roles. I take this opportunity to thank publicly each and every one of them.

Secondly, you have heard previously about the tremendous work that Prerana, her team and organisations right across the country have been doing in relation to prevention of burnout, supporting their staff and looking at endlessly creative and important ways of keeping our staff emotionally and psychologically healthy through this period. I am sure that you will hear a lot more about that later.

A small number of our staff will experience a level of mental distress that means that they need access to rapid assessment and treatment. I am delighted to announce today—you heard it here first—that we will be investing £15 million in special winter support over this particularly challenging period. It will make sure that in every part of the country, for all NHS staff, wherever they work, we are launching a service that will get staff rapid assessment and treatment for mental health conditions, if they need it. That is an incredibly important addition to the plethora of interventions and initiatives that we have put in place.

Q56 **Chair:** I am sure that will be very welcome. There may well be some questions on that.

Before I move on to my colleagues, I want to get to the bottom of the issue of the numbers. In the mental health workforce plan for England published in July 2017, you said that the NHS would need 19,000 additional members of staff in mental health by 2020. Have we delivered that extra 19,000 in the mental health workforce?

***Claire Murdoch:*** That was actually for the end of the period of the five-year forward view, which is March 2021, so we have a little bit longer to achieve that. My latest figures tell me that, from 2016, we increased the mental health workforce by 13,860 whole-time equivalent staff. The sharpest increase has come in the latter part of that period, and the trajectory is strongly upwards.

Q57 **Chair:** Excellent. That is very good news. Can I ask you about what I was talking with Prerana about, which was looking forward at the 10-year plan for mental health? We understand that you cannot publish now the numbers you are asking the Treasury for to support the 10-year mental health plan, but will those numbers be published after the spending review? That is the commitment that we had previously from Baroness Harding.

***Claire Murdoch:*** My colleagues and I have modelled what we need to take us to the 2022-23 period—the end of the long-term plan period. I remind colleagues that we have made a commitment very openly and transparently to see 2 million more patients a year every year by 2023.

That will require a £2.3 billion real-terms investment in service expansion.

In order to deliver that, we estimate that we will need an extra 20,000 staff. That is all part of our plan and our counting, so it is absolutely part of the spending review request. They are people who need training and bringing into service. That is the negotiation that is ongoing. It is true to say that, with full backing from Government, and Simon Stevens and others, we have been keen to be totally transparent about the mental health plan, because that transparency is a way of driving us on.

**Chair:** Excellent. A few other people would like to ask some questions.

Q58 **Dr Evans:** Prerana, thank you for being here. The Chair commented on numbers. There is clearly a lag time for getting numbers in. I am concerned about the current workforce. There are two Rs that seem to be at play; one is retention and one is resilience. Can you comment from your position on what you are doing on both of those things, to try to retain more people and to give them the resilience to be able to deal with the system?

***Prerana Issar:*** On 7 April, we launched a health and wellbeing offer nationally for all 1.3 million NHS staff. As I said at the beginning, the health and wellbeing of our staff was already a priority, but it was put into much sharper relief by the kind of response that was required from our colleagues. It is an offer nationally that has been expanded and built on over the months. We have a clinical reference group that advises us on prevention and an end-to-end pathway for staff.

It starts from a self-help perspective. We have made available lots of materials that people can reach into and access when they need help. I will give a couple of examples. We have made available for free a range of mental health apps, which 150,000 NHS staff have downloaded. Many of those apps, such as Unmind and Headspace, you will know. In them, there is a feedback loop. When you access the app, you put in your feedback. People have been providing feedback that they are sleeping better and are able to recover better from their day due to the apps.

There are lots of tools on our website that we built specifically after the pandemic started. The resources that more than 250,000 people have accessed include talking to children about Covid—we put that resource there; shielding and coming back to work; coaching and mentoring; and line manager skills. There is a huge amount of resources.

We also have a 24-hour, seven-days-a-week text helpline. Experts have said that some people who are feeling really distressed do not actually want to speak; they want to be in touch with someone by text. We have testimonials where people have shared how they felt after texting. I will read out one of them: "At the time of my text, I was in turmoil with anxiety and feeling like a failure. I am normally resilient. Admitting that I am struggling is really hard." We have tried to normalise help-seeking behaviour, because research shows that healthcare professionals are the

last to seek help for themselves. That colleague said: "Having someone acknowledge how hard I am working on the frontline has made me feel reassured. The volunteer also sent me links with further help. Thank you so much for your help on a particularly wobbly day."

That is the text service. We have a helpline from 7 am to 11 pm every single day. That is in our partnership with the Samaritans. We are constantly getting feedback about what issues people want support with.

Q59 **Dr Evans:** That is useful to help with the resilience side. We were fortunate to have—off the top of my head—about 6,000 new doctors step back in after retirement to support the service. It was the same with nurses. What work is going on to retain them in the short term, to make a working environment that means that they want to stay on to help to provide care for the NHS? That seems a good short-term plan while the job numbers go into place.

***Prerana Issar:*** Absolutely. Retention was a big focus even prior to the pandemic, and very much so during the pandemic. There are three levers. We have an evidence-based approach. Employers are also involved, of course. The feedback is about how things feel in a team and how things feel on a ward.

The three drivers of retention that evidence and research have shown, based on some of the work that Professor West has led for many years, are flexibility, health and wellbeing support, and the feeling of belonging and not being discriminated against—the element of equality, diversity and inclusion. Those are the three drivers. We have 12,000 people who are ready to step in. All their pre-employment checks have been completed and they have been assigned to a particular employer. We have 2,200 people who are on a ward and in rotas. We are in constant touch with those people. The clinical leads have individual conversations with people who have offered to return about what will work for them. Flexibility is a key part of it.

Q60 **Dr Evans:** Covid has brought about a big change in the way the NHS works. This can be welcomed, in a way, going forward. One of the biggest problems that people have is the work-life balance. How will you use this opportunity to ensure that the work-life balance is secured, so that we have better resilience in our system?

***Prerana Issar:*** That is a big focus. I am in awe of the response that people have shown during the pandemic. I echo Claire's thanks. It is a huge testament to the NHS and I am sure that everybody on this Committee appreciates what they have done. We have seen that people want flexibility, whether that is working from home, when possible, or having a shift system that is not three 12-hour shifts back to back—shifts that are too long or too short. Professor West mentioned that as well. We are looking at e-rostering and the flexibility apps we are supporting trusts with.

Of course, there is the issue of mental health support and workload. On workload, there is a huge amount of recruitment focus on the healthcare system, for instance, where you can get people into the system over the winter, as well as into the care paths going into the second wave of Covid.

**Chair:** We have a slightly bad line with you there, but I think that we got the gist of it.

Q61 **Dr Davies:** Prerana, just as an overview, what do you feel the current level of wellbeing of those who work in the NHS is? How do you monitor the good as well as the bad aspects?

***Prerana Issar:*** I am just going to open a couple of stats. Thank you for the question, Dr Davies. We have engaged constantly with staff to see how they are feeling. It is at national level, but it is very much at employer level as well, of course. We have chief execs—Claire is here to share her experience—and every manager and leader engaging with staff to see how they are doing. We are supporting managers to spot signs of either stress or fatigue, because that is the best place to support people.

Since 1 July, we have been running a fortnightly PeoplePulse survey from the centre. We have had almost 22,000 responses across 77 organisations. It is an opt-in survey, so we are not mandating it and adding more reporting for employers and staff. It is in addition to our national staff survey, which is currently live.

Across the four surveys, we found that a majority of staff—61.6%—felt able to have a work-life balance. Around a fifth—21%—have not. Two thirds of staff—67.6%—said that they feel supported by the health and wellbeing offers across their local organisation, as well as by the centre's offering. In the last staff survey, the figure was 30%. Staff feeling supported in their health and wellbeing has gone from 30% in the last staff survey to 67.6% in the last couple of months. Sixty-seven per cent. of staff feel that their organisation is proactively supporting their health and wellbeing. That is an outcome of Covid that we absolutely want to capture, to make sure that we do not roll that back. It was not the case pre Covid as regards that support.

We are also listening through our health and wellbeing offer nationally, as I mentioned. For instance, we have just launched a financial wellbeing offer, because people have shared their secondary stressors. Of course, we are all part of this. NHS staff have the responsibility that they have in their job, but every individual also has responsibilities at home. People have shared that they would appreciate support with the secondary stressors. Our financial wellbeing offer, launched on 1 October with Money Advice Service, will provide support for advice on pensions, savings and financial questions. As we see the impact of Covid on the jobs of partners and families, that is coming up as a key issue.

We are constantly looking at how we can support people. For instance, earlier the impact on the Filipino nursing community was mentioned. We have set up a specialist bereavement counselling service in Tagalog for our Filipino colleagues. We also have a wider bereavement counselling service. The helpline number works as a front door, and people are signposted to the different types of support that are needed. We have a constant feedback loop from there as well.

Q62 **Dr Davies:** That is some positive news. A health and wellbeing conversation and personalised plan was promised from September. Can you outline how that has been achieved and the level of roll-out?

***Prerana Issar:*** When the pandemic started and we saw the disproportionate impact of Covid on communities from a black and Asian minority ethnic background, PHE took up the community impact and we led the support for staff. Every six weeks since April, I have convened a national meeting of all the BAME staff network leads and EDI leads across the NHS. Out of that conversation came the idea and the suggestion that we have an individual risk assessment conversation; 96% of at-risk staff have had an individual conversation. Building on that, we have expanded the idea to saying that every member of staff, not only those staff who are at risk, should have a health and wellbeing conversation.

More than a million conversations have already taken place in the last few months. We have talked about what flexibility people need, how they are feeling in their teams, what support they need and what reasonable adjustments should be made. Is there something on how the PPE fits for them, whether for a headscarf or a beard? We want every individual to have a conversation on those kinds of elements.

We are tracking that through systems. I caught the conversation earlier about the people plan and the need for more detail on implementation. The health and wellbeing conversation is being tracked similarly to the other commitments in the people plan. As part of the planning guidance for systems, every system has been asked for three things: service or activity levels, financial goals and people plan goals. They have sent those in. We have gone through every one of the 44 submissions and are tracking that with systems and employers.

Q63 **Dr Davies:** Are you satisfied that the discussions taking place locally are with people staff are happy to open up to, particularly if there have been concerns about bullying?

***Prerana Issar:*** It is a very big question. With 1 million conversations, some will have been done with a lot of skill, compassion and empathy, but the feedback is that some were less empathetic than people would have liked. This is a huge step forward. It is a necessary step forward, but it is not a sufficient step forward. I urge line managers, occupational health teams and wards—everybody—to place a huge amount of emphasis on having both the cultural competence and the line manager skills to be able to have what is quite a sensitive conversation. I want

people to be assured of both their psychological safety and their employment safety.

Q64 **Dr Davies:** My final question is for Claire. Further to the announcement that you made earlier, are you able to attach any timescales to the provision of mental health support services for staff? Can you give some reassurances about the capacity to deliver those services?

***Claire Murdoch:*** Back in April, I asked mental health trusts across the country to work in their local ICSs, with ambulance, acute and community trusts—all trusts—to see what their psychological and mental health needs were. Many systems across the country, in fact most of them, now have a form of rapid assessment and treatment in place. They just did it. They just did the right thing. We are seeking to shore that up and build on it. We are not starting from nowhere. In fact, all but six of the 44 ICSs in the country have something in place already. We are going to shore that up and close the gap around the six.

I think we can move very fast on that. As you would expect, it is something mental health service colleagues feel very passionately about. In addition to seeing patients, they absolutely want to use their skills to treat their own colleagues. Capacity is always a problem. In the NHS, we are busy, but on the basis of what services have managed to deliver to date informally, I feel very confident that we will be able to ramp up very quickly.

In addition, we will be setting up a highly specialist national service for the small number of staff who have very complex trauma, perhaps some of my critical care colleagues. We will be working with another provider on that highly specialist delivery. I feel as confident as it is possible to feel that we will be moving very fast on it. I have been in touch with chief execs across the country and have had the most incredible examples of whom they are seeing now, what the issues are and how quickly they are able to respond to colleagues, usually within a day or two, both to address suffering and to help people to stay at work or to return to work. I am cautiously optimistic that we will be able to move very fast indeed on it.

Q65 **Dr Davies:** For instance, if staff in Merseyside, where there is a Covid hotspot, need support in the coming weeks, will that be available?

***Claire Murdoch:*** It will. I have talked to chief execs in Lancashire and Merseyside—in Merseyside, only yesterday—who have sent me the most impressive range of materials available on support and access. We will be looking at the high-pressured hotspot areas first, to make sure that, although the roll-out will be rapid, we start where we think it is needed most.

Q66 **Dean Russell:** My questions are primarily to Claire Murdoch. You were a witness for us a few months ago. In that session, I asked whether you could let me know what was happening with regard to helping not just NHS staff—I absolutely welcome the announcement today—but the

families of staff. What I was hearing on the frontline was that part of the anxiety for staff was concern that their families were worried about them while they were at work. Can you give me an update on that, please?

***Claire Murdoch:*** Yes. Many of the staff offers also have a facility for families. Those include resources that you can share with your children, as Prerana said earlier, and how to have conversations with those who are worried about you. Another family issue that has come up is staff living with elderly parents and how we protect them. Many of the psychological services on offer have been extended, where there is capacity locally, to family members as well. Although it is not universal nationally, because we have prioritised our staff, many areas have opened rapid access to psychological support to family members as well. I will write to you to say where they are.

Additionally, trusts like my own and many others across the country are running sessions for staff about their families. For example, back in September, sessions were run about anxiety around return to school, on conversations that staff can have with their children and youngsters, or on their own anxieties about youngsters going back to school. Those sorts of sessions—webinars or open tutorials for staff—are massively well received. Of course, it is one of the benefits of a digital world. We are all frustrated about the loss of face to face and when we will all meet again face to face. However, it has opened a very big capacity for trusts and organisations to reach out beyond their staff to family members.

Q67 **Dean Russell:** That is good to hear. I would be very appreciative of the evidence and details around that.

Pharmacists are also part of the NHS family. I am conscious that throughout the pandemic they have been absolutely at the frontline of supporting the nation. I am interested in your views on making sure that mental health support extends to pharmacists, who have probably been in some of the most pressured frontline spaces in the whole NHS.

***Claire Murdoch:*** I fully agree. The pharmacists, community pharmacists and others, have been incredible during the pandemic. I have seen it with my own eyes. They have literally organised volunteers to make sure that they can get medicines to the vulnerable in their local community, and have been a source of hugely useful advice and, where it is appropriate, treatment. I echo your point.

Obviously, it is more difficult to reach out to a more atomised—forgive the use of the word—workforce. Now that we are formalising our health offer for staff today, I am keen that we reach out and make the service available to pharmacists. Prerana mentioned something really important: help seeking is not necessarily in the culture of health staff. If Covid is to leave us some positive legacies, as well as the terrible trauma to society, I hope that one of them will be that the conversation about emotional wellbeing, mental health and mental health support will advance exponentially. I hope that our pharmacy colleagues will be part of that. I

can certainly give you an undertaking that, now that we have formalised the health offer for staff, we will be asking areas to reach out.

Q68 **Dean Russell:** This question is more evidence-based. One of the big terms that we have used in today's session is resilience. I am interested in exploring the evidence on why some people seem to have had resilience throughout the pandemic and others have not. Has there been any exploration of whether that is because of working conditions, the environment or line management support?

I have heard many stories from the frontline when I have been doing my volunteering that the challenges are different almost on a ward-by-ward basis. I do not say that necessarily from a negative perspective, but I know that at the height of the pandemic nurses and other staff were having to work in wards they had not worked in before. They were working in strange environments, so there were a lot of additional external pressures. I am interested in whether research has been done into why some have been resilient and others have not, and whether that was a workplace-based situation.

***Claire Murdoch:*** Your assessment of the difference that we see, whether in individuals or in teams across the country, is a very fair one. The first thing to say about resilience is that, above all, we need to remember that it resides within teams. The military and other colleagues have done a lot of research, and there is a good evidence base, certainly from a work perspective, that it is important to get your team culture right. You heard earlier today from Bernadette; you need more people like her running wards. You need to get your frontline management right, through debriefs, Schwartz Rounds, giving people the opportunity to contribute to their working patterns and flexible working.

The million conversations Prerana referred to earlier have been quite incredible. One of the things we have done is provide more training and support to frontline managers to have those conversations. For some, it will be the first time that they have really talked to staff about where they live, who they live with, how they get to work and what their anxieties are. Being heard is phenomenally important. Above all, resilience needs to reside in teams in all the things we are doing.

Q69 **Dean Russell:** Are there measures around that you can share with us? I appreciate that surveys were shared earlier, but do we have evidence on how that is increasing and the consistency of it across all trusts?

***Claire Murdoch:*** King's and other academic partners are busily researching the impact of Covid on the mental health and psychological wellbeing of our staff. Only a few weeks ago, I talked to Professor Simon Wessely about the range of research that is in place. His response to me when I asked a similar question was, "To be truthful, Claire, we don't know. There are world events similar to this pandemic, but it is pretty unique in the last 100 years." A lot of staff research is under way now,

and we can certainly get you a list of that. We are watching it very closely so that we can tailor our offer.

**Dean Russell:** Could that be published?

**Chair:** Thank you very much, Dean. We are coming to a close, so I will move on to a final quick question from Neale Hanvey.

Q70 **Neale Hanvey:** Thank you, panel, for your contributions this morning. They have been incredibly helpful.

The mental health support that has been described today is excellent, but as somebody who has worked in clinical practice for a number of years, I know that one of the real challenges when you have support available, whether clinical supervision or the types of measures you are talking about today, is that you do not have enough staff. If a member of staff goes off to seek support, it takes a man down, which can pile extra pressure on to those who remain.

I would be interested to hear what you think that the impact and consequences would be of the Treasury not coming up with the goods, in terms of the funding request that has been put in. I would also be interested to hear your view on how it is being opened up to social care staff, who may not have access to that kind of support through their own employer.

***Prerana Issar:*** This takes us right back to where we started. We need more staff. As you would imagine, as chief people officer I have asked for and will be asking for more investment in creating more wellness training places, not just for nurses and doctors but across the board, because we deliver in teams. It would be really difficult if there was no additional investment for more people in the NHS.

In the short term, because those investments will take several years to come to fruition in terms of people joining the NHS, our absolute focus is on the retention of people who are already there, because we cannot afford to have anybody leave. Not only do we want people to stay; we want people to stay well. That has been the focus of this conversation, hasn't it? We absolutely need more investment to expand further the workforce for the NHS.

On the social care side, the implementation of the people plan is through systems. That is one way in which we are trying to make sure that we are not creating a divide between working in the NHS and working in social care, with the constraints that we have in the mandate and where statutory responsibilities sit. Some elements of the health and wellbeing offer, where we have been able to expand, are available to social care as well. Some of them require funding, and there we have some constraints as regards how far we can expand to social care. From a principle or philosophy perspective, we are focused on seeing how we can have an employment offer—our people promise—that exists across health and social care, with some constraints.

***Claire Murdoch:*** I talked about the informal support that sprang up across the country during the first wave of the pandemic. Many of the local ICS areas offered that support to social care staff as well. Particularly where systems were working together closely, that was the natural thing to do. We will see a new chief nurse in social care soon. I am keen to have conversations with him or her, when they are announced, about how we can develop the plan more formally to support social care staff.

To answer your question about time, for sure you need enough time for staff to be released for other things, such as self-care. Having been a busy ward sister once myself, a very long time ago, I would say that you need a really iron culture of prioritising staff. It is a bit like being on an airline. Put your air mask on first, before you do it for others. There is something about the permissions and the urging that Prerana and her team are giving to prioritise wellbeing seriously.

My final point is that with our mental health plan, for example, we will only see 2 million more patients a year every year in mental health if we have the staff. There is no point in spending £2.3 billion on a new car if you do not also buy the petrol to go in it. Of course, our NHS staff are the liquid gold of the NHS; they are the lifeblood, so the two go hand in glove.

**Chair:** That brings this morning's session to a close. Thank you very much, Claire Murdoch and Prerana Issar, for your important evidence this morning. This is the first evidence session for our inquiry into workforce burnout, which is a very important issue. Thank you, too, for answering so many questions on social care, which is very important, as we are the Select Committee on Health and Social Care. We are very grateful for your time and all your evidence. We are also grateful to the other witnesses we heard from earlier this morning. That brings this morning's session to a close.