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About this submission

We are both chartered psychologists that have been working on a project to track the welfare of frontline workers across the course of the Covid-19 pandemic[1]. Throughout this research project, we have collected data on markers of welfare (including burnout, anxiety, symptoms of post-traumatic stress disorder, and overall wellbeing) as well as conducting one-to-one interviews, and soliciting other qualitative data from participants. Our participants have primarily (ca. 85%) constituted those from the health and social care workforce of the UK and Ireland, and our recent submission of evidence to this committee[2] was based purely on data from that workforce in the UK. The evidence herein is presented from the perspective of our professional expertise (in the areas of occupational health and wellbeing) as well as the evidence derived from our continuing project, and is given largely in the perspective of whether Covid-19 has affected progress on commitments. The views expressed do not necessarily reflect those of our employers. This response was prepared in May 2022.

Planning for the Workforce

Was the commitment met overall?

Data available through NHS Digital[3] for England suggest that in December 2019, there were 296,093.04 FTE (Full-time equivalent) nurses and health visitors working in the NHS. The most recent published data available (January 2022) show that there were 319,806.49 FTE, constituting a 23,713.45 FTE change in that time. These figures indicate that 47.4% of the forecast commitment of 50,000 nurses was met (if we were to assume that this commitment equated to 50,000 FTE). However, the proportion of this figure that are health visitors rather than nurses is not known.

Using these same data, the absolute headcount of General Practitioners (GPs) in December 2019 was 43,368 (34,519 FTE). In 2022, the most recent data show the absolute headcount of GPs at 45,280 (35,988 FTE). Overall, these figures indicate an increase of 1,912 GPs (absolute headcount) — so far, meeting 31.9% of the commitment of 6,000 more doctors in General Practice from the 2019 manifesto. At peak, the GP workforce headcount was 45,980 in September 2021, but has since been in decline. Indeed, a report from from The Institute for Government thinktank[4] in April 2021

[1] www.cv19heroes.com
[2] https://committees.parliament.uk/writtenevidence/42589/pdf/
[3] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/

suggests that whilst workforce recruitment for GPs has been strong, it is retention that poses the key threat to fulfilling these manifesto commitments.

Our recent data would suggest that honouring the commitment will prove difficult due to significant impact of the Covid-19 pandemic, and the impact that this has had on the health and wellbeing of the workforce. Based on our findings, health and care staff in the UK felt insufficiently resourced prior to the pandemic, which impacted their ability to carry out their roles going into and throughout the pandemic, and is continuing to have a significant impact on occupational attrition factors such as mental health and burnout (1-4). When questioned in December 2021, 49% of our respondents within health and social care roles in the UK indicated they were actively considering leaving their roles. Many of those workers cited the extra demands placed on them both directly through the sustained pressure the pandemic has incurred, and indirectly through the pressure that many of them perceive to have been a result of poor planning (5). Expanding on this, many of our participants cite that their current situation is a result of (i) the NHS being under-resourced before the pandemic began, (ii) having to tackle a novel infectious disease with insufficient preparation and resource, (iii) the secondary impact this has had on business-as-usual working (particularly through escalating waiting lists), which has impacted their workload and their ability to provide the level of care they seek to, and (iv) through further depleted resource from Covid-19 associated illness (both acute and Long Covid) and absenteeism due to mental health challenges and burnout (1, 2, 5-7).

Estimates from March 2022 show that within a seven day period, absences from the NHS workforce attributed to Covid-19 rose by nearly 20% in one week alone (8), increasing the pressure on a workforce that is already depleted and exhausted. Workload is a well-established consideration in occupational burnout (9), a leading cause of workforce absenteeism in itself (10), and eventual attrition (e.g., 11, 12, 13); constituting a potentially self-perpetuating cycle if not addressed. The added impact of Long Covid[5], and the absenteeism associated with it (14), is another factor that will not improve whilst circulating levels of Covid-19 remain high. The available evidence so far, whilst not conclusive, do not appear to suggest that vaccination significantly prevents the incidence of Long Covid (15, 16) beyond reducing the risk of infection itself. As vaccination also does not entirely prevent breakthrough infection (17), that protection through vaccination appears to wane over time (18, 19), and that current vaccines may not confer protection against emerging variants (also more common with higher community infection) (20), it would seem there is currently no way to prevent the incidence of Long Covid other than seeking to prevent infection with SARS-CoV-2 itself. In this

[4] https://www.instituteforgovernment.org.uk/sites/default/files/publications/taking-stock-conservative-manifesto.pdf
[5] https://www.theguardian.com/society/2022/jan/24/long-covid-nearly-2m-days-lost-in-nhs-staff-absences-in-england

respect, Covid-19 has been a key mitigating factor to honouring the commitments to the health and care workforce, however much of this mitigation can be controlled by continuing to suppress the community spread of SARS-CoV-2. As a key recommendation, our participants noted that one single thing that could be done to support their welfare currently would be to minimise circulating levels of Covid-19 through the reinstatement of behavioural interventions such as the use of masks, recommendations of physical distancing, and self-isolation with infection (5).

Was it an appropriate commitment?

As the workforce in health and care has struggled to meet the increasing needs of the population, a commitment to increase the workforce is undoubtedly needed. What has unfolded since the commitment was made, however, has appeared to be insufficient. This presents the issue that not only have these commitments not yet been fulfilled, but the likelihood of these being fulfilled is further threatened by the impact of Covid-19, which means even more resource is required to support workers across the NHS and social care. Whilst the impact of the pandemic has been severe, the severity of this impact could be lessened through efforts to contain the spread of the virus, which we now know is contractable more than once.

The depletion of the workforce due to burnout and occupational stress is having an impact on patient care, with over 6 million patients currently on the waiting list in England[6]. There is an acknowledgement that the demand for hospital treatment exceeded NHS capacity pre-pandemic[7], further supporting the notion that the NHS was already under-resourced before the impact that Covid-19 has brought. The stagnation of workforce numbers, and the threat of decline due to exhaustion (that is to a degree preventable with stronger efforts to control SARS-CoV-2 spread), will only serve to increase this problem. Moreover, for those who remain in these roles, the experience of burnout and mental health distress that very many will be suffering will impact their ability to provide the standard of care that they strive to. In analyses from the 12-month mark into the pandemic (March to April 2021), our work has shown that 75% of respondents showed sufficient symptoms to indicate a diagnosis of post-traumatic stress symptoms (21), and this may likely increase as the pandemic continues.

[6] https://nhswaitlist.lcp.uk.com/
[7] https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/nhs-backlog-data-analysis

Wellbeing at work

Was the commitment met overall?

Mental health

The commitments to support the mental health and wellbeing of health and care workforce were greatly needed at the time these were made. Mental health is a key driver of occupational health concerns as well as a key contributor to absenteeism[8]. The commitment to supporting the wellbeing of the workforce across the NHS and social care will also be supportive of the commitment to ensure appropriate staffing in these sectors. Therefore, the consideration of wellbeing at work for those in health and social care has the ability to impact the honouring of the commitments made to workforce staffing as well. The onset of the pandemic saw a 20% rise in mental health distress in NHS staff (22), and continues to be indicated as a severe problem in ongoing analyses and publications (21).

In October 2020, it was announced that NHS England and NHS Improvement would be investing an extra £15,000,000 in mental health support for the workforce[9], which demonstrates a substantial effort to work towards this commitment. However, the evidence we have gathered from those working in these sectors is that their lived experience of mental health support through work during this time has been insufficient (1, 2, 5, 7). Of those workers who have accessed support, many described how the limited nature of the support (e.g., a maximum of six sessions with one counsellor) was not sufficient during times of chronic stress and trauma where long-term, continuous support is required (2). Our data have also indicated that many workers are experiencing ongoing trauma responses (2, 21), and they are likely to need ongoing psychological support over the coming years.

Bullying

Data from 2018 indicate that over a quarter of NHS staff had experienced bullying from patients, service users, their families, or other members of the public[10], constituting a significant problem that requires response. Data gathered during the pandemic indicates that incidences of bullying have actually increased in frequency amongst health and care staff (26). Our own work has detailed how participants feel workplace bullying has been directly related to narratives surrounding the NHS Covid-19 response such as GPs "hiding behind Covid" (5, 7). Further, they perceive that these narratives have not been adequately addressed by the government and – in some cases – have been perpetuated by government rhetoric (e.g., the criticisms made against GPs by key figures in the government[11]).

[8] https://www.hse.gov.uk/stress/mental-health.htm
[9] https://www.england.nhs.uk/2020/10/strengthening-mental-health-support-for-staff/
[10] https://www.nhsconfed.org/publications/nhs-staff-survey-2020
[11] https://www.theguardian.com/society/2021/nov/17/sajid-javids-criticisms-fuelling-abuse-of-doctors-says-

A recent news report indicated that 72,000 assaults took place on NHS workers over four years[12] – the extent that this figure is accurate, or representative, is unknown but this report certainly raises questions about the extent that workers' welfare is being protected. Further research is required to systematically ascertain the experiences of those working 'at the coalface' in health and social care settings, as well as how to improve the supports and structures available to them.

Listening to the views of the staff

The Covid-19 pandemic brought about organisational change across health and social care settings. It has long been established that employee participation in decision-making during periods of organisational change not only boosts job satisfaction and patient outcomes (23), but also, reduces staff mobility (24). Unfortunately, through the Covid-19 pandemic, health and social care workers described their frustration at not being consulted about decisions affecting them and their clients or patients, despite their knowledge and experience, particularly in relation to policies and procedures relating to managing Covid-19 (25).

Was it an appropriate commitment?

Mental health

Whilst a commitment to providing support for mental health for the workforce is appropriate, and very much needed, our analyses of available evidence indicate that mental health supports are not consistently accessible for all workers in health and social care. This under-provision is made worse by the need for mental health supports increasing as a result of the psychological and emotional toll of working on the frontline during the pandemic.

This lack of sufficient support has been further evidenced by the emergence of charity campaigns to meet these gaps in provision of much-needed mental health support to frontline health and care workers, such as that offered by The Healthcare Workers' Foundation[13] and Frontline 19[14] amongst others.

Our participants have noted that the depleted workforce currently is down to two main factors: absences due to Covid-19 (acute infection and Long Covid) and due to mental health (5). Given that depleted workforces create more strain on those still present at work (9, 10), and that this affects

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[12] https://news.sky.com/story/more-than-72-000-assaults-on-nhs-staff-took-place-over-four-years-but-very-few-were-reported-to-police-sky-news-can-reveal-12601481#:~:text=Exclusive-,More%20than%2072%2C000%20assaults%20on%20NHS%20staff%20took%20place%20over,Wales%20responded%20to%20Sky's%20questionnaire.

[13] https://healthcareworkersfoundation.org/

[14] https://www.frontline19.com/

the care provided by those present at work (9), actions to support the physical and mental health of those in need are required. Barriers to accessing mental health supports (e.g., location, cost [both financial and time cost], stigma) need to be identified and navigated to promote the accessibility of immediately available support. There needs to be a specific commitment made to provide flexible and immediate psychological supports available to workers during acute periods of distress, but also, over the longer term so that workers can engage with one trusted professional for a longer duration as required.

Bullying

The commitment to reduce bullying has clearly been needed, but evidence suggests that this bullying has only increased. In some cases, these increases have been directly attributed to the lack of contradiction of unhelpful media narratives[15][16][17][18][19] as well as instances where voices from government have actively supported those unhelpful narratives [20][21][22]. Therefore, it would seem that the commitment to reduce bullying rates in the NHS is not sufficiently specific, and is perhaps not being committed to universally across all members of government. Setting measurable and time-specific metrics for the reduction of bullying may support the honouring of this commitment in the years to come.

Listening to the views of staff

It is vital to listen to the views of health and social care staff, but further, it is essential to engage in participatory decision-making where a range of views and perspectives are considered when making decisions that affect both staff and patients. Our analyses suggest that frontline workers do not feel adequately consulted about key decisions that are being made about them and their work (5), and so more can be done to provide specificity to the commitment to listen to their views.

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[15] https://www.dailymail.co.uk/news/article-10371299/NHS-workers-took-average-14-DAYS-sick-year-Covid.html
[16] https://www.telegraph.co.uk/columnists/2021/08/24/gps-improving-work-life-balance-worsening-life-death-balance/
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[21] https://www.dailymail.co.uk/news/article-8210119/Nursing-chief-blasts-Health-Secretary-Matt-Hancock-PPE.html
[22] https://www.dailymail.co.uk/health/article-10781301/Ministers-shame-hospitals-unis-ignoring-visiting-rules.html

Concluding remarks

Staff need to be protected from both physical and psychological harm inflicted on them at work, with unequivocal support for this goal communicated at every level of leadership in government and in relevant health and social care organisations. The commitments set out by the government go some way to attempting to abrogate the harm experienced by those in these roles, however many of the commitments lack specificity and measurable outcomes, and arguably require more substantial support and depth in response to the issues presented by the pandemic.

The experiences of those working on the ground suggest that the filtering down of the actions of these commitments has not been felt. The pandemic has largely exacerbated the pre-existing issues inherent in the NHS and social care sector, however some of these could be alleviated and perhaps prevented with proper protection of staff through a renewed commitment to containing the spread of SARS-CoV-2. The morbidity associated with the virus (in both its acute and Long Covid forms) is having a toll on workers both physically and psychologically, and this can be decreased by the implementation of adequate safeguards. Moreover, the potential morbidity from the as-yet not fully appreciated long term consequences of infection (evidence for which is starting to accumulate, e.g.: 27, 28, 29) will also be minimised by renewed efforts to contain the virus. In short, there is an opportunity to reduce existing harm and prevent further harm with adequate and appropriate action.

The absenteeism resultant from both Covid-19 infection and through mental health distress is clearly taking a toll on the workforce, and impacting the leaving intentions of workers. This again may be prevented through the adequate suppression and control of viral spread. Our recent work has outlined that staff are overwhelmingly in favour of the return of key safeguards such as mandated mask wearing in crowded and indoor spaces, and isolation of those infected, an opinion that they feel is not being heard by government (5).

Alongside the adequate suppression of Covid-19 spread, there is a need to ensure that the day-to-day working conditions of the workforce are supportive by ensuring staff are retained (through the reduction of bullying and improved access to mental health support), and increasing efforts to recruit more staff into positions with career-long support and protection from psychological and physical harm.

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