

## Written evidence submitted by The King's Fund (WBR0017)

### Introduction

The King's Fund is an independent charitable organisation working to improve health and care in England. Our vision is that the best possible health and care is available to all. We aim to be a catalyst for change and to inspire improvements in health and care by:

- generating and sharing ideas and evidence
- offering rigorous analysis and independent challenge
- bringing people together to discuss, share and learn
- supporting and developing people, teams and organisations
- helping people to make sense of the health and care system.

We welcome the opportunity to provide evidence to this inquiry. Our evidence particularly draws on our forthcoming report *The courage of compassion*, on the health and wellbeing of nurses and midwives commissioned by the RCN Foundation (an independent charity and part of the Royal College of Nursing (RCN) Group), which we will provide to the Committee when published. We would be happy to provide oral evidence and to answer any questions that the Committee has related to this submission.

We have structured our submission in three sections, covering:

- an overview of the resilience of the NHS and social care workforce, including the impact of Covid-19
- what we know about causes of burnout in the NHS and social care workforce – and what can help reduce it
- implications for national policy.

### Resilience of the NHS and social care workforce

Since 2018, we have argued that [workforce challenges](#) are an even greater risk to the NHS in England than the long-standing concerns of funding and access, and are having a direct impact on patient care and staff wellbeing. With consistently around 100,000 vacancies, the NHS workforce is overstretched and could not realistically be described as resilient. Furthermore, a number of key causes of this fragility have been either failing to improve or getting worse, including:

- significant shortages of key groups of staff, widespread vacancies and tolerance of excessive workloads
- an incoherent approach to workforce planning and inadequate funding for education and training, with a reliance on overseas recruitment as a consequence
- difficulty in retaining existing staff (including, for nurses, persistently high drop-out rates among students), with inability to achieve a work/life balance increasing rapidly as the [reason given](#) for resignations
- fragmented responsibilities since the Health and Social Care Act 2012, with a lack of clarity about who at a national level is in charge for workforce issues

- no national workforce strategy to set a course for improvement, and a number of policy decisions (on, for example, immigration, English language testing and student bursaries) which made improvement harder rather than easier.

The [NHS Long-term Plan](#) acknowledged the impact of workforce shortages and promised a national workforce strategy – an NHS People Plan. These promising steps were however subject to several delays, including delay due to the coronavirus pandemic, and the [recently published People Plan](#) is another stop-gap that falls a long way short of the workforce strategy needed.

The English adult social care workforce is distributed across about 18,500 providers, many of which are small, and are not supported by a comparable infrastructure to the NHS (such as workforce planning processes, national leadership or a national staff survey). As a result, the health and care workforces are traditionally overseen in separate, different ways – even though they are inter-dependent. The sector offers notably [low pay](#) and limited opportunities for career progression, at the same time as (like the NHS) asking its staff to provide increasingly high-intensity care for people with complex needs. With some [120,000 vacancies](#) and a [turnover rate of 30%](#), the social care workforce is if anything even more fragile than the NHS. But because it does not operate as a single national system in the same way as the NHS and has less data available at the national level, its fragility has been less visible in national media and policy debate.

Overall, before the pandemic it was a picture of significant fragility in both the NHS and social care workforces which had not been managed effectively at a national level.

The pandemic re-set that context. It highlighted the exceptional personal resilience and commitment of staff that enabled the health and care system to cope. It also highlighted further areas of fragility which were perhaps previously discounted or normalised. Examples include:

- key to the workforce’s ability to cope was the need to increase staffing capacity. The surge in volunteering and the return to practice of many health care professionals were impressive but they also highlighted how thinly stretched the workforce was, even with a lengthy pause on elective health care
- the public demonstrated how much they value key workers. This contrasted with the system’s inability to ensure basic personal protective equipment (PPE) necessary for a safe working environment, exposing staff to significant risk
- the pandemic raised awareness of the need to actively ensure that different staff groups are not made vulnerable by normalised discrimination and disadvantage; our own [research](#) has highlighted continuing experiences of exclusion and discrimination by NHS staff from minority ethnic groups
- NHS staff rapidly formed teams which delivered effective care and were supportive (so-called “[teaming](#)”). Anecdotally, this has been linked to factors such as greater delegation of authority, greater flexibility in individuals’ role assumptions, supportive gestures such as free car parking, greater attention to wellbeing and more supportive regulation; there is a need to evaluate which factors enabled these skills in resilient teamworking and to ensure that the learning from this experience will be taken forward
- the toll on staff’s mental and emotional wellbeing has been significant. [Nurses](#) reported widespread concern for their physical and mental health and [sickness absences](#) in social care tripled. Over 600 health and care staff [died from coronavirus](#). Positive responses such as the [Samaritans](#) helpline illustrate that despite the fragmented, locally-focused nature of the social care sector, national interventions are important too.

- research into emergency situations – from pandemics to both natural and man-made disasters – consistently highlights that negative impacts on people’s emotional wellbeing – including front-line staff – and their need for support in order to carry on coping (“psychological first aid”) can be expected to last for 5-10 years. For example, in New Zealand there is still a need for this type of relatively low-level support nine years after the Christchurch earthquake and its thousands of aftershocks.

These examples illustrate the need to think about resilience in terms of underlying stressors (excessive workload, basic facilities, discrimination); ways of managing stressors (supportive teamworking); and ways of mitigating stressors (psychological support). Tackling underlying stressors is clearly the most important and there is a need to address all of these at the organisation and system levels rather than relying only on individuals being more resilient.

As the first stages of the pandemic recede and attention switches to the urgent backlog that has built up, it is not currently clear how the system will re-engage with the potentially promising policy developments arising from the NHS Long-term Plan or how it will ensure the capacity to learn from experience in order to increase workforce resilience.

## **Burnout**

NHS staff are [50% more likely](#) to experience high levels of work-related stress compared with the general working population and this both damages their health and affects care quality and organisational performance. As well as affecting individuals, poor staff health and wellbeing in NHS trusts is associated with poorer care quality, patient satisfaction, financial performance and higher levels of staff absenteeism, turnover and intention to quit, and in the acute sector, higher levels of patient mortality.

Research has shown a number of key factors which contribute to stress and burnout in the health and care workforce.

- The [NHS staff survey](#) paints an alarming picture of high and increasing proportions of staff reporting feeling unwell as a result of work stress (40%), coming to work despite not feeling well enough to perform their duties (57%) or experiencing unrealistic time pressures (77%). While we do not have the same national data on social care workers, [research](#) suggests significant numbers are on the brink of burnout. [Chronic excessive workload](#) is one of the most important – if not *the* most important – causes of work-related stress, and yet it is [increasingly normalised](#) for NHS staff to have multiple competing, urgent requirements, and for these to overlap with making major clinical decisions.
- Shifts crammed with [15-minute visits](#) can leave social care workers demoralised by not being able to meet people’s needs. Up to 61% of [nurses](#) (from a survey which includes nurses working in social care as well as health care) are too busy to provide the level of care they would like. The high level of ‘moral distress’ associated with this is pervasive in staff experiences across the health and care sector. Moral distress is associated with high rates of turnover, burnout and dissatisfaction.
- The same survey of nurses found that 60% feel their pay band is inappropriate (a notable increase from the 39% who said this when the same survey was conducted two years earlier). This year’s NHS staff survey findings were similar (only 38% were satisfied with their pay, although this is an improvement on last year). As we noted earlier, low pay is a particular issue in the social care workforce. Although it has been widely recognised during

the pandemic, there is no guarantee that this will lead to any change: recessions normally increase the number of people willing to work for low wages and as redundancies increase in other sectors, we are already hearing claims of easier recruitment in social care. Unless there are purposeful policy interventions, market forces may reduce pressure for reform.

- In the [NHS](#), 35% of staff work paid additional hours and 56% work unpaid additional hours, on top of their contracted hours. We do not have equivalent data for social care. Long working hours are [clearly associated](#) with burnout, musculoskeletal injuries and intention to quit. Although it is intuitive that long shifts within a normal working week may also cause stress, [evidence](#) is mixed in this regard and more research is needed.
- Discrimination has substantial influences on workplace stress, but year after year [ethnic minority staff in the NHS](#) report worse (and often shocking) experiences when compared with white staff and continue to be under-represented in senior posts. Unfortunately, we do not have equivalent data for social care.
- The NHS staff survey shows only [relatively small changes](#) over the last five years to rates of reported bullying and harassment, which continue to be very high. In 2019 28.5% of staff reported being bullied or harassed by patients, 12% by managers, and 19% by other staff. There are also high numbers of staff who report experiencing physical abuse, for example up to 40% of health care assistants. This lack of psychological and physical safety is a significant factor in workplace stress.
- Specifically in relation to nurses, there are significant concerns about drop-out rates among students. 24% of [student nurses](#) drop out of training, compared to a higher education average of 6.5%. As well as raising concerns about the wellbeing of the individual students, this high attrition rate has significant implications for the NHS's ability to fill its large number of vacancies.

There are however known strategies and interventions which can help reduce stress and burnout. These are not theoretical interventions: we can point to examples where progress is already being made in NHS and social care organisations. In our view, the most important are those which address the causes of stress, as opposed to interventions to manage or mitigate stress. For example:

- [Nottingham University Hospitals NHS Trust](#) has a system of 'shared governance' which actively involves staff at all levels in decision-making. This is an example of how workplace cultures which empower staff to have influence, to help shape decisions and to feel that their voice is heard – which are all associated with resilience.
- [North East London NHS Foundation Trust](#) is implementing a wide-ranging strategy to reduce discrimination, focusing on recruitment, career progression, disciplinary cases, reverse mentoring and developing a fair, compassionate and learning culture.
- [The Royal Free London NHS Foundation Trust](#) has improved night staff's access to nutritious food during their breaks – although often perceived as a minor issue, taking proper breaks and having access to food, drinks and a space to rest are significant for avoiding stress.
- [NHS Lanarkshire](#) has focused on supporting teams to work effectively, including flexible use of the full range of skills in multi-disciplinary working. Supportive, mutually respectful teams in which team members can iron out clinical workflows so that processes run smoothly, are strongly associated with staff wellbeing (and team performance).
- [Health Education and Improvement Wales](#) has developed a strategy, resources and talent pipeline to promote skilled, compassionate leadership across NHS services in Wales. The focus on leaders reflects their role in influencing the broader workplace culture to make it

more supportive and clearly driven by value of compassion and fairness, in order to reduce workplace stress and to motivate staff.

- [Erskine Care Homes](#) has developed integrated learning and career pathways to help staff to plan their career direction and access training for it. This sort of approach can not only make staff feel valued and supported but can also help with retention.
- [Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust](#) is demonstrating that the health and care workforce itself is a highly skilled asset for building resilience, through the education and support it provides to care home staff in Cumbria.
- [East London NHS Foundation Trust](#) engaged with staff to identify and eliminate non-value-adding activities. Removing bureaucratic processes and freeing up staff time for patient care can remove stressors, motivate staff and enhance role clarity.
- [Central Manchester NHS Foundation Trust](#) focused on improving staff management and in particular the appraisal and revalidation process. Good management, including being able to reflect openly on negative as well as positive experiences, is important for avoiding stress and modelling the desired workplace culture.

These are just some examples, but they illustrate that there is much that can already be done without the need for long lead-in times or further research. They indicate that action is needed on a wide rather than narrow front, and will often involve practical steps which also intentionally influence workplace culture.

In addition, although they have not yet been evaluated, anecdotally there have been many examples during the pandemic which appear to have helped staff avoid overwhelming stress in both the NHS and social care. These could be developed further and embedded. Examples include:

- Greater delegation of decision-making to teams
- Improved communication within teams
- Gestures to demonstrate that staff are valued, such as free meals
- Supportive rather than directive approaches from regulators and commissioners
- Adoption of technology, for example for remote consultations
- More flexible teamworking with roles often shared rather than rigidly demarcated.

### **Implications for national policy**

It is essential that national policy addresses the fundamental importance of reducing stress in the health and care workforce and the need to instil a supportive, compassionate and inclusive workplace culture. These priorities have been identified for some time in [national policies](#), but so far with [little impact and insufficient commitment](#). The [NHS People Plan for 2020/21](#) also clearly identifies them as priorities but it seems likely to repeat this pattern again: as its title implies, its focus is only for the remaining seven months of this financial year and its scope is only the NHS. There is a need for greater ambition across the NHS and social care, action as well as words over the long term, and accountability for measurable change.

Workforce planning and purposeful culture change inherently require a long-term perspective and progress will inevitably be limited if the approach is to build up change through a series of short-term steps. Previous incremental attempts to address them have not achieved radical improvement. Furthermore, as the NHS staff survey in particular illustrates, many of the issues that need consideration – such as ending the discrimination that ethnic minority staff experience – have

continued and even been normalised over many years. There is a need for long-term investment at a level commensurate with the urgent need for improvement – not just single year settlements. But by no means all of the issues that we identify in this submission are dependent on funding and sustained leadership and support by national bodies and ministers are just as important to keep up momentum.

Within a long-term approach, it is clear that improving working conditions and pay in social care will ultimately require reform and transformation of the sector itself. That will mean addressing more than just how social care services are commissioned and how they work with the wider local health and care systems: changes to funding – including the amount of funding, as well as the mechanisms for delivering it – will be the key issue in transforming social care.

In this submission we have repeatedly stressed that only limited evidence about the impact of stressors on social care staff is available at a national level. Although the need for the NHS People Plan has been recognised, there is no sign of a national workforce strategy for social care. While we have pointed to extensive data in the NHS, much of it is in fact limited to NHS trusts and does not include primary care services such as general practice. It is of course possible to make progress in NHS trusts, primary care and social care separately – these sectors all have significant differences. But a strategic approach across the whole of the health and care sector is likely to be far more efficient and effective, and to align better with emerging thinking about the role of ICSs, than treating the social care and primary care workforces as after-thoughts to NHS trusts. Better national data on the primary care and social care workforces will be important and we underline that implementing workforce policy across all sectors will require proper resourcing of both capacity and capability in ICSs.

Within a long-term, cross-sector approach, we believe national policy should set ambitions and ensure accountability in the following key areas. Some health and care organisations are already progressing some of these: the issue is not to design policy that is radically new, but to bring together and promote existing good practice, and to ensure progress on all of these fronts rather than only a few.

- Underpinning all workforce policy and to take pressure off staff, shortages and vacant posts should be filled through a [combination of measures](#) including ambitious targets to eliminate (not just [halve](#), as at present) vacancies, support packages for individual health and care organisations, reductions in barriers to international recruitment in the short term (e.g. supportive immigration policy) and increasing training places for the longer term. To implement these policies, ICSs should be supported and resourced to develop the capacity and capabilities needed for system-wide approaches to workforce development.
- National bodies and commissioners should support and require health and care organisations to review and understand staff workloads and, with staff, take steps to avoid chronic excessive workload – from removing non-value-adding tasks and improving processes, to re-designing care pathways and changing cultural norms. Organisations can help support this by adopting continuous quality improvement approaches to drive out waste and engage staff in the design and delivery of improvements.
- Social care staff should be paid, valued and supported equally to their NHS equivalents, as part of wider reform and transformation of social care in England.
- National bodies should promote and monitor the development of workplace cultures and governance processes which enable staff at all levels to influence decisions in their organisation and have their voices heard, changing the workplace culture to be focused less

on hierarchy and more on valuing colleagues' contributions. The [well-led framework](#) developed by the Care Quality Commission, NHS England and NHS Improvement may need to be updated for this purpose.

- Concerted effort is needed to ensure that health and care organisations act on the concern for ethnic minority staff seen during the pandemic, by developing comprehensive strategies to ensure equality and inclusion, including in human resources management processes such as recruitment and promotion.
- There should be national minimum standards for fundamental facilities such as PPE, other essential equipment including IT, breaks and access to food and drinks.
- There should be clearer good practice guidance on rostering staff, including the use of e-rostering and working long hours such as 12-hour shifts.
- Organisations should be supported to actively develop effective teamworking in frontline services, and to include it in individuals' appraisals and revalidation.
- As in [Wales](#), England should have a national strategy and leadership development programme to promote compassionate and inclusive leadership.
- Expectations and guidance for good people management and supervision in the health and care sectors should be clearer.
- Training and professional development should be adequately funded and available to staff.

Finally, we note that concerns about stress, burnout and resilience are not unique to England and should be priorities for all four UK countries. There is potential to further develop the ways in which English workforce policy learns from (and contributes to) workforce policy in Scotland, Wales and Northern Ireland.

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