Written evidence submitted by The Royal College of Psychiatrists (WBR0031)

None of the ambitions of the NHS Long Term Plan[1] (LTP) are possible without the outstanding staff of the NHS and social care sector. Now more than ever, steps need to be taken to retain frontline workers and maintain their physical health, mental health and overall wellbeing.

The Royal College of Psychiatrists (RCPsych) is the professional medical body responsible for supporting psychiatrists throughout their careers and for setting and raising standards of psychiatry in the UK. The College aims to improve the outcomes of people with mental illness and the mental health of individuals, their families and communities.

As doctors who specialise in supporting people with mental illness, psychiatrists have a role in assisting other health and social professionals with their mental health. Psychiatrists also have wider responsibilities and bring unique benefits to team leadership, demonstrating resilience in difficult circumstances. However, like any other health and social care professionals, psychiatrists are also subject to stress, exhaustion, poor mental health and burnout.

Our recommendations are based on the strong evidence we have collected from psychiatrists and experts across the UK, as well as our own research and examples of good practice. This submission focuses on the experiences and needs of psychiatrists as well as the wider multi-disciplinary teams who they work with. It provides insights into the many actions required to create a comprehensive strategy for caring well for staff of health and social care services.

We hope those will prove helpful to address workforce burnout and improve resilience in the NHS and social care. For general information about this submission, please contact Jonathan Blay, Public Affairs Manager: or Zoé Mulliez, Policy and Campaigns Manager

Summary

A wide range of factors impact on the resilience of the NHS and social care workforce. Those include primary stressors (the nature of the work done, including exposure to traumatic and otherwise challenging stressors) but, also to secondary stressors, which include the nature and strength of the bonds between staff, the culture in which staff work, the ways in which employers govern, lead and manage services, the supporting facilities available to staff, as well as personal circumstances and relationships outside of work[i].

There is very strong evidence that strong leadership, especially at shop-floor supervisor level, and a supportive team culture are crucial to protect the mental health and wellbeing of staff working on the frontline during and after the COVID-19 pandemic. A range of actions need to be taken to prevent burnout by tackling stressors at different levels: these can be both the longer-term actions such as ensuring there are enough staff to deliver high-quality care, but also short-term actions such as providing an opportunity for staff to speak with each other about their wellbeing, sufficient breaks and practical matters such as parking spaces and a place to rest with access to hot food and drinks.

Recommendations

1/ Strategic planning, leadership and mitigation of stressors

As we move into the next phase of the COVID-19 pandemic, we are calling for actions to be taken by the **Government,** including:

- Continue to provide active national support to, and active monitoring of, staff through a sustained and coordinated approach to mental health and wellbeing during the recovery period, and provide clear guidance to employers based on recommendations included in the College's Going for Growth plan[ii].
- Encourage new ways of working and delivering care, based on the innovative methods used during the COVID-19 pandemic that should also contribute to a better work-life balance.
- Articulate what strong, diverse and compassionate leadership at all levels looks like and ensure it can be implemented for long-term benefit.
- Ensure that health and care professionals receive diversity and equality training and promote effective training for NHS and social care organisations to monitor and address factors that put Black, Asian and Minority Ethnic (BAME) groups at a disadvantage.
- Invest in infrastructure and technology to make the NHS a more attractive place to work, which will make a real difference in improving staff wellbeing and retention[iii].
- Implement the NHS People Plan for 2020/21[iv] to foster a culture of inclusion and belonging and take action to train and grow the workforce. Publish a longer-term and more detailed People Plan after the Spending Review to further expand the workforce and ensure education and training are fit for the future.
- Build on the current planned increases to the continuing professional development (CPD) budget for nurses (as announced at the Spending Round 2019) and work towards full restoration of up to £300m per year. A substantial proportion should be ring-fenced for mental health that is in line with the size of the mental health workforce, with an additional sum to reflect past disparity.

In addition, it is important that **providers of health and care services**:

- Continue to provide significant support for staff mental health and retention, through implementing the NHS People Plan to 2020/21 and the recommendations of the NHS Staff and Learners' Mental Wellbeing Report[v] (also known as the Pearson Review). This should include:
    - Take practical measures to improve the wellbeing of mental health staff and get the 'basics' right,
    - Ensure both staff and patient safety,

    - Protect time and facilities for supervision and continuing professional development (CPD).
- Embed the health and wellbeing recommendations included in the College's Going for Growth plan[vi] following the first COVID-19 outbreak.
- Carry out risk assessments for all staff to offer them the best protection possible. Given the high and disproportionate numbers of deaths of BAME staff due to COVID-19, risk assessments should be carried out for all BAME staff as a priority.
- Provide training for NHS and care managers on topics such as active listening skills, and basic understanding of the likely impacts of exposure to significant moral/ethical dilemmas and psychological trauma.
- Provide guidance on the need for teams to:
    - Have preparatory briefings, which include discussions around moral and ethical challenges as well as the likely workplace pressures and traumatic exposures,
    - Avoid psychological debriefing, or routine post-incident counselling for staff working in potentially traumatic areas.
- Find practical ways of ensuring staff are rewarded and valued for their contribution through opportunities for flexible working, benefits and high-quality workplace facilities that will make a real difference in improving staff wellbeing and retention.

2/ Increasing and sustaining the workforce

The BMA found that a third of doctors have treated patients with long term COVID-19 symptoms, including chronic fatigue and anosmia[vii]. This means that a percentage of healthcare staff may be affected by long-term symptoms, which will have an impact on returning to work arrangements, cover, professional development and career progression. It is essential that sufficient workforce capacity is in place.

We are calling on the **Government** to develop recruitment initiatives for understaffed areas of health and social care such as mental health care, including:

- Commit to a multi-year settlement for workforce training and education, necessary to deliver the Long-Term Plan workforce commitments.
- Double the number of medical school places in England and ensure that all medical schools have plans in place to enhance medical students' exposure to and interest in psychiatry. Our Choose Psychiatry: Guidance for medical schools[viii] provide helpful checklists for medical schools to develop their plans. The Government will subsequently need to commission adequate and appropriate foundation and specialty training posts to support the increased cohort of medical school graduates.
- Recruit more Physician Associates and other roles (such as Advanced Clinical Practitioners) in mental health and learning disability. Our members reported that having Physician Associates has been the one constant during the crisis and helped massively in maintaining safe patient care on the wards and helping colleagues.
- Review appraisal and revalidation for retired doctors and tax penalties to prevent the loss of highly skilled and experienced senior professionals, as there is evidence that consultants are still retiring early despite recent changes to NHS pensions.

3/ Responding to staff in need

When staff do face difficulties, it is critically important that **organisations** offer the support that they need, including:

- Adopt a 'nip it in the bud' approach which encourage staff to access sources of support (e.g. colleagues, supervisors, peer supporters, team leaders, chaplains) early on.
- Provide universal informal supporting interventions for all staff as well as targeted selective interventions for staff who experience more substantial stress based on implementing evidence-based peer support programmes. RCPsych has worked with the Royal College of Physicians to produce a handy two-page guide[ix] to the values, principles and practice of peer support.

- Provide indicated interventions for staff whose needs are greater or who fail to recover; these may, for example, be based on the tenets of increasing access to psychological therapies (e.g. IAPT)[x] which take into account the specific needs of healthcare staff.
- Regularly assess the needs of staff who require further support and ensure that they can access relevant and evidence-based health and social care services that are appropriate to their assessed needs. Boards should ensure that they have established pathways of care for referring staff who may require specialised assessment and treatment to specialist services that are able to respond speedily[xi].
- Provide tailored support to at-risk groups, such as staff from BAME groups, and staff who may have suffered bereavement from the loss of colleagues.

How resilient was the NHS and social care workforce under pre-COVID-19 operating conditions, and how might that resilience be strengthened in the future?

The NHS in general - and mental health services in particular - have been working under significant pressure, making them much less resilient when the COVID-19 crisis struck. The 2019 annual NHS staff survey found that over 40% of NHS staff reported feeling unwell as a result of work-related stress in the last 12 months[1]. Lord Carter's review into unwarranted variations in mental health community health services found that sickness rates for staff working in mental health trusts were twice as high as the UK average.[xii]

One of the biggest causes of workforce burnout in mental health services has been the lack of professionals to support all the patients who need help. The most recent NHS survey found that only around one in three staff working in mental healthcare said they had enough staff in their organisation for them to do their job properly.[xiii]

Stepping forward to 2020/21: The mental health workforce plan for England[xiv] set an objective to recruit an extra 570 consultant psychiatrists between 2017 and 2021. In addition, NHS England plans to recruit 470 additional consultant psychiatrists and 80 non-consultant psychiatrists by the end of 2023/24. Recent workforce forecasts from HEE indicate that only 71 additional consultant psychiatrists will be added to the mental health NHS workforce by 2023/24 if action is not taken. Similarly, only 257 mental health nurses will be added to the NHS workforce by 2023/24 against a requirement of 7,000 needed to deliver the LTP.

If we are to ensure that in the long term the NHS is more resilient, we need to have enough staff to deliver the care people need. The upcoming Spending Review is a chance to set out a long-term plan to invest in the NHS workforce including steps to:

- Double the number of medical school places in England, by 2028/29, and allocate those places to schools that have a clear plan to encourage more students to choose a shortage specialty, including psychiatry.
- Commit to a multi-year settlement for workforce training and education to allow for the growth in the mental health workforce, including via new roles.
- Continue to provide active national support for staff through a sustained and coordinated approach to mental health and wellbeing during the recovery period and, provide clear guidance to employers based on recommendations included in our Going for Growth plan.
- Restore the CPD budget of £300m per year for the whole workforce. A substantial proportion should be ring-fenced for mental health services to reflect both the size of the mental health workforce and the need for all staff to better understand mental health and mental healthcare.
- Encourage new ways of working and delivering care, based on the innovative methods used during the COVID-19 pandemic.

What has the impact of the COVID-19 pandemic been on resilience, levels of workforce stress, and burnout across the NHS and social care sectors?

Doctors from across the UK reported the negative effect that COVID-19 has had on their mental health and wellbeing. They described increased stress, anxiety and emotional exhaustion, caused by long working hours in unfamiliar settings, intensified conditions, worries about Personal Protective Equipment (PEE), fear of contracting the virus and passing it on to their loved ones, losing a high number of patients and seeing bereaved families[xv].

Over the past few months, RCPsych has run regular surveys to provide members with the opportunity to share their experiences of many aspects relating to the COVID-19 response locally, including on workforce and wellbeing issues[xvi]. In May 2020, over half of our members surveyed said their wellbeing had worsened during the crisis (506 of 931).

[1] NHS Staff Survey. Accessible from: http://www.nhsstaffsurveyresults.com/

Our survey shows that the wellbeing of people from BAME groups has been disproportionately affected by COVID-19 compared to professionals from white backgrounds. In addition, many psychiatrists felt their wards were not set up for infection control which may have had an impact on levels of workforce stress.

The BMJ has published an assessment of the mental health impact of staff working with patients suffering from COVID-19 and other similar outbreaks showing the danger of not giving staff the chance to 'reset' following a crisis[xvii] . The study suggests that staff working with patients with COVID-19 are 70% more likely to develop both acute and post-traumatic stress disorder (PTSD) or to suffer from psychological distress.

Emerging evidence from pulse surveys of staff working in intensive care unit (ICU) settings (led by King's College London and University College London) show that up to 50% of ICU staff are reporting symptoms suggestive of a diagnosis of PTSD with higher levels of depression and anxiety symptoms being reported than in the general population and other key workers. It is notable that recent publications suggest that nursing staff, as a group, are at higher risk of suicide than other workers[xviii] and a recent report by the Society of Occupational Medicine (SOM) again highlighted the significant mental health difficulties faced by nurses within the NHS[xix].

What is the current scale of workforce burnout across NHS and social care? How does it manifest, how is it assessed, and what are its causes and contributing factors? To what extent are NHS and care staff able to balance their working and personal lives?

Burnout is included in the 11th Revision of the International Classification of Diseases (ICD-11). Burnout is a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed. It is characterized by three dimensions: feelings of energy depletion or exhaustion; increased mental distance from one's job, of feelings of negativism or cynicism related to one's job; and reduced professional efficacy[xx]. As such, burnout refers specifically to phenomena in the occupational context and should not be applied to describe experiences in other areas of life.

RCPsych runs the Psychiatrists' Support Service (PSS) providing free, rapid, high-quality peer support by telephone to psychiatrists of all grades who may be experiencing personal or work-related difficulties. Psychiatrists who call the service face different problems, some of which may have been present for some time. Burnout is one of the most common with 19% of all calls in 2020 being related to it in some way.

Different options are offered to support psychiatrists suffering from burnout, including direct support from a Peer Support Psychiatrist. Peer Support Psychiatrists listen and support, but do not provide medical advice. They use a resilience coaching model to encourage callers to explore their problems and consider what possible action they might take, including reaching out to other relevant sources of support, such as our PSS Survival Guide, the BMA Counselling and Doctor Advisor Service, the Doctors' Support Network or the Practitioner Health Programme.

At the beginning of the COVID-19 pandemic, PSS anticipated there might be an increase in calls to the service. As a result, an additional 12 Peer Support Psychiatrists have been recruited and trained, doubling the pool of Peer Supporters. At the start of lockdown, calls to the service dropped below expected levels, returning to normal in early May, and in the last few weeks, call volume has increased further.

Very few calls that have been received have related directly to the pandemic, but most are related to it in some way. This is consistent with the substantial impacts on staff of their experiences of secondary stressors. It is expected that, as the pandemic continues and lockdown eases, the level of calls will fluctuate and potentially further increase. The service is now equipped to respond to an increase with the larger pool of Peer Support Psychiatrists available to respond.

The College is calling for a dedicated tool to explore national and regional data trends on workforce wellbeing outcomes and indicators, across different healthcare professional groups. This would enable staff, organisations and the public to monitor and analyse trends and progression.

What are the impacts of workforce burnout on service delivery, staff, patients and service users across the NHS and social care sectors?

Work-life balance is reported as a factor in 13% of NHS leavers (45,000 people over five years). Over time, extending working lives by a year could represent a supply boost of between 3% and 5% of staff (assuming average service of 20-30 years with breaks) with perhaps £30 million in avoided agency costs over five years[xxi].

60% of clinical staff have reported missing meals at work on at least a weekly basis over the previous six weeks, compared with 38% of non-clinical staff and 35% of postgraduate trainees[xxii]. The annual NHS staff survey in 2019 found that over 40% of NHS staff reported feeling unwell as a result of work-related stress in the last 12 months[xxiii].

This impacts negatively on the capacity of staff to treat patients to the best of their abilities. A meta-analysis published in 2019[xxiv] provides evidence that doctor's burnout may jeopardize patient care. Reversal of this risk must be viewed as a fundamental healthcare policy goal across the globe. Healthcare organisations are encouraged to invest in efforts to improve doctors' wellness, particularly for early-career doctors. The methods of recording patient care quality and safety outcomes require improvements to concisely capture the outcome of burnout on the performance of health care organisations.

The literature indicates that both individual-focused and structural or organisational strategies can result in clinically meaningful reductions in burnout amongst doctors[xxv]. Further research is needed to establish which interventions are most effective in specific populations, as well as how individual and organisational solutions might be combined to deliver even greater improvements in doctor's wellbeing than those achieved with individual solutions.

What long term projections for the future health and social care workforce are available, and how many more staff are required so that burnout and pressure on the frontline are reduced? To what extent are staff establishments in line with current and future resilience requirements?

The most recent NHS survey found that only around one in three staff working in mental healthcare said they had enough staff in their organisation for them to do their job properly.[xxvi]

Stepping forward to 2020/21: The mental health workforce plan for England[xxvii] set an objective to recruit an extra 570 consultant psychiatrists between 2017 and 2021. In addition, NHS England plan to recruit 470 additional consultant psychiatrists and 80 non consultant psychiatrists by the end of 2023/24. Recent workforce forecasts from HEE indicate that only 71 additional consultant psychiatrists will be added to the mental health NHS workforce by 2023/24 if urgent action is not taken. Similarly, only 257 mental health nurses will be added to the NHS workforce by 2023/24 against a requirement of 7,000 needed to deliver the LTP.

According to HEE, delays to the Spending Review and the impact of the COVID-19 pandemic on international recruitment are the main reasons behind this poor outlook. The recently published NHS People Plan to 2020/21[xxviii] recognised the pressing need to support significant expansion in psychiatrists. Recruiting psychiatrists from overseas is crucial for achieving this ambition. As of September 2018, 46% of all NHS psychiatrists and 51% of NHS consultant psychiatrists in England had qualified abroad[xxix].

Overseas psychiatrists have long had crucial roles in delivering excellent patient care and we need to continue to support international medical graduates. However, the pandemic means that it would be both unsustainable and

unethical to over-rely on international recruitment. Therefore, we must train more psychiatrists here in the UK, which means we need more medical school places and training placements.

To what extent are there sufficient numbers of NHS and social care professionals in training for service and resilience planning? On what basis are decisions made about the supply and demand for professionals in training?

There has been a significant increase in the number of doctors graduating from medical schools who choose to specialise in psychiatry.

In July 2020, HEE published the latest recruitment data for core training positions starting from August 2020, which showed that England had advertised 334 core training places in psychiatry in England, which have all been filled. Our Choose Psychiatry campaign to attract doctors to the specialty has been steadily building over the last few years. We are confident that it has helped to increase the fill rate in England from 67.3% in 2017 to 84.8% in 2018, 94.8% in 2019 and 100% in 2020, as per the figures published by HEE[xxx].

We strongly believe that our campaign will continue to be successful. Between March 26 and July 30, NHS Health Careers has seen increases in interest in many mental health areas on their site, including a 17% increase in visits to the psychiatry section in comparison to the same period last year (36,833 vs 31,339)[xxxi].

We now need to ensure that talented students interested in mental health get the opportunity to study at medical school, hence the need to increase the number of places. The College has modelled an estimated number of new medical school places required to deliver a sustainable supply of psychiatrists in the future and sustain the Government's commitments over the next 10 years. Our comprehensive briefing[xxxii] argues that, at the 2020 CSR, the government should commit to expand the number of places from the 7,500 currently available to 9,000 by 2022/23, and then create 1,000 places each year to 2028/29.

In addition, while the number of applicants for core psychiatric training are at almost 100% of the positions available, we need to bear in mind that the number of positions is lower compared to precedent years. HEE is already investing in measures to expand psychiatry places, starting with an additional 17 core psychiatry training programmes in 2020/21 in areas where it is hard to recruit[xxxiii]. We must increase and sustain those efforts.

Will the measures announced in the People Plan so far be enough to increase resilience, improve working life and productivity, and reduce the risk of workforce burnout across the NHS, both now and in the future?

We welcomed the content of the second chapter of the People Plan - 'Looking after our people' - and its focus on the NHS People offer during COVID19. We also welcomed the new 'NHS People Promise' published alongside the People Plan.

It is good to see the list of things that staff can expect from their employers, including:

- a wellbeing guardian,
- safe spaces for staff to rest and recuperate,
- free car parking at their place of work at least for the duration of the pandemic,
- psychological support and treatment,
- support for people through sickness,
- physically healthy work environments,
- support to switch off from work.

Those should make a positive impact on staff wellbeing, working life and productivity.

In particular, we welcome the focus of the plan on improving the culture of the NHS as a workplace and on developing team working. Some NHS staff have commented that the focus of some NHS organisations on improving team working during the acute phase of the COVID-19 pandemic has been welcome and beneficial. Staff reported that this should not be lost as the NHS returns to 'business as usual'.

We also welcome the focus on allowing NHS staff to work more flexibly, including flexibility of training for junior doctors, such as less than full-time training, out-of-programme pauses and opportunities to develop portfolio careers.

However, the positive impact of the People Plan for 2020/21 can only be realised if it is fully funded and fully implemented.

What further measures will be required to tackle and mitigate the causes of workforce stress and burnout, and what should be put in place to achieve parity for the social care workforce?

The People Plan contains some very positive steps forward. However, we are looking forward to seeing more concrete funded proposals after the Spending Review. The College has put together a list of proposals that will have a profound impact on improving staff working life and productivity, while reducing the risk of workforce burnout.

Those include:

- A commitment to double the number of medical school places: we don't have enough doctors to meet the needs of a growing, aging population now or in the future. More doctors will help alleviate some of the pressures experienced by NHS staff, increase productivity and reduce the risk of burnout.
- Increases to the continuing professional development (CPD) budget, so that all staff continue to gain the skills they need.
- A multi-year settlement for workforce training and education to allow for the workforce growth necessary to deliver the Long-Term Plan and to address some of the key NHS workforce issues.

For staff who do develop problems we need to offer them the right treatment and support. The NICE guidelines, published in 2018, on managing people who have PTSD recommend that adults should be offered a trauma-focused CBT intervention, or in some cases EMDR, if they have acute stress disorder or clinically important symptoms of PTSD, and have been exposed to one or more traumatic events within the last month. These interventions include cognitive processing therapy; cognitive therapy for PTSD; narrative exposure therapy; and prolonged exposure therapy. As above, EMDR therapy is also a NICE approved treatment for PTSD.

Care teams should not wait until they consider someone is fully 'work-ready' before recommencing appropriate work. Instead, they should follow vocational rehabilitation approaches, such as individual placement and support (IPS), which follow the principle that people should be supported to return to appropriate work as soon as they reasonably can.

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