Written evidence submitted by Agincare Limited (WBR0040)

Workforce Burnout and Resilience in the NHS and Social Care

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?

Our Pre-COVID 19 social care workforce faced the well-known challenges working in Social Care in pre-COVID operating conditions. Difficulties attracting and retaining staff within the social care sector (as it has been viewed and articulated as a "low skilled / low pay" sector by some in influential positions) impacted on staff resilience. There is hope that due to the impact of COVID-19 the Social care sector will be viewed and promoted as a sector that provides an essential service particularly considering the UK age demographic and is in fact a 'high skill' sector requiring for some roles (i.e Nursing staff) accredited professional qualifications, and this will assist in attraction / retention within the sector to supplement the work currently being undertaken in our company on attraction / reward 7 recognition / training & development.

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?

Our workforce experienced increased levels of stress in the workplace due to staff absence caused by the COVID 19 pandemic. Staff shortages were immediate and difficult to plan in advance and increased stress and tested resilience of those staff continuing in the workplace. In addition, shortages/inconsistency in supply of PPE created difficulties as did publicity surrounding the release of NHS patients in to Care Homes.

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?

See answers above.

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

Widespread continuance of working at home in the public sector is having a negative impact on communications relating to referral and re-assessment processes meaning people may not be getting the care they need when they need it. This causes stress to our staff and additional work needed to follow up.

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?

Current vacancy rates in social care versus ageing demographic is likely to add further stress and reduction in resilience, as demand rises if our workforce does not increase.

We have recently been recruiting approximately 25% of our staff from EU markets – predominantly as Care Assistants. Under current proposals for the new points-based immigration system, Care Assistants / Senior Care Assistants will not meet the required salary thresholds and/or are not a designated 'Specific Shortage Occupation' meaning no visas for social care staff. This will further negatively impact on vacancy rates and place further pressure on existing staff to work more.

Specifically, for our Live in Care division (including servicing NHS Projects) many Live-In staff are EU resident, EU passport holders in the UK for work placements. These workers tend to be in placement for longer period of time and so increasing consistency and quality of care levels. There is a particular concern related to this from January / February 2021 when EU citizen workers who may be in placement in December 2020 fly home at the end of that placement and can never come back. This could certainly test resilience of our Care staff.

In addition, the new point-based immigration system indicates a lack of parity in treatment of NHS staff (eligible for visa) versus Social Care staff (not eligible for visa) and reinforces assumptions that Social care is "low skilled, low paid".

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?

Those currently in training for our social care roles are all to cover current staff resource requirements, there is no spare human resource over and above immediate staff requirements. We are efficient in supplying mandatory training promptly for new hires and we have many of our current employees on accredited training programmes and in-house training programmes. This training includes content related to dealing with changing conditions in the workplace generated by COVID-19. Our staff have been fully briefed and informed as best they can. The inconsistency in messaging and 'best practice' from Government sources has sometimes created uncertainty and considerable discussion about what are the right messages to give to our staff regarding best practices in the workplace for service & resilience planning.

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?

The People Plan applies predominantly to the NHS. It would be a welcome addition to include the Social Care sector more prominently within the People Plan.

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?

It is uncertain what the future Brexit trade agreement will consist of and there is concern from staff and customers that this may adversely affect supplies of certain medication. Obviously if it is not possible or more difficult to obtain what is needed to keep people well this creates extra strain on the system.

If as is likely to be the case, there is a requirement to recruit an increasing number of those with no social care experience this could represent further risk to care levels and staff resilience as it takes time to get those with no experience up to speed.

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