Written evidence submitted by The British Psychological Society (WBR0046)

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Under its Royal Charter, the objective of the British Psychological Society is "to promote the advancement and diffusion of the knowledge of psychology pure and applied and especially to promote the efficiency and usefulness of members by setting up a high standard of professional education and knowledge". We are committed to providing and disseminating evidence-based expertise and advice, engaging with policy and decision makers, and promoting the highest standards in learning and teaching, professional practice and research.

The British Psychological Society is an examining body granting certificates and diplomas in specialist areas of professional applied psychology.

Publication and Queries
We are content for our response, as well as our name and address, to be made public. We are also content for the Committee to contact us in the future in relation to this inquiry.

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About this Response

The response was led on behalf of the Society by: Andrew Baldwin, Policy Advisor (Work)

British Psychological Society response to The House of Commons Health and Social Care Committee

Workforce burnout and resilience in the NHS and social care - Call for Evidence

1.	**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?**
	We know that the NHS was struggling with a stressed and under-resourced workforce pre-COVID-19. Prior to the crisis, 40.3% of NHS staff reported that they suffered from work-related stress (NHS Staff Survey, 2020), rising from 36.8% in 2016. Further statistics are available in a number of recent key reports. Health Education England's *NHS Staff and Learners' Mental Wellbeing Commission* gives a clear picture of the long term nature of these issues (HEE, 2019), while the psychologist Professor Michael West gives a lengthy account of the state of the NHS in his King's Fund blog on the 2019 NHS Staff Survey (West, 2020). This blog post itself followed on from *Caring for doctors, Caring for patients*, which highlighted the impact burnout in doctors is currently having (West & Coia, 2018). Fellow psychologists Professor Gail Kinman and Dr Kevin Teoh authored two recent reports based on literature published over the last 10 years; *What could make a difference to the mental health of UK doctors?* and *The Mental Health and Wellbeing of Nurses and Midwives in the United Kingdom* (alongside Professor Anne Harriss), both of which demonstrated that doctors and nurses and midwives respectively were at higher risk of work-related stress, anxiety and depression. (Kinman & Teoh, 2018) (Kinman et al. 2020). This is reinforced by similar observations from the Health and Safety Executive for all those working in human health and social work activities (HSE, 2019). The Society is not convinced that resilience is the main issue here. The NHS workforce is extremely 'resilient', but believe it is increased workload coupled with a lack of support that cause issues. To that end the Committee should consider setting out a clear, dynamic definition of 'resilience' that recognises its fluidity and enables the NHS to take a whole-sector approach to supporting staff mental health and wellbeing. We recommend a move away from viewing resilience as a fixed characteristic of individuals. Resilience is not a characteristic or a skill but is a dynamic interaction between the person and their environment. We know that burnout is linked to an increase in psychological stressors within a workplace, and NHS jobs involve exposure to a huge range of potential stressors including competing demands, interpersonal conflict, complex decision making, moral injury, rapid patient turnover, shift work, long hours and patient mortality. Staff susceptibility to these stressors could be reduced in future if NHS Trusts focus on the balance between personality traits, job demands and support systems to achieve employee wellbeing, as described by the Job–Demands–Resources model. However, the Society's view is that this is a systemic issue and that there no one single cure. The HEE Commission recommendations (HEE, 2019) and the People Plan will be central to tackling the causes across a number of levels. Another way of measuring resilience is through presenteeism. We know that there is a longitudinal relationship between job demands, burnout, and presenteeism (Demerouti et al. 2009). Excessive job demands cause more presenteeism which, if left untreated, will cause burnout. Returning to the NHS staff survey, in 2019 56.5% of respondents said they have gone to work in the last three months, despite not

	feeling well enough to perform their duties. This is similar to 2018 (56.5%) and 2017 (56.6%) (NHS Staff Survey, 2020). So we see high levels of presenteeism through the NHS staff survey, which can be viewed as a long-term manifestation of a disconnect in the jobs-demands-resources model. Put simply, staff have been working too much, for too long a period, and have been pressured into that situation (either by themselves, the management or the overall culture).
2.	**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?**
	We have seen an exacerbation of the stressors mentioned in the answer to Q1. Decision making can now involve regularly deciding who to prioritise, moral injury is exacerbated by a lack of control, especially when patients or care home residents are dying and there is no treatment for them. On this point, people join the NHS or work in social care to make a difference and make people better; many covid cases deny them the ability to make the difference they want to, leading to a feeling of helplessness. And longer hours, rapidly changing shift patterns and the added complications of using PPE for long periods all add to stress and exhaustion. The way these additional stressors have impacted on staff has differed though, as evident by the range of reactions (or compensation strategies, see Q1) they developed. The Society's *psychological needs of healthcare staff as a result of the Coronavirus pandemic* guide identified the following (BPS, 2020): • Some staff will have coped successfully using their own preferred style, individual resources and social support. Many may be changed in a positive way, experiencing personal development and post traumatic growth. • Some may have experienced intrusive thinking about what they 'should' have done differently,

	particularly in making life or death decisions, and experience shame or guilt (moral injury). Dissonance with a 'heroes' narrative may make this harder to disclose problems and may exacerbate distress. • Others may feel differently about their job and experience resentment towards individuals and towards the organisation (e.g. due to poor leadership, decision making or access to PPE), where the social contract has changed after not feeling valued or looked after. • Individual difficulties have wider family and social impacts which may further exacerbate these longer term impacts. • Certain staff may be at risk of chronic psychological difficulties (including but not limited to burnout and PTSD). On the first point, it is encouraging to see so many positive reactions and Dr Michael West's recent King's Fund blog outlines that "staff have taken the initiative and taken on greater responsibility", "camaraderie, daily briefings, huddles and regular time to discuss patients has dramatically improved teamwork" and "compassionate and collective leadership have been more in evidence and welcomed by staff" (West, 2020). But the last point is especially important if these staff members were among the 40.3% reporting work-related stress before the pandemic, or covered within the percentage of staff reporting bullying within the last 12 months (28.5% on average, but 32.7% working in mental health and 47.4% of ambulance staff) (NHS Staff Survey, 2020). They will need extra support to ensure existing failures aren't exacerbated to the point that staff develop further negative psychological conditions. We have also seen staff affected differently based on local circumstances, for example: • Junior staff not being aware of the support available to them (those feeling most supported tend to be well embedded in team environments). • Non-front line staff feeling guilty, for example when re-assigned to a post vacated by staff moved to Covid wards or when shielding loved ones at home (feelings of having let their colleagues down). This also impacts on retired staff who chose not to return to the frontline. • Staff concerns about PPE (not feeling protected, fear of being infected through no fault of their own, or of possessing it and feeling guilty about 'taking it' from those more in need who do not have it). The focus now should be on the potential for a second wave during winter. Staff have employed the coping strategies above, and have been affected psychologically different way, but these strategies may play out differently next time. The adrenalin and excitement of working on something new is replaced by dread of going through it again and the fear of being re-traumatised.
3.	**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?**
	We are still waiting for the 2020 NHS staff survey and pulse survey to close, so current burnout statistics are difficult to assess. Individual NHS Trusts have done local surveys so we advise looking there first and extrapolating nationally (dependent on the questions each Trust asked). Anecdotally, we know that staff wellbeing referrals to psychologists have increased (some have reported triple the usual amount) and that this is to be done without creating waiting lists, with the obvious impact this will have on psychologists' own health and wellbeing. The overall reasons behind burnout are well known, but a recent longitudinal study of burnout in mental health professionals (Davis, 2020) which evaluated a large range of factors previously associated with

	burnout (O'Connor et al. 2018) showed that overcommitment and workload-related stress were associated with a higher risk of exhaustion and stress related to organisational processes (e.g. poor management and supervision) was associated with a higher risk of disengagement. Overcommitment and increased exhaustion were also associated with work-family conflict and overtime, indicating work-life balance impacts burnout. Conversely, higher levels of job autonomy and self-efficacy were associated with lower risk of exhaustion, higher levels of autonomy and job satisfaction associated with lower levels of disengagement and supervisor and colleague support were associated with lower burnout levels. The extent to which NHS and care staff are able to balance their work and personal lives, as well as how staff experience the significant demands and challenges of their roles therefore depends on where they are on the spectrum above. This suggests a whole system approach is needed to ensure every Trust is organised to boost job autonomy, self-efficacy and satisfaction, particularly through support of supervisors and managers. The emphasis should be on organisational change, not individual resilience and an emphasis on compassionate leadership which nurtures creativity and innovation rather than a command and control approach, may be a beneficial approach going forwards (West, 2017).
4.	**What are the impacts of workforce burnout on service delivery, staff, patients and service users across the NHS and social care sectors?**
	The psychological evidence is clear that burnout has negative impacts not only on the employee, but on the services they can provide. It leads to (Salvagioni et al., 2017): • emotional exhaustion, characterized by emotional depletion and loss of energy • depersonalization or cynicism, detachment from work and clients and emotional hardening • reduced personal accomplishment or inefficacy (a feeling of personal or professional inadequacy) and reduced productivity and coping skills All three areas impact negatively on service delivery, staff, patients and service users. For example, in two studies, researchers found that doctors with high levels of burnout had between 45% and 63% higher odds of making a major medical error in the following three months, compared with those who had low levels (West, 2009), but the simplest explanation is to acknowledge that the less exposure you have to these negative impacts, the less likely you are to suffer from burnout, and the better care you are able to give.
5.	**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 Society would like to see more use of psychologists, not just in supporting patients, but in supporting staff as well. Staff need support in how to talk about their psychological health and need avenues to reflect on their experiences because normality has been warped to the extent that staff accept emotional exhaustion, depersonalisation and inefficacy as part of the job. As we saw in Q2, the way people react to the same situation varies significantly, so psychologists can assess and understand the individual impact to ensure the right method of treatment.

	Currently, this role is being provided ad hoc and to varying levels by those psychologists working with patients who have 'doubled up' on their workload by acting as support for staff as well, outside of their job specification. This is unsustainable and unfair on those workers, as it will in turn increase their likelihood of burnout. The need for more staff has been documented widely, not least in the NHS Long Term Plan and Five Year Forward Plan, but we would welcome more psychologists with a specific focus on staff wellbeing. Linked to this, commissioning services must include protected time for psychologists to deliver trust-wide support to colleagues as well as their services to the public or they risk burn-out We also need to focus not only on the individual, but also on the organisation. As noted above, burnout is linked to a disconnect in the job-demands-resources model, where better job autonomy and self-efficacy can reduce the likelihood of exhaustion. To fix the occupational failures we want to see the NHS use occupational psychologists to redesign workplaces to be psychologically healthy, alleviating some of the existing stressors by encouraging compassionate leadership, redesigning control and developing recruitment, onboarding and retention.
6.	**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?**
	In England, in the last decade, the number of clinical psychologists increased by 9%, although in Scotland, while there has also been a steady increase since 2002, the growth in the year to June 2019 was more modest (0.6%). There is no data on whether these roles are patient-focused or staff-focused. There is also no data on which NHS Trusts are using occupational psychologists to enhance their organisational development, and we recommend those currently doing so should promote this to encourage others to focus on the structural issues leading to burnout. The number of vacancies posted rose from 2,375 in 2018 to 2,560 in 2019 and, only halfway through 2020, this was already at 2,115. Few of these recent vacancies were recorded as being a 'Covid-19' vacancy but further investigation is required to understand whether any of the increase is because or despite the pandemic. Psychology remains the second largest degree at university, in part due to the wealth of transferable skills it provides to graduates which are relevant in most workplaces. But the number pursuing psychology into an NHS position remains low – analysis of data from 6 months after graduation show that nearly a tenth of those completing their first undergraduate psychology degrees have taken up employment in the NHS, however it was far higher – around a third – for those completing postgraduate courses. Something is preventing more from taking up a position in the NHS, and action must be taken to understand and address this.
7.	**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 Society was pleased to see the People Plan recognises the important triple role psychologists can play in supporting patients, staff and organisations. In terms of patients, it is good to see continued investment in training to support significant expansion in the future mental health workforce and to support significant expansion in psychological therapies for children and young people. For staff, psychologists can support the national health and wellbeing programme and help drive the proposed pilots on improving staff mental health. They should be central to the resilience hubs currently being established. And for organisations, the plan makes it clear psychologists will have a key role to play with the central themes of "more staff, working differently, in a compassionate and inclusive culture". Practitioner psychologists will be key to instilling behaviour change that paves the way for the desired culture shifts. While compassionate leadership, action on diversity, action on staff retention and establishing workplace planning processes are all central to the work occupational psychologists do in businesses up and down the country. However, we are concerned that unless the structural and systemic issues are dealt with, the Plan might not be as effective as it could be. For example, the section on overhauling recruitment and promotion practices outlines that changes will be done in just two months. To do this properly will take longer than that and should be all-encompassing (values-based recruitment in general) involving occupational psychologists who can recommend changes to the whole system of recruitment to achieve this specific purpose. There is little point overhauling recruitment if the factors negatively affecting retention, such as burnout and company culture haven't been addressed. The same is true across the board, not just on recruitment.
8.	**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?**
	As mentioned above, better use of occupational psychology will help the NHS to build psychologically healthy workplaces that allow workers to thrive. The evidence above shows long-term, structural issues with the way staff are treated, almost to the point of being set up to fail. Addressing burnout needs to be made a specific part of the People Plan, because the WHO refers to burnout as a "syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed." The focus therefore needs to be on why that management is lacking; are they unsupported, suffering burnout and set up to fail as well? Staff have an expectation that management will look after them, but that does not always happen, perhaps because management don't feel supported themselves. So a long-term culture shift needs to take place, through the People Plan, asking does this organisation know how to care for its staff? It is this long-term focus across the organisation, not short-term measures, which will help with resilience. The concern with short-term is that focusing on resilience while ignoring toxic cultures will not help and may even make things worse. It leads to an acceptance of poor practice as part of the job, so we need to call out toxic issues, not accept them (as by accepting them we end up encouraging them).

The evidence of good practice is out there and the NHS Confederation has done a lot to highlight this on their website. We want to see the successful interventions each individual NHS Trust enacted collated, analysed, and promoted to all Trusts as evidence of what works, but it needs to be done in a way that works locally – the top down approach does not always work on every Trust. This will ensure all managers have access to interventions that have worked so they can improve their management of staff.

Ultimately though, as the People Plan acknowledges, if the aim is "more staff, working differently, in a compassionate and inclusive culture"; then psychologists and psychology will be instrumental in developing that culture; of creating the psychologically healthy world of work needed to deal with burnout in the NHS.

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