Written evidence submitted by research team from the Universities of Exeter, Hull, and Oxford (WBR0082)

Workforce burnout in the NHS

Written evidence submitted by the 'Care Under Pressure' research team from the Universities of Exeter, Hull, and Oxford, October 2020.

Introduction

- 'Care Under Pressure' is a National Institute of Health Research (NIHR) funded interdisciplinary research project that synthesised pre-existing evidence in order to understand the causes of mental ill-health in doctors, across specialties and career stages, and make informed recommendations to tackle this problem.

- The findings were published in a final report on the NIHR website and in a peer-reviewed journal article in BMC Medicine earlier this year (1, 2). For full project information and resources, please visit: http://sites.exeter.ac.uk/cup/.

- To illustrate the findings and recommendations, the project team worked with diverse stakeholders (including patients), two artists and a film maker, to develop a series of graphic illustrations and videos. One example is provided below.

- This submission addresses several of the questions and points of the Commission's call for evidence, by outlining the background and findings of the Care Under Pressure project.

The impact of NHS workforce burnout on service delivery, staff, patients, and service users (before and during COVID-19)

- Doctors' mental ill-health affects doctors and other healthcare professionals, but also patient care and satisfaction (3, 4). The high incidence of mental ill-health in doctors alongside related problems such as **recruitment, retention, absenteeism and presenteeism**, has a clear impact on healthcare service delivery (5).

- The **urgency and salience** of the problem of mental ill-health in doctors, even before COVID-19, was reflected by the growing number of systematic reviews and primary research studies (6-8), opinion pieces (9), recommendations (10, 11), and of doctors' memoirs (12).

- The **COVID-19** pandemic makes these issues more urgent not only because of the additional physical, professional and psychological strain it is currently exerting on doctors (13), but also in relation to a likely surge in workload in relation to non-COVID-19 related patient care after the peak of the pandemic (14).

- Most research and interventions are undertaken within **disciplinary silos** and do not consider simultaneously the many dimensions (individual, organisational, professional etc.) that may negatively affect doctors' wellbeing (15-17). In particular, the current emphasis on **resilience** (and in the COVID-19 period on heroism (18)) places responsibility for wellbeing with the individual. Resilience training alone is not likely to solve such a complex and multidimensional issue, and may even aggravate how doctors experience work-related pressures, contributing to mental ill-health (19, 20).

How to improve working life and productivity, and reduce the risk of workforce burnout across the NHS (both now and in the future)

Care Under Pressure findings:

- Doctors were more likely to experience mental ill-health when they felt isolated or unable to do their job and when they feared repercussions of help-seeking.
- Interventions emphasising relationships and belonging were more likely to promote wellbeing.
- Interventions creating a people-focussed working culture, balancing positive/negative performance and acknowledging positive/negative aspects of a medical career helped doctors to thrive.
- The way that interventions were implemented seemed critically important. Doctors needed to have confidence in an intervention for the intervention to be effective.

Care Under Pressure recommendations:

- For policy makers: Policies that aim to secure the future of the NHS workforce must foster a supportive work culture in which individuals can thrive. Policies and interventions that target the individual in the absence of a supportive work culture are unlikely to succeed.
- For employers: Ensure influential nominated Board-level responsibility for the wellbeing of staff. This should include regular immersion in practice settings, as well as regular reports on progress against key performance indicators (e.g. absenteeism might be detected by sickness absence, rota gaps and vacant posts; presenteeism might be detected by complaints and errors; workforce retention might be detected by staff turnover; general staff wellbeing might be detected via annual staff surveys, markers of overwork and occupational health referrals).
- For team leaders: Actively look out for behaviours that may be potentially stigmatising and encourage help-seeking. In performance reviews, emphasise the positive as well as the negative and ensure the doctor knows their hard work in often challenging circumstances is valued. Make clear that prioritising own health is important for patient care.
- For doctors: Recognise when you are working under pressure and, even when your workload is high, prioritise your relationships at work.
- For other healthcare team members: Recognise that the whole team may, at times, be providing care under pressure. Try to normalise discussions of struggle in the context of challenging work.

- For patients: Know that doctors and other health professionals are usually doing the best job they can in difficult circumstances. A thank you when things go well will always be appreciated!
- For researchers: Use research syntheses and stakeholder involvement to target your research to the areas of greatest need. Research of all kinds will be needed to develop theory and interventions, and design appropriate outcome measures, approaches to evaluation and implementation, in relation to doctors' mental ill-health.
- For those refining/designing interventions: Adopt our 10 Care Under Pressure principles (see below).

Care Under Pressure conclusions and 10 principles

A key conclusion from the Care Under Pressure project was that we do not need MORE interventions, but we need to IMPROVE the ones that we already have. To help those refining/designing interventional strategies to improve and preserve mental health, and tackle doctors' mental ill-health, we developed **10 principles, by which existing interventions might be refined:**

1. Be clear about who the intervention is for (given the continuum from full health, to 'under pressure', to mental ill-health).
2. Give options by signposting to a range of interventions (e.g. a 'one stop shop' of local, regional and national resources).
3. Ensure that information about the intervention is readily and rapidly available.
4. Ensure that interventions are accessible to someone who works long and inflexible hours.
5. At the initial enquiry stage, invest time in building trust and normalising stigma and struggle.
6. Provide interventions in groups whenever possible, to prioritise connectedness, relationships and belonging.
7. Ensure interventions for individuals are endorsed by or embedded in the workplace, where possible.
8. Encourage and empower individuals to tackle low-level everyday hassles at work, to free up capacity to deal with bigger issues.
9. Emphasise that prioritising and investing in physical and mental health is essential for optimal patient care.
10. Evaluate and improve the intervention regularly, using data such as numbers and types of attendee, programme adherence and user perceptions.

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