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Workforce burnout and resilience in the NHS and social care written evidence

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I have a professional nursing background and have researched the nursing and healthcare workforce for over 20 years, studying staff wellbeing at work. I am responding ot the following questions in the call for evidence.

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?

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

Stress among health care staff is greater than in the general working population and explains more than 25% of staff absence (1). NHS staff sickness absence rates are double the national average (2) and are estimated to cost £1.1 billion (3). Depression, anxiety, a loss of idealism and empathy are also reported by nurses and doctors (4, 5). The mental health of the NHS workforce is a major healthcare issue, leading to presenteeism, absenteeism and affects workforce retention (3). Various reports have highlighted the need to reduce stress and improve mental health in NHS staff (3, 6-8). Burnout and emotional exhaustion are common with high sickness absence and high turnover rates (9, 10). Without the right support and attention staff are vulnerable to chronic stress and mental illness (4), with up to one third of healthcare professionals experiencing forms of psychological distress that necessitate clinical intervention evidenced in my own recent research (11). Neglecting the wellbeing of healthcare staff has significant implications for staff and patients, as there are known links from my research between staff wellbeing at work and patient experiences of care (12, 13).

Thus in pre-Covid conditions the NHS workforce whilst largely very resilient also experience high levels of poor mental health caused by workplace issues (emotional and physical challenges in patient care delivery; heavy workloads, shift work, bureaucracy, high levels of bullying and harassment in the NHS and dealing with challenging patient conditions) which I am currently researching in an NIHR study examining the causes and potential interventions for poor mental health in Nurses, midwives and paramedics: ***Care Under Pressure 2: Caring for the Carers a realist review of interventions to minimise the incidence of mental ill-health in nurses, midwives and paramedics***

https://www.journalslibrary.nihr.ac.uk/programmes/hsdr/NIHR129528/#/

Nurses, midwives and paramedics are over 40% of the clinical workforce; have high rates of sickness absence due to mental ill-health with significant attrition and substantial financial implications. Changing the work environment to prevent the development of mental ill-health is preferable to alleviating 'symptoms', such as absenteeism and workforce attrition. Thus, strategies are needed that span the spectrum from prevention to treatment, and that target both individual and organisational behaviours. Aim: To improve understanding of how, why and in what contexts nurses,

midwives and paramedics experience work-related mental ill-health and determine which high-quality interventions can be implemented to minimise mental ill-health in these staff groups.

Previous research I have led has shown a link between healthcare staff wellbeing and the experiences of patients – with healthcare staff wellbeing at work shaping patient experiences of care for good or ill and the quality of staff happiness and wellbeing by the quality of immediate working relationships and by workplace behaviours of staff towards other staff (14).

I have also previously suggested a problem with the use of the word resilience. Some resilience is obviously needed with the challenging work health and social care professionals undertake, but staff need their employers, their teams, the profession and the public to actively support them with action and resources. This means enough staff, a good pipeline of well-educated nurses, who are not having to pay to be educated to staff the NHS. The withdrawal of the nursing bursary and the requirement for nurses to pay fees have significantly reduced the nursing pipeline and created inequity; nurses and midwives who undertake 2300 hours of clinical practice during their education need the same support as Doctors in their clinical training- government support via a bursary and no fees at this time. As for resilience, drawing on experiences of interviewing NHS staff and the work of Michael Traynor (15, 16) I have argued that "resilience must never be seen as an individual responsibility, it is a collective and organisational responsibility" (17). In the military the resilience of the team appears to be *"more related to the bonds between team members than the psychological make-up or coping styles of any individual"* (Greenberg et al 2015). However in healthcare it has become an individual responsibility with individual nurses midwives and doctors being given 'resilience training'. Yet resilience is an organisational and team responsibility and cannot sit solely in the shoulders of individual staff otherwise *"staff can feel it is another stick to beat them with; if staff are stressed and struggling psychologically (through lack of resources or ethical and emotional challenges as in Covid-19) nurses can feel it is their 'fault' because they haven't implemented the training adequately or been 'resilient enough'"* (17).

Schwartz Rounds (Rounds)

Schwartz Rounds mentioned in the People Plan are an intervention that reduces poor mental health in healthcare staff (including burnout) for those that attend regularly (18). Schwartz Rounds named after a patient, Kenneth Schwartz, who died of lung cancer aged 39. When he was terminally ill he noticed that staff who empathised and connected with him made 'the unbearable bearable' (19). He also noticed that some staff engaged readily and showed empathy (though might not be able to do this every day) whilst others could not. Before his death Ken founded the Schwartz Centre for Compassionate Care in the US and Schwartz Rounds were developed as a way of supporting staff, and were brought ot the UK By the Point of Care foundation in 2009.

I led the first national evaluation of Schwartz Rounds in the UK and found that Rounds enable staff to support each other by sharing the social, emotional and ethical experiences of their work with each other strengthening their opportunities to deliver compassionate care. Rounds provide a safe psychological space for staff to share positive and difficult work experiences and are usually run monthly for an hour allowing staff have insight into their own responses and feelings facilitating better connections with patients and colleagues. Rounds provide a safe space to reflect reconnecting staff with their values and why they came into nursing in the first place. The evaluation we undertook, found that staff attending Rounds valued time to hear colleagues' stories, which often resonated and informed changes to behaviours improving compassionate care and staff connections ot each other. Schwartz Rounds improved teamwork, feelings of isolation, and encouraged staff to show empathy and compassion for patients, colleagues and self. Our research found that approx.

one third of NHS staff are regularly attending work with high stress and poor psychological wellbeing (requiring intervention), the same as in our previous study in 2012. However, in terms of Schwartz Rounds our research also showed that poor psychological wellbeing in healthcare staff (measured in a longitudinal survey with the General Health Questionnaire (GHQ12) tool halved in staff who regularly attended Rounds (18). See our YouTube video here which explains how Rounds work and what they are:

https://www.youtube.com/watch?v=C34ygCIdjCo

However, we also found it is not easy for all staff to attend – even those that want to. Our evaluation found that patient facing nurses and health care assistants (HCAs) were the groups least likely to be able to attend Rounds. Rounds often run at lunchtimes, when nurses and HCAs are often busy supporting patient meals but many other times of the day were trialled with little impact. Nurses reported twelve-hour shifts patterns offering only two half hour breaks not the hour plus required to attend Rounds were an impediment for many in terms of attendance. When there were two day shifts (7-3 and 1-9pm for example) for Nurses there was an overlap in the afternoon (still seen in Australia) where staff could be supported to attend Rounds for example; undertake training and observe procedures and undertake extra care for patients- these have new been lost with the advent of 12 hour shifts.

CoVid-19 Pandemic work- longitudinal survey and interviews with Nurses

I am also a key member of the team examining the Impact of Covid on Nurses (ICON) study – led by Associate Professor Keith Couper, University of Warwick where we have undertaken three surveys of nurses and midwives in the UK and have interviewed a sub sample of respondents.

Stage 1- longitudinal survey – stage 1

The survey used three validated research tools – the DASS (Depression and Anxiety) scale, the Impact of Events Scale and in addition at time 3 the 'Maslach Burnout Inventory' which is the leading measure of burnout (as defined by the WHO). The survey was rapidly deployed via the RCN (Royal College of Nursing) and NMC (Nursing and Midwifery Council) to nurses across the UK. There was a high uptake by nurses (2,600 time 1; 4,500 time 2 and 2,500 time 3, despite the crisis. The survey was a means of gathering important data during the pandemic, giving participants a voice and helping them to feel recognised by senior professionals within their field.

Stage 2 – Interviews - part completed

One-to-one in-depth interviews with nurses after the Covid-19 peak and again 6-9 months later to examine coping strategies used during the peak, identify mental health issues arising from Covid-19 and analyse their recovery from psychological trauma.

Twenty seven nurses who participated in time 1 and time 2 surveys were selected to participate in two rounds of in-depth interviews with an experienced researcher. The first round of interviews were completed in July 2020 with the information transcribed and ongoing analysis of the results taking place at present. The second round of interviews is due to take place in December 2020/ January 2021.

New guidance to support psychological needs of nursing staff during Covid-19 pandemic

Early in the pandemic (April 2020) I published a paper with Professor Jackie Bridges (17) drawing on previous studies she has undertaken in nurse wellbeing (outside of pandemics) and previous experience in other (non Covid-19) pandemics. With this evidence and thirty years of expertise in nurse workforce and wellbeing research we developed evidenced informed guidelines with

Professor Cath Taylor to support psychological wellbeing in NHS staff, particularly nurses and midwives. Published in the Journal of Clinical Nursing, we identified the stressors and challenges nurses face during the Covid-19 pandemic and developed guidance offering strategies for nursing team members across health and social care settings to support their psychological wellbeing. The importance of peer and team support is highlighted in the guidance and outlines of what managers, organisations and leaders can do to support nurses at this most critical of times is also included: https://www.surrey.ac.uk/sites/default/files/2020-05/guidance-to-support-nurses-psychological-well-being-during-covid-19-crisis-final.pdf

We have also developed an infographic which is hosted in a number of websites and has been displayed in the NHS:

The guidance:

- Prioritises the need for staff to have sufficient food, drink, rest and recovery, and to be protected from infection risk.
- Emphasises managers clearly and frequently signalling that staff wellbeing is a priority, mandating and monitoring work breaks, encouraging opportunities for teams to meet together and support each other, and ensuring support is accessible to all team members.
- Highlights the need for communication and mutual support amongst nursing staff when work intensity may mean that such opportunities are otherwise missed.
- Stresses the importance of openly acknowledging the emotional impact of nursing work and ensuring that staff have access to more formal psychological support if they need it.
- Recommends creating a 'buddying up' system to help new or temporary team members feel safe, valued and welcome as quickly as possible.

- Proposes a review of how welcoming and comfortable staff break rooms are and, in the absence of such break rooms re-purposing an existing space to enable rest and recuperation and a space to be alone and process work challenges.
- Advises managers/ leaders in organisations to be highly visible and approachable, inviting regular feedback from staff across the team.

In conclusion, prior to the outbreak of Covid-19 nurses were already under considerable stress due to understaffing (44,000 registered nurse vacancies in the UK) and the emotional and physical intensity of their work. High levels of stress in the workplace mean that nurses are a high risk group with figures from the ONS in 2017 indicating that the suicide rate in the profession is 23 per cent higher than the national average. In previous infectious disease outbreaks, nurses have had the highest levels of occupational stress and resulting distress compared to other groups and we have evidence to suggest stress rates are very high following Cocid-19. We will have more information on this soon and some granular detail form our ICON (Impact of Covid on Nurses) interviews.

Thus we believe the current crisis will further increase stress levels of nursing staff which will negatively affect their psychological wellbeing. Stressors include unprecedented patient numbers, concerns about not having access to the correct personal protective equipment, worry about their own families, difficult ethical and moral conflict and potentially moral distress or injury.

I am very pleased to see the UK government is interested in taking this evidence re workforce burnout and resilience in the NHS and social care written evidence. I am really pleased to see HMG taking this opportunity to fully recognise the inherent stresses and emotional strain that nurses and other health care professionals bear on behalf of society and ensure support, not only through this crisis but after it is all over. When healthcare is back to 'normal' on-going support for nurses' and other health and social care professionals wellbeing will remain critically important. While Covid-19 places particularly high stress on staff, there is very little in the guidance that we have written and the evidence presented above that is not relevant to staff wellbeing "pre-Covid" and when the pandemic is over, we look forward to the guidelines being used to establish better support for nurses and nursing into the future.

Professor Jill Maben was Deputy Director and Director of the National Nursing Research Unit at Kings College London 2007-2014, researching the nursing and midwifery workforce. Jill undertook one of the first studies to demonstrate relationships between staff wellbeing and patient experience at the team and individual level. She also recently completed the first UK national evaluation of Schwartz Centre Rounds in the UK: *"A Longitudinal National Evaluation of Schwartz Centre Rounds®: an intervention to enhance compassion in relationships between staff and patients through providing support for staff and promoting their wellbeing"* and is currently evaluating the implementation of Local Speak Up Guardians in the UK: *"Evaluation of the implementation of Freedom to Speak Up Guardian (FTSUGs) in Acute Trusts and Mental Health Trusts" and "Poor mental health of nurses, midwives and paramedics".* Jill was awarded an OBE in June 2014 for services to nursing and healthcare. In 2013 she was in the Health Services Journal 'Top 100 leaders' and was also included on Health Service Journal's inaugural list of Most Inspirational Women in Healthcare the same year.

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