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Health and Social Care
Committee

Workforce burnout and resilience in the NHS and social care

Second Report of Session 2021–22

*Report, together with formal minutes relating
to the report*

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Health and Social Care Committee

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Summary

Against a context of workforce shortages, funding pressures and reconfiguration of services, concerns about the morale of the NHS and social care workforce are not new. Even before the pandemic, one third of the doctors who responded to a survey published by the BMJ in January 2020 were described as burned out, with those in emergency medicine and general practice most impacted.¹

In June 2019, the predecessor Health and Social Care Committee held a one-off evidence session² with Baroness Harding on the *Interim People Plan*,³ intended to complement the *NHS Long Term Plan* and focus on the challenges specific to the health service workforce. Key proposals included making the NHS the ‘best place to work’ and improving leadership culture. In July 2020 *We are the NHS: People Plan for 2020/21–action for us all*⁴ was published, along with *Our NHS People Promise*,⁵ with further detail expected after that Autumn’s Spending Review.

But following that, the covid-19 pandemic had increased workforce pressures exponentially. 92% of trusts told NHS Providers they had concerns about staff wellbeing, stress and burnout following the pandemic.⁶ Witnesses told the Committee of their worry about the “exhaustion of large groups of staff”⁷ and we heard about staff who were going above and beyond in the face of their own trauma, with an “unimaginable” impact on those who had to return to busy hospital wards after supporting people through the death of their loved ones over the phone.⁸ In social care, colleagues faced “heartbreak” at the excess deaths of those for whom they were caring, coupled with a sense of feeling “abandoned” as the focus early in the pandemic had been on the NHS.⁹ Our inquiry into *Social care: funding and workforce* had already been told how difficult the pandemic was for social care workers.¹⁰ Covid-19 significantly increased pressure on social care teams—not least in the impact on staff of large numbers of deaths among service users—but there was still no equivalent to the *People Plan*, a point already raised in the Committee’s current inquiry into *Social care: funding and workforce*. Workforce burnout was described by many as the highest in the history of the NHS and care systems and as such, it is an extraordinarily dangerous risk to the future functioning of both services.

1 McKinley N, McCain RS, Convie L, et al, “[Resilience, burnout and coping mechanisms in UK doctors: a cross-sectional study](#)”, *BMJ Open* 2020;10:e031765

2 Oral evidence taken on 4 July 2019, [HC \(2017–19\) 2226](#)

3 NHS England, [Interim NHS People Plan](#) (June 2019)

4 NHS England, [We are the NHS: People Plan 2020/21 - action for us all](#) (July 2020)

5 NHS England, [Our NHS People Promise](#) (July 2020)

6 NHS Providers, [Recovery position: the impact of the pandemic on the workforce](#) (accessed 22 April 2021)

7 Oral evidence taken on 14 May 2020, [HC \(2019–21\) 320, Q94](#) [Richard Murray, Chief Executive, The King’s Fund]

8 Macmillan Cancer Support ([WBR0053](#))

9 Diocese of Rochester ([WBR0030](#))

10 House of Commons Health and Social Care Committee, Third Report of Session 2019–21, [Social care: funding and workforce](#), HC 206

1 Introduction

1. The NHS employs around 1.3 million people in England,¹¹ and there are around 1.65 million jobs in adult social care.¹² Together both services potentially account for around 8.6% of the working age population.¹³ Not only is our health and wellbeing dependent upon their commitment, but many people will have friends and family who work in the NHS or care system. It is essential they are able to carry out their duties safely and effectively.

2. The Committee is enormously grateful to staff and volunteers across health and social care who have gone above and beyond during the pandemic. It should surprise no-one that they stepped up at this time of national crisis. Indeed, during our inquiry we heard that:

Discretionary effort is the rocket fuel that powers the NHS, effectively. If staff worked to contract and worked to rule, we simply would not be able to provide anything like the quality of care that we need to. Part of the problem is that we are relying relentlessly on the good will of our staff.¹⁴

3. However, that discretionary effort is not sustainable. Workforce burnout was an issue in the NHS and social care workforce long before covid-19 and it needs to be tackled now if we are to attract and retain skilled staff, keep them physically and mentally well, and provide high quality care to patients and service users.

4. We launched our inquiry into workforce burnout and resilience in July 2020, with the following terms of reference:

- 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 has the impact of the COVID-19 pandemic been on resilience, levels of workforce stress, and burnout across the NHS and social care sectors?
- 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?
- What are the impacts of workforce burnout on service delivery, staff, patients and service users across the NHS and social care sectors?
- 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?

11 Gov.uk, [NHS workforce](#), accessed 21 April 2021

12 Skills for care, [The size and structure of the adult social care sector and workforce in England](#), accessed 21 April 2021

13 According to the 2011 Census, the working age population (people aged 16 to 64 years) of England was 34.3 million. Gov.uk. [Working age population](#), accessed 11 May 2021

14 [Q128](#), Chris Hopson, NHS Providers

- 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?
- 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?
- 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?

5. In response to the terms of reference, we received over 100 written submissions. In addition, we held four oral evidence sessions, and carried out seven anonymous in-depth interviews with frontline staff.

6. Our Report is set out in five chapters. In Chapter (2) we consider the scale of the problem and the factors underlying workforce burnout. In Chapter (3) we consider workforce culture and how it needs to change to better support staff in the health and care sector. In Chapter (4) we consider the effect of the covid-19 pandemic on workforce burnout and resilience. In Chapter (5) we consider the need for better workforce planning to ensure that the health and care sector has the level of staff that it needs.

7. In Chapters (3) and (4) we also consider the specific pressures that have been placed on staff from Black, Asian and minority ethnic backgrounds both before and as a result of the pandemic.

2 The scale of and impact of workforce burnout in the NHS and social care

Background

8. In our report, *Delivering core NHS and care services during the pandemic and beyond*, we set out our concerns that:

Some NHS and care staff are suffering from fatigue, exhaustion and a general feeling of being “burnt out” and that the wellbeing of staff (particularly their mental health) is at significant risk.¹⁵

We therefore recommended that NHS England and Improvement:

Develop a full and comprehensive definition of “workforce burnout”, and set out how the wellbeing of all NHS staff is being monitored and assessed ... by the middle of October 2020.¹⁶

9. We further recommended that NHS England and Improvement:

Set out in detail what further specific steps it would like to take over the coming years to support the mental and physical wellbeing of all staff and a plan to deal with the specific issue of sustained workplace pressure due to the current pandemic and backlog associated with the coronavirus. This information should be made available to us in advance of any forthcoming Government spending announcements or by the end of October 2020 (whichever is earlier) in order for us to clarify what NHSE/I’s priorities for NHS staff are, and to judge how far the Government’s eventual spending commitments enable their implementation.¹⁷

10. In its response to our Report, NHS England and Improvement told us that it would invest, during winter 2020, “a further £30m (£15m for specialist mental health services and £15m for enhanced health and wellbeing more broadly) to strengthen the support offer to staff” and that it was “very likely” that ongoing investment on a similar scale will be needed at least for the next three years. NHS England and Improvement also said that:

Research is currently underway to better understand the factors associated with burnout, with the aim of identifying evidence-based interventions to address it ... we are engaging at national and local levels to monitor and assess wellbeing.¹⁸

Our report follows up on that work and looks in more detail at the scale and causes of burnout and how it can be tackled.

15 House of Commons Health and Social Care Committee, [Delivering core NHS and care services during the pandemic and beyond](#), HC 320, para 137

16 House of Commons Health and Social Care Committee, [Delivering core NHS and care services during the pandemic and beyond](#), HC 320, para 140

17 House of Commons Health and Social Care Committee, [Delivering core NHS and care services during the pandemic and beyond](#), HC 320, para 139

18 NHS England and Improvement, [Delivering core NHS and care services during the pandemic and beyond: written response](#), accessed 27 April 2021

What is burnout and what causes it?

11. In its written submission to the inquiry,¹⁹ the Royal College of Psychiatrists referenced the World Health Organization’s definition of workplace ‘burnout’ as:

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, or feelings of negativism or cynicism related to one’s job; and reduced professional efficacy.²⁰

The Royal College of Psychiatrists highlighted that the definition refers “specifically to phenomena in the occupational context and should not be applied to describe experiences in other areas of life.”²¹

12. In oral evidence, Professor Michael West of the King’s Fund gave the following definition of burnout:

Very simply, stress and burnout at work are when the demands on us exceed the resources that we have; the level of work demands is very high and the resources we have to respond are not sometimes adequate, whether to do with our own personal resources, such as lack of skills, lack of training, lack of equipment, or the resources in our teams or organisations such as staff shortages, lack of PPE equipment, inadequate technologies or, more broadly, lack of the training and skills needed.²²

He added that the term was often used to describe a constellation of three factors; “emotional exhaustion”; “a sense of what is sometimes called depersonalisation: cynicism or detachment” and a “lack of personal accomplishment—that they are not really making a difference”. In relation to the NHS, Professor West concluded that burnout could also be described as “moral distress”, where the individual concerned believes that “I am not providing the quality of care that I should be providing for the people I am offering services for.”²³

13. These definitions provided our inquiry with a useful framework with which to examine burnout and its consequences.

Quantifying the size of the problem

14. The NHS Staff Survey has suggested that an unacceptably high proportion of NHS staff experience negative impacts as a result of stress in the workplace and that the proportion of staff suffering from stress is on an upward trend. The 2019 survey found that 40.3% of respondents reported feeling unwell as a result of work-related stress in the last 12 months, up from 36.8% in 2016.²⁴ The most recent iteration of the survey, where fieldwork took place during the pandemic, indicated that 44% of respondents have now reported feeling unwell as a result of work-related stress in the last 12 months. The latest survey also found

19 Royal College of Psychiatrists ([WBR0031](#))

20 Royal College of Psychiatrists ([WBR0031](#))

21 World Health Organization, [ICD-11 for Mortality and Morbidity Statistics](#), accessed 26 April 2021

22 [Q23](#), Professor Michael West, The King’s Fund

23 [Q23](#), Professor Michael West, The King’s Fund

24 NHS Staff Survey Co-ordination Centre, [NHS Staff Survey: national results briefing](#), accessed 28 April 2021

that 46.4% of staff said that they had gone to work in the last three months despite not feeling well enough to perform their duties - although this was ‘notably fewer’ than in previous years.²⁵

15. The GMC’s *Caring for doctors, caring for patients* report, published in 2019, considered the level of burnout among doctors. The GMC’s report found that in 2018, nearly one in four doctors in training in the UK, and one in five trainers said they felt burnt out to a high or very high degree because of their work.²⁶ In his submission, Professor Tom Bourne told us that the level of burnout among hospital doctors in the UK was “very high—and particularly so amongst trainees,” with over 40% of trainees affected.²⁷

16. Unfortunately, as the King’s Fund highlighted to us, data comparable to the NHS Staff Survey is not available for social care workers.²⁸ In oral evidence, Professor Martin Green OBE, Chief Executive, Care England confirmed to us the absence of comparative data for the care sector:

Unfortunately, the problem in social care is that we do not have comprehensive datasets. We do not have things like the staff survey in a uniform way, although there is some work being done by Skills for Care to try to make sure that we have some understanding of what is going on in social care. One of our challenges is that it is a very fragmented system.²⁹

17. In oral evidence, we asked Professor Jeremy Dawson, Professor of Health Management at Sheffield University about the feasibility of introducing an equivalent staff survey for social care. While he acknowledged that it would be “much more difficult”, he told us that he had seen the benefit that the staff survey for the NHS has had over the last 17 years, and was confident that “if it could be carried out in social care, similar improvements could be driven by the same route.”³⁰

18. Notwithstanding the absence of data in the care sector, workforce burnout was raised as a serious problem by a wide range of organisations representing staff. They included organisations representing orthopaedic surgeons, dentists, pharmacists, nurses, cardiothoracic surgeons, anaesthetists, midwives, health visitors and general practitioners, palliative care workers and paediatric intensive care workers, in addition to those representing staff in adult social care.³¹

25 NHS Staff Survey Co-ordination Centre, [NHS Staff Survey: national results briefing](#), accessed 28 April 2021

26 General Medical Council, [Caring for doctors, caring for patients](#), accessed 26 April 2021

27 Professor Tom Bourne ([WBR0079](#))

28 The King’s Fund ([WBR0017](#))

29 [Q27](#), Professor Martin Green OBE, Chief Executive, Care England

30 [Q132](#), Professor Jeremy Dawson, Professor of Health Management, Sheffield University

31 British Orthopaedic Association ([WBR0056](#)), British Dental Association ([WBR0055](#)), Pharmaceutical Services Negotiating Committee ([WBR0089](#)), Nursing and Midwifery Council ([WBR0080](#)), Royal College of Nursing ([WBR0049](#)), Society for Cardiothoracic Surgery, Great Britain and Ireland ([WBR0036](#)), Association of Anaesthetists ([WBR0028](#)), Royal College of Anaesthetists ([WBR0099](#)), Royal College of Midwives ([WBR0025](#)), Institute of Health Visiting ([WBR0019](#)), Paediatric Intensive Care Society ([WBR0011](#)), Royal College of GPs ([WBR0076](#)), Sue Ryder ([WBR0022](#)), Care England ([WBR0012](#)), Skills for Care ([WBR0071](#)), United Kingdom Homecare Association ([WBR0045](#)) and others

19. When he gave oral evidence, Professor West told us that a shared metric was needed in order to understand the extent of burnout across health and care:

We need to establish a single measure across our whole health and care system—Professor Green talked about the need for measurement in the social care system as well—which gives us a very clear and standardised indication of the extent of the problems.³²

Effect of burnout

20. Work-related stress has a wide range of consequences. The King’s Fund’s written submission stated that NHS staff were 50% more likely to experience high levels of work-related stress compared with the general working population. This was likely to damage their health and affect care quality, and was associated with patient satisfaction, financial performance, absenteeism and organisational performance. Poor staff health and wellbeing was also linked with turnover and intention to quit, along with higher levels of patient mortality in the acute sector.³³

Chronic excessive workload

21. Chronic excessive workload has been identified as a key factor of burnout and staff shortages were identified as “the most important factor in determining chronic excessive workload”,³⁴ with shortages of around “one in 10 or one in 12 staff” in the NHS in January 2020, before the pandemic fully hit.³⁵

22. In his oral evidence, Professor West explained the relationship between excessive workload and burnout:

I want to be clear about the issue of excessive workload. The danger is that we do not see it. It is like the pattern on the wallpaper that we no longer see, but it is the No. 1 predictor of staff stress and staff intention to quit. It is also the No. 1 predictor of patient dissatisfaction. It is highly associated with the level of errors.³⁶

He explained that the risks of excessive workload could not be tackled without a comprehensive strategy:

Unless we have a well worked-out plan for how we can fill all the vacancies and reduce the attrition rate of staff in the NHS [...] we are going to be in trouble”.

23. Professor West went on to tell us that the high attrition rate was not confined to nurses, midwives and doctors, but applied to groups of staff across the NHS; and that a “well- worked-out, thought-through strategy, based on a vision of the kind of health and care we want to be providing in 10 years’ time”, was “fundamental” in the ability for the NHS to plan for the numbers that will be required in the years to come.³⁷

32 [Q37](#), Professor Michael West, The King’s Fund

33 The King’s Fund ([WBR0017](#))

34 [Q26](#), Professor Michael West, The King’s Fund

35 [Q26](#), Professor Michael West, The King’s Fund

36 [Q26](#), Professor Michael West, The King’s Fund

37 [Q26](#), Professor Michael West, The King’s Fund

Effect of vacancies in the health and care sector

24. A number of written submissions to our inquiry also highlighted the link between shortages in the health and care workforce and burnout, along with the scale and impact of vacancies across the NHS and social care workforce. For example, the Royal College of Nursing (RCN) noted that prior to the onset of the pandemic there were 50,000 nursing vacancies in the NHS across the UK.³⁸ Furthermore, its 2019 employment survey identified that nearly a quarter of nurses and midwives were looking for a job outside the NHS.³⁹ In a similar vein, the Royal College of Psychiatrists told us that one of the biggest causes of workforce burnout in mental health services was the “lack of professionals to support all the patients who need help”.⁴⁰

25. That picture is replicated in adult social care. In October 2020, Skills for Care estimated that 7.3% of roles in adult social care had been vacant during the financial year 2019–20, equivalent to approximately 112,000 vacancies at any one time.⁴¹ Skills for Care’s annual *State of the adult social care sector and workforce* report found that the number of registered nurses had continued to decrease, down 2,800 jobs (7%) between 2018–19 and 2019–20 and 15,500 jobs (30%) since 2012–13.⁴² In addition, the staff turnover rate of directly employed staff working in the adult social care sector was 30.4% in 2019–20, equating to approximately 430,000 people leaving their jobs over the course of the year. As around 66% of recruitment was from within adult social care, this meant that approximately 149,000 had left the sector.

Intensity of workload

26. While staff numbers are crucial, we also heard that intensity of workload was a factor in causing burnout. Professor West told us that staff could “deal” with “episodic, transient demands” but it became a problem when that demand became “chronic.” Stress tended to be chronic in the healthcare sector, with the measure of stress “at one point in time and then again six months later” usually at a similar level. Whether intensification was in terms of “amount or quality”, chronic work stress predicted a number of serious conditions including cardiovascular disorders, cardiovascular disease, addictions, diabetes, cancer and depression.⁴³

27. Anonymous evidence from a Practice Manager demonstrated how the covid-19 pandemic had increased the intensity of workloads, despite the decrease in face-to-face work:

Obviously, we do a lot less face-to-face work now, but we actually have a lot more patient contact. We worked out we probably have 50% more patient contact than we had before. It may be done by telephone, but there is still far more of it. Also I think it’s far more... because the patients are so worried and themselves so stressed and depressed, it’s far more draining on the staff. The patient contacts are exhausting in some cases because you’re

38 Royal College of Nursing ([WBR0049](#))

39 The King’s Fund, [The courage of compassion: summary](#), accessed 26 April 2021

40 The Royal College of Psychiatrists ([WBR0031](#))

41 Skills for Care, [The state of the adult social care sector and workforce in England](#), accessed 27 April 2021

42 Skills for Care, [The state of the adult social care sector and workforce in England 2019–20](#), accessed 14 May 2021

43 [Q32](#), Professor Michael West, The King’s Fund

trying to support people who are really in a very bad way. We've definitely never worked so hard in our lives as we've worked in the last year. It's been relentless.⁴⁴

Pay and reward

28. Although pay and reward were not the focus of this inquiry we received evidence that suggested that pay could also contribute to stress and burnout in health and care. Low pay is a particular issue in the social care workforce, while it is estimated that 56% of NHS staff work unpaid additional hours on top of their contract.⁴⁵ For the Local Government Association (LGA), pay was not the only area of reward discrepancy between the social care and NHS workforces, with less favourable sick pay and pension arrangements likely where social care workers are employed in the independent sector rather than by a local authority. It also pointed out that NHS workers were also more likely to have access to retail and other discounts, although this was beginning to change.⁴⁶

Discrimination

29. Discrimination was also raised as a factor in burnout. The King's Fund highlighted that Black, Asian and minority ethnic staff in the NHS reported worse "and often shocking" experiences compared with White staff and were under-represented in senior posts.⁴⁷ More widely across the NHS, rates of all types of bullying and harassment continued to be very high, according to the King's Fund.⁴⁸ The 2020 NHS Staff Survey set out the following data in relation to bullying or harassing behaviour directed towards NHS staff:

- 26.7% of staff reported being bullied, harassed or abused by patients/service users, their relatives, or other members of the public in the past twelve months.
- 12.4% reported that behaviour by managers.
- 18.7% reported that behaviour by other colleagues.⁴⁹

Systems and working cultures

30. Although our terms of reference included workforce resilience in the NHS and social care; a number of written submissions cautioned against focussing on the resilience of individual members of staff. Instead, they advised that the focus should be on systems and systemic solutions. The Healthcare Safety Investigations Branch (HSIB) told us that:

Although staff need to be psychologically well-supported, the idea that they can be trained to be 'more resilient' limits the potential benefit that this inquiry can achieve for the NHS. We would encourage the Committee to

44 Transcript of interviews with health and care workers ([WBR0111](#))

45 The King's Fund ([WBR0017](#))

46 LGA ([WBR0010](#))

47 The King's Fund ([WBR0017](#))

48 The King's Fund ([WBR0017](#))

49 NHS Staff Survey Co-ordination Centre, [NHS Staff Survey: national results briefing](#), accessed 28 April 2021

explore how Covid has shown where the system can be better designed, so that it can better adapt to demands and shift the burden from individuals on to the system.⁵⁰

The Healthcare Safety Investigation Branch added that safety science had established that patient safety would “gain more by looking at organisational resilience than staff resilience”. The British Society for Rheumatology also warned against appearing to apportion blame to individuals. Rather, the Society said that the focus be on “addressing current rota gaps and unsustainable workloads” to build resilience at a system level.⁵¹

31. The Academy Trainee Doctors Group said that the term “moral injury” was preferable to burnout and resilience as it “more accurately frames the problem as being driven predominantly by external factors”.⁵² In her oral evidence, Professor Dame Clare Gerada agreed. She said that resilience described “bending with the pressure, bouncing back and learning from that” and that “no amount of resilience training or psychological or physical PPE will protect you from a toxic environment”.⁵³ This was also supported by Our Frontline, which recommended that working culture and organisational factors should be the focus when tackling mental health issues amongst staff:

While we understand the need to focus on and build the resilience of the workforce, much of our evidence points towards poor working cultures and organisational factors being the biggest drivers of poor mental health for those working on the frontline. These factors, and the root causes of poor mental health across the workforce, need to be tackled as a priority if we want to see a truly resilient health and social care sector.⁵⁴

The impact of burnout

32. Burnout not only affects staff but can have an impact on patients and patient safety. The GMC’s Report, *Caring for doctors, caring for patients*, had previously found:

Abundant evidence that workplace stress in healthcare organisations affects quality of care for patients as well as doctors’ own health [...] Patient satisfaction is also markedly higher in healthcare organisations and teams where staff health and wellbeing are better.⁵⁵

33. This was also the view of the Medical Protection Society. The Society told us that burnout directly and indirectly affected medicolegal risk and that the poor wellbeing of doctors had “major implications for patient outcomes and the overall performance of healthcare organisations”.⁵⁶ In a similar vein, the Royal College of Midwives noted that:

Staff who are burnt out are at increased risk of error-making and are more likely to suffer from low engagement (lack of vigour, dedication and absorption in work), cynicism, and compassion fatigue.⁵⁷

50 The Healthcare Safety Investigation Branch (HSIB) ([WBR0075](#))

51 British Society for Rheumatology ([WBR0048](#))

52 Academy Trainee Doctors’ Group ([WBR0058](#))

53 [Q98](#), Professor Dame Clare Gerada, Medical Director, Practitioner Health

54 Mind - on behalf of Our Frontline, Samaritans, Hospice UK, Shout 85258 ([WBR0057](#))

55 General Medical Council, *Caring for doctors, caring for patients*, accessed 26 April 2021

56 Medical Protection Society ([WBR0044](#))

57 Royal College of Midwives ([WBR0025](#))

Similarly, the RCN's written evidence cited a meta-analysis of 21 studies which concluded that burnout was linked to a decline in patient safety and outcomes, and an increase in patient dissatisfaction and complaints.⁵⁸

34. An anonymous submission from a consultant, eloquently illustrated the impact of burnout on staff and the pressure felt by colleagues whose decisions in relation to care could face intense scrutiny:

It feels like you're a jug that's pouring all the time, into all the areas, and you're driving yourself fairly hard. [...] I think you just push and push at that and then eventually other things come along and it kind of empties your resources and suddenly you can't cope anymore. The jug is suddenly empty and it comes as quite a shock.

One of the things that empties that jug, that I've seen in myself and colleagues, is complaints, court hearings and difficult coroners cases.

[...]

Doing intensive care, I make difficult life and death decisions a lot. It's a very high-pressured speciality so as you start to feel a bit more paranoid, and if you have those decisions challenged in court, you start to question yourself. That's exhausting because you have to be confident in what you're doing for the team and second guessing all decisions cripples you.

The consultant added that a cause of burnout was the undermining of confidence that came from "complaints and things like that, combined with chronic high levels of stress".⁵⁹

35. Burnout is a widespread reality in today's NHS and has negative consequences for the mental health of individual staff, impacting on their colleagues and the patients and service users they care for. There are many causes of burnout, but chronic excessive workload is a key driver and must be tackled as a priority. This will not happen until the service has the right number of people, with the right mix of skills across both the NHS and care system.

36. Understanding the scale and impact of workforce burnout can only be achieved with a metric for staff wellbeing and staff mental health that covers both the NHS and social care. We therefore recommend that the Department for Health and Social Care extends the NHS Staff Survey to cover the care sector.

37. We further recommend that the NHS Staff Survey and any social care equivalent includes an overall staff wellbeing measure, so that employers and national bodies can better understand staff wellbeing and take action based on that understanding. The Staff Survey already allocates a scale out of 10 for each 'theme' it covers, which could provide the starting point for the calculation of such a measure.

38. We welcome the additional support provided to health and care staff during the pandemic. However, we conclude that such additional support will need to be maintained during the recovery period and beyond to stop further staff from leaving. Furthermore simply offering support services, however important, is not on its

58 Royal College of Nursing ([WBR0049](#))

59 Transcript of interviews with health and care workers ([WBR0111](#))

own enough. The Department and employers need to ensure that those services are accessible to all and used by all who need them. This will require removing barriers to seeking help, and embedding a culture where staff are explicitly given permission and time away from work to seek help when it is needed.

39. *We recommend that Integrated Care Systems (ICSs) be required to facilitate access to wellbeing support for NHS and social care workers across their systems, and that they are accountable for the accessibility and take-up of those services.*

40. *We further recommend that the level of resources allocated to mental health support for health and care staff be maintained as and when the NHS and social care return to 'business as usual' after the pandemic; and that the adequacy of resources allocated to that support be monitored on a regular basis.*

3 Workplace culture

Introduction

41. In 2018, the General Medical Council asked Professor Michael West and Dame Denise Coia to carry out a UK-wide review into the factors which impact on the mental health and wellbeing of medical students and doctors. The Report, *Caring for doctors, caring for patients*,⁶⁰ highlighted an A,B,C of core work needs that had to be met to ensure wellbeing and motivation at work, and to minimise workplace stress:

- Autonomy/control—the need to have control over our work lives, and to act consistently with our work and life values.
- Belonging—the need to be connected to, cared for, and caring of others around us in the workplace and to feel valued, respected and supported.
- Competence—the need to experience effectiveness and deliver valued outcomes, such as high-quality care.⁶¹

42. Although *Caring for doctors, caring for patients*⁶² focusses on doctors, the King's Fund published similar work that focussed on nurses and midwives. In its report, *The courage of compassion*⁶³ the King's Fund sets out a series of recommendations to support staff wellbeing:

- Mechanisms for staff to influence culture, processes and decisions.
- Just, fair and psychologically safe cultures, ensuring equity, proactive and positive approaches to diversity and universal inclusion.
- Minimum standards for facilities and working conditions.
- Effective multidisciplinary teamworking.
- Compassionate leadership and nurturing cultures.
- Tackling excessive work demands.
- Effective support, professional reflection, mentorship and supervision.
- The right systems and frameworks for learning, education and development.⁶⁴

43. In this chapter we consider the extent to which workplace culture in health and social care delivers on those aims to support staff. In particular, we focus on the opportunities for staff to speak up and the role of compassionate leadership in promoting a supportive culture at work.

60 General Medical Council, [Caring for doctors, caring for patients](#), accessed 26 April 2021

61 General Medical Council, [Caring for doctors, caring for patients](#), accessed 26 April 2021

62 General Medical Council, [Caring for doctors, caring for patients](#), accessed 26 April 2021

63 The King's Fund, [The courage of compassion: summary](#), accessed 26 April 2021

64 The King's Fund, [The courage of compassion: summary](#), accessed 26 April 2021

A culture of 'speaking up'

44. During our inquiry, a number of witnesses highlighted the importance of creating a culture across the health and social care sectors where staff feel supported to speak up when they see things going wrong. The National Guardian's Office (NGO) was established in 2016 to provide a forum for staff and receives non-identifiable information from staff through Freedom to Speak Up Guardians. In its December 2020 report the NGO published interim data which indicated that a record number of cases were brought between 1 April and 30 September 2020,⁶⁵ although the proportion of cases that included either an element of patient safety or quality (19.4%) or an element of bullying and harassment (30.1%) were lower than the same period in the previous year. Concerns raised through the Speak Up Guardians, included social distancing; personal protective equipment (PPE); redeployment of workers and general anxiety around the pandemic (including risk to households). Worker safety and wellbeing during the pandemic was also a key theme, with some staff reluctant to speak up due to the crisis.⁶⁶

45. At the launch of the report, Dr Henrietta Hughes OBE, National Guardian for the NHS said:

I am so grateful for the commitment and passion of Freedom to Speak Up Guardians who continue to support workers to speak up in such challenging and difficult circumstances. Workers' voices form a key pillar of the NHS People Plan. But it is beholden on all leaders and managers to listen to what workers are saying and act upon what they hear.⁶⁷

46. Freedom to Speak Up Guardians have not been established in social care, which Dr Hughes described as "a yawning gap" when she gave evidence to the Committee.⁶⁸ Dr Hughes strongly believed that "Freedom to Speak Up, or equivalent alternative channels", should be in place so that "workers looking after patients in whatever setting" had the ability to speak up about their concerns, safe in the knowledge that leaders would be listening, and that the right actions will be taken as a result.⁶⁹

47. It is imperative staff have the opportunity and the confidence to speak up. However, this needs to be matched with a culture in which organisations demonstrate that they are not just listening to, but also acting on, staff feedback. While NHS organisations have a formal structure to raise concerns through Freedom to Speak Up Guardians, there is no equivalent for adult social care. We therefore recommend that the Department develops a strategy for the creation of Freedom to Speak Up Guardians in social care.

65 National Guardian, Speaking up to Freedom to Speak Up Guardians: Q1 – 2 2020/21: Interim Data, accessed 27 April 2021

66 National Guardian, Speaking up to Freedom to Speak Up Guardians: Q1 – 2 2020/21: Interim Data, accessed 27 April 2021

67 National Guardian, Record number of cases brought to Freedom to Speak Up Guardians, accessed 27 April 2021

68 [Q153](#), Dr Henrietta Hughes OBE, National Guardian for the NHS

69 [Q153](#), Dr Henrietta Hughes OBE, National Guardian for the NHS

Compassionate leadership

48. Compassionate leadership was also raised during this inquiry as an important factor in encouraging positive workplace cultures. The King’s Fund defines compassionate leadership in the following terms:

[It] means leaders listening with fascination to those they lead, arriving at a shared (rather than imposed) understanding of the challenges they face, empathising with and caring for them, and then taking action to help or support them.⁷⁰

49. Dr Hughes, the National Guardian, said all leaders needed to see that a core part of an NHS leader’s role was “being genuinely interested in and valuing the views of your workforce”. While she acknowledged that “the vast majority of leaders” took that on board, she said that there remained some organisations that “do not take it as seriously and, for whatever reason, are less interested in the views of their staff.” Dr Hughes told us that those organisations were not seeing desired improvements in staff wellbeing, staff safety and patient safety and experience.⁷¹

50. A number of witnesses highlighted barriers to providing compassionate and effective leadership. Chris Hopson, Chief Executive of NHS Providers, told us that operational targets and centralised management were two such barriers. He said that the delivery of operational targets had often come “at the expense of quality of care, staff experience and patient experience.”⁷² Under the centralised NHS system, staff at the centre wanted “huge amounts of detail” from Trusts, specifying in “lots of detail” what the frontline should be doing.⁷³ He told us that the micromanaging from above undermined the ability to enable and empower staff to “lead to the best of their skills and ability.”⁷⁴ Chris Hopson went on to say that this resulted in disempowering leaders by “tying them up in too many knots and telling them how to do their job”, which did not reflect the reality that “each one of those jobs leading the 217 trusts is different”.⁷⁵

51. Professor Jeremy Dawson, Professor of Health Management, University of Sheffield, agreed that a workplace culture that gave staff autonomy and the opportunity to influence was likely to deliver better outcomes for both patients and staff:

We have evidence that shows that organisations where there is more ability for staff to take part in making decisions and influencing how things are decided are the trusts that have lower mortality rates. They have better outcomes generally for patients and better outcomes generally for staff.⁷⁶

52. In a centralised system, it is vital that the national bodies in the NHS take a lead in encouraging and supporting leaders to be compassionate. However, the National Guardian’s evidence suggested that the national bodies providing oversight and direction to local systems were not exemplars of the culture that the People Plan seeks to encourage. Dr Hughes told us that while both NHS England and Improvement and the Care Quality

70 The King’s Fund, [Five myths of compassionate leadership](#), accessed 28 April 2021

71 [Q135](#), Dr Henrietta Hughes OBE, National Guardian for the NHS

72 [Q154](#), Chris Hopson, Chief Executive, NHS Providers

73 [Q148](#), Chris Hopson, Chief Executive, NHS Providers

74 [Q123](#), Chris Hopson, Chief Executive, NHS Providers

75 [Q123](#), Chris Hopson, Chief Executive, NHS Providers

76 [Q131](#), Professor Jeremy Dawson, Professor of Health Management, Sheffield University

Commission had appointed Freedom to Speak Up Guardians, the culture in those organisations, as perceived by their Guardians, was on a par with organisations rated as either “Requires improvement” or “Inadequate” by the CQC.⁷⁷ Dr Hughes emphasised to us the importance of those organisations improving so that as national bodies they could provide support and encouragement to leaders across the NHS to better support and empower their workforce.⁷⁸

53. In his oral evidence, Paul Farmer, Chief Executive of Mind and representing Our Frontline, told us that one solution would be to introduce a “scorecard approach” for individual NHS and social care employers that measured mental wellbeing. The scorecard would monitor both negative factors including sickness absence due to mental ill health, and positive factors including the extent to which colleagues feel in control of their workload, or well-supported by their line manager. However, he cautioned that such an approach needed to be an incentive not a stick with which to beat organisations:

We have found from all the organisations that we have worked with that standing over people and saying, “You will behave better around your wellbeing,” does not work. It is about creating a culture of encouragement and bringing in best practice.⁷⁹

54. Dr Adrian James, President of the Royal College of Psychiatrists, added that quality improvement initiatives owned at the board level could also better enable staff and senior managers to raise issues and tackle them:

It starts with having board-level sign-up that it is something important, maybe with a board sponsor. In the end, it empowers staff on the ground, perhaps with a quality improvement coach, to look at what works for them.⁸⁰

Dr James added that empowering staff that work together on the frontline gave them “a sense of control and mastery over what they are doing”. He said that those staff “generally have the solutions, but they need high-level backing” and believed that the People Plan needed to be underpinned by a methodology to ensure that this approach was delivered.⁸¹

55. The National Guardian agreed that culture needed to be prioritised:

When we get the culture right, the safety follows, and then the money follows. That has to be the order. Ensuring that all regulators are aligned in that, so that they can support the right cultures in the providers, is absolutely key.⁸²

77 [Q137](#), Dr Henrietta Hughes OBE, National Guardian for the NHS

78 [Q137](#), Dr Henrietta Hughes OBE, National Guardian for the NHS

79 [Q114](#), Paul Farmer CBE, Chief Executive Officer, Mind

80 [Q117](#), Dr Adrian James, President, Royal College of Psychiatrists

81 [Q117](#), Dr Adrian James, President, Royal College of Psychiatrists

82 [Q158](#), Dr Henrietta Hughes OBE, National Guardian for the NHS

56. Helené Donnelly OBE, Ambassador for Cultural Change at Midlands Partnership NHS Trust and former Mid Staffs whistleblower, told us that there was a “real appetite” for compassionate leadership across the service but it was undermined by managers, and in particular, middle managers being “sandwiched between their teams and trying to support them, but also trying constantly to meet targets with ever-increasing pressure.”⁸³ She explained that

When the pressure is on and the blinkers are on, that goes out the window and some of the negative behaviour continues. [...] certain behaviours, certain managers, certain leaders or senior clinicians even, because they are very good at getting the job done, delivering and hitting targets, almost have a free pass to behave in any way they want. That is not acceptable, and we have to stamp it out.⁸⁴

57. For Ms Donnelly, “role modelling” across senior leadership roles and the national bodies would produce the kind of culture change required. She told us that “if you get it right at that level, other more junior leaders will see that that is the right way to behave.”⁸⁵

Bullying and unprofessional behaviour

58. Ms Donnelly told the Committee that although the “vast majority of staff” throughout health and social care worked exceptionally hard, bullying remained a “real problem” that had to be acknowledged and addressed. She said that it was “in the minority” but emphasised that the results of that behaviour could be “catastrophic”.⁸⁶ A second problem highlighted by Ms Donnelly was the practice whereby those who had behaved negatively did not leave the system altogether, but instead moved on elsewhere:

Alongside that, we need to address the issue of just moving the problem, both internally within individual organisations and across the whole NHS. We have particular individuals and characters who are known to display persistently negative bullying and intimidating behaviours, but they are too difficult to handle so they just get moved along.

Ms Donnelly concluded that this approach merely passed on the problem and led to “more and more staff to feel apathetic and disillusioned”.⁸⁷

59. Ms Donnelly also highlighted the fact that despite the excellent work of the National Guardians, some Trusts were “still not getting it.”⁸⁸ In those cases, “significant deep dive drills” were required to identify where the problems lay and what the barriers were. She added that “greater accountability and sanctions” were required for those who “refuse

83 [Q138](#), Helené Donnelly OBE, Ambassador for Cultural Change/Lead Freedom to Speak Up Guardian, Midlands Partnership NHS Foundation Trust

84 [Q138](#), Helené Donnelly OBE, Ambassador for Cultural Change/Lead Freedom to Speak Up Guardian, Midlands Partnership NHS Foundation Trust

85 [Q139](#), Helené Donnelly OBE, Ambassador for Cultural Change/Lead Freedom to Speak Up Guardian, Midlands Partnership NHS Foundation Trust

86 [Q134](#), Helené Donnelly OBE, Ambassador for Cultural Change/Lead Freedom to Speak Up Guardian, Midlands Partnership NHS Foundation Trust

87 [Q157](#), Helené Donnelly OBE, Ambassador for Cultural Change/Lead Freedom to Speak Up Guardian, Midlands Partnership NHS Foundation Trust

88 [Q157](#), Helené Donnelly OBE, Ambassador for Cultural Change/Lead Freedom to Speak Up Guardian, Midlands Partnership NHS Foundation Trust

to reflect and those who persistently and consistently display bullying and intimidating behaviours, even when support has been offered.”⁸⁹ To tackle these problems, she recommended:

- The creation of a national body or a steering group comprising all the relevant stakeholders to provide “tangible traction on improving cultures, compassionate leadership and stamping out bullying once and for all”.
- The provision of peer support and expert support to organisations that are struggling; and
- Greater accountability in relation to individuals and organisations who fail to address the problems in workforce culture.⁹⁰

60. Resetting the work/life balance for staff is also considered by witnesses to be an important factor in improving workplace culture. Rather than being an optional extra or a logistical challenge, flexible working should be seen as a means by which the NHS and social care can keep more staff in health and care careers for longer. Prerana Issar, NHS Chief People Officer, agreed with the importance of promoting flexible working as a way in which employers could demonstrate compassionate leadership. She told us that staff in the NHS wanted flexibility “whether that is working from home, when possible, or having a shift system that is not three 12-hour shifts ‘back to back’” and that the NHS was looking into “e-rostering and the flexibility apps” to support Trusts to that end.⁹¹

61. Improvements to workplace culture have been made, but equally, there is more work to be done. Embedding and facilitating cultures which support compassionate leadership must be at the heart of that work. There is a strong appetite for that leadership from both managers and staff, but structural barriers remain. The Department, the NHS and individual trusts need to focus on removing those barriers so that their leaders can lead to their full potential. The establishment of statutory Integrated Care Systems provides an opportunity for those systems to lead a transformation of support for NHS leaders in their areas that includes mental health support, development of proper career structures, and a review of targets.

62. We recommend that NHS England undertake a review of the role of targets across the NHS which seeks to balance the operational grip they undoubtedly deliver to senior managers against the risks of inadvertently creating a culture which deprioritises care of both staff and patients.

63. We further recommend that the Department of Health and Social Care work with stakeholders to develop staff wellbeing indicators, on which NHS bodies can be judged.

89 [Q157](#), Helené Donnelly OBE, Ambassador for Cultural Change/Lead Freedom to Speak Up Guardian, Midlands Partnership NHS Foundation Trust

90 [Q157](#), Helené Donnelly OBE, Ambassador for Cultural Change/Lead Freedom to Speak Up Guardian, Midlands Partnership NHS Foundation Trust

91 [Q60](#), Prerana Issar, NHS Chief People Officer, NHS England and NHS Improvement

Workplace culture and staff from Black, Asian and minority ethnic backgrounds

64. In our Report, *Delivering core NHS and care services during the pandemic and beyond* we considered the specific issues and barriers faced by staff from Black, Asian and minority ethnic backgrounds, and undertook to revisit those issues in this inquiry.⁹² In this section we consider their experience of workforce culture. In the next chapter, we consider the specific impact that the pandemic had on them.

Workforce data on ethnicity

65. As at the end of March 2020, around 1.3 million people were employed by NHS trusts and clinical commissioning groups in England. Of those staff whose ethnicity was known, White staff made up 77.9% of the NHS workforce, Asian staff 10.7%, Black staff 6.5%, staff from the Other ethnic groups 2.6%, staff with Mixed ethnicity 1.9% and staff from the Chinese ethnic group 0.6%.⁹³ Data published by the Department also provides information on ethnicity in relation to the roles and seniority of staff working in the NHS. The data published in January 2021 showed that:

- among medical staff (junior and senior doctors, and other doctors working for hospitals and community health services) a higher percentage of junior doctors than senior doctors were from the Black, Chinese and Mixed ethnic groups
- among non-medical staff (clinical staff - for example, nurses and midwives, health visitors, and ambulance staff - and staff working in managerial, administrative and support roles), there was a higher percentage of people from Asian, Black, Mixed and Other ethnic backgrounds in 'support' and 'middle' grades compared with 'senior' and 'very senior manager' grades.⁹⁴

66. In 2015, NHS England introduced the Workforce Race Equality Standard (WRES) to “hold a mirror up to the NHS and spur action to close gaps in workplace inequalities between our black and minority ethnic (BME) and white staff”.⁹⁵ The latest WRES report (which covers 2020) indicated mixed results in closing those gaps. It found that:

- The total number of BME staff at very senior manager (VSM) pay band had increased from 108 in 2017 to 153 in 2020.
- 10% of board members in NHS trusts were from a BME background, up from 7.0% in 2017.
- 6.8% of very senior managers in NHS trusts were from a BME background, up from 5.4% in 2016.

92 House of Commons Health and Social Care Committee, [Delivering core NHS and care services during the pandemic and beyond](#), HC 320, para 154

93 Gov.uk, [NHS workforce](#), accessed 6 May 2021

94 Gov.uk, [NHS workforce](#), accessed 27 April 2021

95 NHS England and Improvement, [NHS Workforce Race Equality Standard: 2019 data analysis report for trusts](#), accessed 27 April 2021

However, 23.4% of NHS Trusts still had no board members from a minority ethnic background.⁹⁶

The Workforce Race Equality Standard report also found that:

- White applicants were 1.61 times more likely to be appointed from shortlisting compared to BME applicants, compared with 1.46 in 2019 with “no overall improvement over the past five years”.
- 71.2% of BME staff believed that their organisation provided equal opportunities for career progression/promotion compared with 86.9% of White staff.
- Staff perceptions of discrimination, bullying, harassment and abuse, and on beliefs regarding equal opportunities in the workplace, had not improved over time for either BME or White staff.
- 30.3% of BME staff, and 27.9% of White staff, reported experiencing harassment, bullying or abuse from patients, relatives or the public—an increase for both groups.⁹⁷

67. The NHS Staff Survey also covered experiences of bullying, harassment and abuse at work. 595,270 NHS employees across 280 NHS organisations responded to the 2020 Survey. The results of that survey found that 13.1% of staff reported experiencing discrimination at work; that ethnic background continued to be the most common reason cited for discrimination; and that ethnic background was mentioned by 48.2% of staff that claimed to have experienced discrimination at work.⁹⁸

68. The Committee welcomes the Workforce Race Equality Standard (WRES), along with the People Plan, as an important step towards an NHS which offers equal opportunities to all its staff. We were pleased to hear in our oral evidence session that work had begun to provide similar information to the WRES in social care. This year’s WRES report concludes that ‘now is the time to translate the data to actions.’ We agree. Part of this must be to ensure that the boards of the new ICSs appropriately represent the populations they serve.

69. We therefore recommend that WRES data be made part of the ‘balanced basket of indicators’ we suggest for Integrated Care Systems, with the result that they become accountable for progress across their domains. As part of this process, organisations should set themselves ambitious yet achievable targets that include timings.

96 NHS England and Improvement, [Workforce Race Equality Standard 2020 Data Analysis Report for NHS Trusts and Clinical Commissioning Groups](#), accessed 27 April 2021

97 NHS England and Improvement, [Workforce Race Equality Standard 2020 Data Analysis Report for NHS Trusts and Clinical Commissioning Groups](#), accessed 27 April 2021

98 NHS Staff Survey Co-ordination Centre, [NHS Staff Survey: national results briefing](#), accessed 28 April 2021

Challenges faced by Black, Asian and minority ethnic staff

70. A number of written submissions to our inquiry set out the specific challenges staff from Black, Asian and minority ethnic backgrounds faced in relation to workplace culture, burnout and resilience.⁹⁹ In oral evidence, Dr Chaand Nagpaul CBE, Chair of the BMA Council, told us that there was a:

Very definite and worrying impact on BAME doctors, who feel particularly unable to speak out and are more likely to be blamed. There is a lot of evidence that they experience worse inequalities in the NHS.¹⁰⁰

71. The Royal College of Midwives also highlighted similar experiences in relation to its members. The Royal College pointed to data from 2019 indicating that 42% of midwives had reported experiencing discrimination based on their ethnic background.¹⁰¹

72. Lord Adebawale told us that “leaders in the NHS, who are mainly white, generally are not held accountable for leading all the people all the time”. He described this situation as a “systemic issue” in which in the 20% of the workforce that come from Black, Asian and minority ethnic backgrounds are not being adequately represented by their leaders. He explained the problem in the following terms:

In business, if 20% of your workforce were receiving more bullying, were not being promoted, were refusing to work in the NHS and were working for agencies, costing the NHS money, were dying disproportionately and where repeated staff surveys showed that they were unhappy—that is an understatement—you would make it part of the generality of what you held leaders accountable for.¹⁰²

73. Lord Adebawale told us that although the Workforce Race Equality Standard had made a positive impact on culture, significant problems remained. He highlighted the “20% of our staff feeling disengaged or under-led” and that the NHS had to “make the people we put in leadership positions lead all the people all the time.”¹⁰³

74. Lord Adebawale also highlighted the need for leaders to be held accountable; and that it needed to be “a core measure of system performance and individual performance”. While he supported the work of the CQC, he found it “astonishing” that a trust could be rated “Outstanding” while 30% of its BAME staff stated that they were performing below standard because of bullying and harassment.¹⁰⁴

75. Looking forward to the establishment of Integrated Care Systems (ICSs), Lord Adebawale said that the accountability of leaders also needed to be applied to those in social care. He said that leaders of ICSs needed data from trusts, primary care, community trusts, mental health trusts and the voluntary sector in their system to enable them to identify “where the leadership gaps are and how that relates to performance in population

99 Including: Royal College of GPs ([WBR0076](#)), Royal College of Emergency Medicine ([WBR0070](#)), The Royal College of Psychiatrists ([WBR0031](#)), Royal College of Midwives ([WBR0025](#)), LGA ([WBR0010](#)), Academy of Medical Royal Colleges ([WBR0009](#)),

100 [Q79](#), Dr Chaand Nagpaul CBE, Chair, BMA Council

101 Royal College of Midwives ([WBR0025](#))

102 [Q162](#), Lord Adebawale, Chair, NHS Confederation

103 [Q162](#), Lord Adebawale, Chair, NHS Confederation

104 [Q170](#), Lord Adebawale, Chair, NHS Confederation

health”. If that information was available, he believed that you could “bring on board” the 20% of staff that feel that they are “not part of the leadership debate, not part of the patient debate and not part of the forward view of the NHS and social care system”.¹⁰⁵ He also emphasised that addressing the issues faced by staff from Black, Asian and minority ethnic backgrounds - such as inequity in vaccine take-up - could not be seen as a side issue and that it was not “reasonable” to expect “black staff to solve their problems”.¹⁰⁶

76. One definition of institutional racism, used in the Macpherson report into the death of Stephen Lawrence, is:

The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people.¹⁰⁷

77. When he came before us, we questioned Dr Nagpaul on whether the NHS could be described as institutionally racist. While Dr Nagpaul did not use that phrasing, he said that there were “definite structural factors” that resulted in inequalities for doctors from a BAME background and those inequalities increased for doctors that came overseas.¹⁰⁸

78. The King’s Fund’s report *Workforce race inequalities and inclusion in NHS providers*, published in July 2020, examined three case studies that had implemented similar interventions aimed at addressing race inequalities and inclusion. Those interventions included:

- establishing staff networks
- ensuring psychologically safe routes for raising concerns (specifically by appointing Freedom to Speak Up Guardians)
- enabling staff development and career progression.¹⁰⁹

79. The King’s Fund said that the combination of those interventions could support ethnic minority staff in feeling their organisations were committing to making positive changes. However, it cautioned that there was potential for some staff to react negatively to them. For example, the King’s Fund noted that while interventions made it safer to talk about race, it meant “being prepared to hear about and confront some ugly truths about behaviours between colleagues.” Furthermore, the King’s Fund noted that leadership for race equality and inclusion created an emotional burden on leaders.¹¹⁰

105 [Q170](#), Lord Adebowale, Chair, NHS Confederation

106 [Q170](#), Lord Victor Adebowale, Chair, NHS Confederation

107 Sir William Macpherson of Cluny, [The Stephen Lawrence Inquiry](#) (February 1999), para 6.34

108 [Q91](#), Dr Chaand Nagpaul CBE, Chair, BMA Council

109 The King’s Fund, [Workforce race inequalities and inclusion in NHS providers](#), accessed 28 April 2021

110 The King’s Fund, [Workforce race inequalities and inclusion in NHS providers](#), accessed 28 April 2021

80. Tricia Pereira, Head of Operations Adults Social Care & Adult Safeguarding, London Borough of Merton. gave a similar picture of the situation in social care. She told us that:

The experiences of [Black, Asian and minority ethnic] staff are the same, no matter what part of the sector they work in. The systemic racism and inequalities are exactly the same.¹¹¹

However, she highlighted the fact that the “visibility, the value and the parity” was not in place in social care as it was in the NHS, adding that:¹¹²

When you talk about leadership and aspiration, there are very few visible senior leaders in social care, even less so perhaps than in the NHS. For people who are aspiring, if the visibility is not there, they feel that perhaps they would not belong in those particular roles. If the systems are not there, but there are barriers or challenges for you to progress into certain roles, that is what we need to address and tackle.¹¹³

She believed that any focus on the NHS should be expanded to include social care, stating that: “We want to be included, and we want parity. We want to be the same.”¹¹⁴

81. We heard that colleagues from Black, Asian and minority ethnic backgrounds across the NHS and social care continue to face additional challenges. As stated above, we welcome the commitments of the People Plan to a truly inclusive workforce, and the accountability brought by the WRES. But the People Plan does not include social care, which means there are no plans in place to tackle discrimination in a workforce of over 1.6 million people.

82. We recommend that adult social care have its own People Plan, which includes parallel commitments to those for the NHS on diversity and inclusion.

Staff from overseas

83. The health and social care sector depends on the contribution of workers from outside the UK. When he gave oral evidence, Dr Chaand Nagpaul CBE, Chair of the BMA Council, told us that the NHS’s medical workforce relied on that contribution,¹¹⁵ and that the UK needed to provide doctors with better induction, support and the time to “understand the NHS”.¹¹⁶ He explained that that staff from overseas received only a half a day General Medical Council induction and were then “thrown into a ward or a GP practice”. That lack of training and support, he believed, resulted in some running into difficulties, which he described as “a major issue”.¹¹⁷

84. Professor Michael West agreed. He identified three issues that needed to be addressed for overseas workers:

- How we attract people.

111 [Q176](#), Tricia Pereira, Head of Operations Adults Social Care & Adult Safeguarding, London Borough of Merton

112 [Q176](#), Tricia Pereira, Head of Operations Adults Social Care & Adult Safeguarding, London Borough of Merton

113 [Q176](#), Tricia Pereira, Head of Operations Adults Social Care & Adult Safeguarding, London Borough of Merton

114 [Q176](#), Tricia Pereira, Head of Operations Adults Social Care & Adult Safeguarding, London Borough of Merton

115 [Q88](#), Dr Chaand Nagpaul CBE, Chair, BMA Council

116 [Q88](#), Dr Chaand Nagpaul CBE, Chair, BMA Council

117 [Q88](#), Dr Chaand Nagpaul CBE, Chair, BMA Council

- How we manage the transition in the most supportive way to enable them to be effective practitioners.
- How we retain them and create conditions in our organisations where that are not getting burned out, but are supported and valued and feel they are making a positive difference to patients and communities.¹¹⁸

85. Several written submissions raised concerns about the ability to recruit sufficient numbers of staff from overseas to both the NHS and the care sector as a result of immigration reform and/or Brexit, in the context of the challenge posed by the covid-19 pandemic.¹¹⁹ In oral evidence Anita Charlesworth from the Health Foundation told us that, due to the covid-19 pandemic and subsequent constraints on travel, numbers coming from overseas and joining the professional register for nursing in the six months up to September [2020] were 2,000 - a third of the rate for the previous six months. She argued that the NHS needed a “national policy framework around migration, as does social care” because the UK would still need “international recruitment for a period.”¹²⁰

86. Oonagh Smyth from Skills for Care told us that although adult social care employed around 113,000 workers from the EU and around 134,000 from outside of the EU, care workers were not listed as an eligible occupation in the skilled workers route. In the context of “112,000 vacancies every day”, and with increasing demand in that sector, we needed to be “clear” about where we were going to recruit people from.¹²¹

87. On 14 January 2021, Lord Bethell, Minister for Innovation in the Department for Health and Social Care, acknowledged in response to a Parliamentary Question about care home staff that “occupations such as direct care roles which do not meet the skills and salary threshold” would not be eligible for the new Skilled Worker route. He noted that fewer than 5% of all workers joining the sector in a direct care role in 2019–20 had arrived from the EU in the previous 12 months; and that the Government therefore expected employers to be able to “recruit domestically to outnumber any decreased flow of workers from the EU.”¹²²

88. Anita Charlesworth told us that the post-covid-19 pandemic presented the Government with an opportunity to tackle the shortfall in domestic recruitment. She said that the NHS had experienced a “huge increase” in the number of people from the UK applying for both jobs and training opportunities in the NHS and that the Government needed to capitalise on that. In relation to social care, Anita Charlesworth said that the pandemic has “essentially, fast-tracked structural changes” that had resulted in a large number of people with skills in customer care and in human relationships but without employment. She said that those skills would be “very valuable in social care” and that the Government needed to invest in training them in social care. However, she added that the training needed to ensure that employment in social care was “not a temporary job while you are looking for the long term”, but became “a career for people where they feel valued and they can earn a decent living.”¹²³

118 [Q36](#), Professor Michael West, Senior Visiting Fellow, The King’s Fund

119 NHS Providers ([WBR0007](#)), Care England ([WBR0012](#)), Royal College of Midwives ([WBR0025](#))

120 [Q209](#), Anita Charlesworth, Director of Research and REAL Centre, The Health Foundation

121 [Q210](#), Oonagh Smyth, Chief Executive Officer, Skills for Care

122 [UIN HL11696](#) [on care homes: migrant workers] 14 January 2021

123 [Q198](#), Anita Charlesworth, Director of Research and REAL Centre, The Health Foundation

89. When she came before us, Helen Whately, the Minister for Care, acknowledged the challenges facing the health and care sector in recruiting the necessary numbers of staff and told us that the Government valued “the input and work of international recruits”. However, she said that in terms of reducing the vacancies and the gaps in the social care workforce, the Government’s focus was on “encouraging and supporting those in the UK to take on those jobs”.¹²⁴

90. Staff from overseas play a key role in enabling the NHS and social care to function. Whatever role overseas staff will play in the long-term, they are essential to the health and social care system in the short-term and medium-long term because any move to shift to more domestic supply is likely to take time. Workforce planning, in both the NHS and social care therefore will need to include strategies for the recruitment, transition, and training of overseas workers in the health and care sector.

91. We recommend that the Department develops an NHS and social care national policy framework around migration to support national and local workforce planning and identify the balance between domestic and international recruitment in the short, medium and long-term.

4 The impact of covid-19 on burnout

Introduction

92. The pandemic presented the health and care sector with unprecedented challenges that exacerbated existing problems in the workforce. In its written evidence, the NHS Confederation outlined a range of factors resulting from the pandemic that had impacted on the mental wellbeing of the workforce. They included:

- Increased workload and working hours.
- Intensity of working in different / COVID-19-safe environment.
- The impact of the heroes narrative.
- Emotional strain from seeing large numbers of patients dying.
- Anxiety about their own and loved ones' health and infection risk.
- Guilt experienced by those shielding or working from home.
- Worries about being able to provide high-quality care.¹²⁵

NHS Providers also emphasised that covid-19 had exacerbated existing challenges around workforce, burnout and resilience.¹²⁶

93. The British Psychological Society also highlighted factors affecting wellbeing during the pandemic, including junior staff unaware of the support available to them; non-front line staff feeling guilty, when re-assigned to a post vacated by staff moved to Covid wards or when shielding loved ones; and 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).¹²⁷

94. Healthcare Safety Investigation Branch staff who had returned to the frontline during the crisis phase of the pandemic also observed a range of factors that added to the risk of burnout.¹²⁸

- unfamiliar working conditions—unknown environments, disease, and boundary of competence
- reduced staff ratios and skill mix, which can compound other safety risks.
- lack of standardisation across wards for equipment, layout, and bed numbering systems.
- design of personal protective equipment (PPE) storage with unintended negative consequences (e.g. delays in donning, difficulty accessing PPE).

125 NHS Confederation ([WBR0051](#))

126 NHS Providers ([WBR0007](#))

127 British Psychological Society ([WBR0046](#))

128 Healthcare Safety Investigation Branch ([WBR0075](#))

- escalation pathways not known or provided, or staffed, or the designated person for escalation inexperienced in that area or that task
- rapidly changing guidance - for those who worked part time, procedures and guidance changed, often dramatically, during days off.¹²⁹

95. The availability of PPE at the start of the pandemic and its effect on staff was also raised by organisations from both health and social care. A Royal College of Emergency Medicine survey in June 2020 found that 32% of respondents had episodes where they lacked access to PPE items when having clinical contact with suspected or confirmed covid-19 patients, and 34% reported having to reuse disposable PPE items. 97% of respondents to that survey felt that PPE had an impact on their ability to communicate effectively with patients.¹³⁰

96. The Royal College of Psychiatrists runs the Psychiatrists' Support Service (PSS) providing free peer support by telephone to psychiatrists of all grades who may be experiencing personal or work-related difficulties. In its written submission the Royal College said that burnout was one of the most common issues presented, with 19% of all calls in 2020 being related to it in some way.¹³¹

Effect of the pandemic on NHS staff

97. Several organisations that submitted evidence had surveyed their members on the effect of the pandemic on their staff. In June 2020, an NHS Providers survey found that 9 out of 10 trust leaders were concerned about staff wellbeing, stress and burnout following the pandemic,¹³² while the British Medical Association's written submission highlighted that nearly half of the doctors that had responded to its survey reported suffering from depression, anxiety, stress, burnout, emotional distress or another mental health condition. Those figures were accompanied by data that indicated that the BMA's mental health and wellbeing support services experienced a 40% increase in their use over March, April and May 2020.¹³³ The Royal College of Psychiatrists has run regular surveys during the pandemic. In May 2020, over half of its members surveyed said that their wellbeing had worsened during the crisis (506 of 931), with the wellbeing of people from BAME groups disproportionately affected.¹³⁴ Similarly, in oral evidence to the Public Accounts Committee in July 2020, Prerana Issar, NHS Chief People Officer, described "worrying signs of burn-out and anxiety" among nursing staff" and highlighted a Nursing Times survey indicating that 90% of nurse respondents felt higher rates of anxiety than before the pandemic.¹³⁵

129 Healthcare Safety Investigation Branch ([WBR0075](#))

130 Royal College of Emergency Medicine ([WBR0070](#))

131 The Royal College of Psychiatrists ([WBR0031](#))

132 NHS Providers ([WBR0007](#))

133 British Medical Association (BMA) ([WBR0069](#))

134 The Royal College of Psychiatrists ([WBR0031](#))

135 Oral evidence taken before the Public Accounts Committee on 20 July 2020, HC (2019–21) 408, [Q40](#) [Prerana Issar]

98. The increases in levels of stress have also been accompanied by rises in absences. FirstCare (an absence management provider) reported that from April–June 2020, absences relating to mental health increased by 22% compared to the same period in 2019.¹³⁶ In a similar vein, the Nuffield Trust reported that the staff absence rate in the NHS in April 2020 was the highest since records began and that it had exceeded even the “winter peaks of sickness absence over the last 11 years”.¹³⁷

99. In October 2020, the Parliamentary Office of Science and Technology (POST) published a paper, *Mental health impacts of COVID-19 on NHS healthcare staff*. That paper stated that the pandemic may have removed many of the usual coping mechanisms previously used by staff, including socialising with friends and family. According to POST, the BMA reported that well-being support services had seen an increase in calls from doctors who were feeling anxious about going to work to face increasingly challenging situations.¹³⁸ POST found that frontline workers that were directly engaged in the diagnosis and treatment of covid-19 were particularly vulnerable; including nurses, paramedics and those working in frontline specialities, such as emergency medicine and intensive care.¹³⁹

100. These statistics give the overall picture of the additional stress placed on staff in the health and care sector. But they do not give a sense of the human cost of that stress. A number of submissions contained personal testimony that made clear the effect on individuals. In its written evidence, Macmillan Cancer Support quoted the words of a Lead Cancer Nurse on the emotional impact of the pandemic:

We’ve all got that Covid fatigue. We’re exhausted by the way we’re living and working. And it’s really difficult. The thing is, we’re coming up to winter, we’ve got to step up to the mark again. And it’s whether we have the resilience to deal with that. And, of course, we’ll have to because there’s just no more capacity and no more staff to handle it.¹⁴⁰

101. Another quote from a Macmillan GP explained that even the most resilient of colleagues were “cracking” under the pressure.¹⁴¹ The BMA’s submission included testimony from a doctor who faced feelings of guilt from the belief that they had put their family at risk by working during the pandemic:

I signed up to be a doctor. But my family didn’t choose this career path, I feel like I’ve forced the risk on them and I can’t get away from the guilt.¹⁴²

102. In oral evidence, Professor Dame Clare Gerada, told us of the emotional load facing all staff in the NHS during the pandemic:

I always talk about the porter. The porter who has to wheel a dead baby to the mortuary is just as much in need of space and time to talk about that

136 FirstCare ([WBR0015](#))

137 Nuffield Trust, [Chart of the week: Sickness absence rates in the NHS in April were at their highest since records began](#), accessed 26 April 2021

138 Parliamentary Office of Science and Technology, [Mental health impacts of COVID-19 on NHS healthcare staff](#), accessed 26 April 2021

139 Parliamentary Office of Science and Technology, [Mental health impacts of COVID-19 on NHS healthcare staff](#), accessed 26 April 2021

140 Macmillan Cancer Support ([WBR0053](#))

141 Macmillan Cancer Support ([WBR0053](#))

142 British Medical Association (BMA) ([WBR0069](#))

and what he has just done as is, for example, the consultant in ITU who has lost a patient. It is anybody who is doing front-facing emotional toil. It is more so if you are involved in clinical work, of course, but it should not leave behind all the others.¹⁴³

Another Macmillan nurse highlighted the personal stress caused by patients not receiving treatment:

In the background I was also worrying about the cancer patients and them getting their diagnosis because everything just stopped. And I'm still worrying about that now, will we ever catch up? Will there be too many late diagnoses? We're going to be in for an explosion and how are we going to manage that?¹⁴⁴

Professor Dame Clare Gerada told us that the two most important solutions were to “address the intensity of the workload” and to “allow spaces in protected time where people can come together to talk about the emotional impact of their work”.¹⁴⁵

103. Although our call for evidence closed at the end of October, we received submissions that included references to the potential impact of a second wave of covid-19. The Royal College of Psychiatrists pointed to a BMJ assessment of the mental health impact of staff working with patients suffering from covid-19 and other similar outbreaks. It highlighted the risk of not giving staff the chance to “reset” following a crisis. That assessment suggested staff working with patients with covid-19 were 70% more likely to develop both acute and post-traumatic stress disorder (PTSD) or to suffer from psychological distress.¹⁴⁶

Covid-19: social care staff

104. The evidence we received on the effect of the pandemic on NHS staff was echoed by the submissions covering staff working in social care. Care England told us that social care workers had had to grapple with long hours (sometimes not being able to take leave) and the need to be adaptable in response to changing needs.¹⁴⁷ The United Kingdom Homecare Association (UKCA) noted staff had “worked above and beyond their contractual requirements in an emergency situation” and that this could not be considered a long-term position.¹⁴⁸

105. The effect on staff was made clear by Skills for Care which found that the percentage of days lost to sickness had almost tripled from 3% to 8% from March to July 2020 compared to usual levels. This figure would equate to around 6.35 million additional days lost to sickness than would usually be expected in that period.¹⁴⁹ In addition, the LGA told the Committee that self-isolation and quarantine had exacerbated absence levels, with staff feeling anxiety and guilt about putting their own families at risk.¹⁵⁰

143 [Q97](#), Professor Dame Clare Gerada

144 Macmillan Cancer Support ([WBR0053](#))

145 [Q97](#), Professor Dame Clare Gerada

146 The Royal College of Psychiatrists ([WBR0031](#))

147 Care England ([WBR0012](#))

148 United Kingdom Homecare Association ([WBR0045](#))

149 Skills for Care ([WBR0071](#))

150 LGA ([WBR0010](#))

106. Care England explained that adult social care staff had also had to take the place of residents “relatives and loved ones” including “helping residents isolate in their bedrooms, at the bedside of dying residents”. Care England told us that staff had felt bereft and grief stricken when residents died and were concerned for their own safety as a result of a lack of testing. It concluded that the “physical and mental strain on staff during this period was “unprecedented”.¹⁵¹ The Diocese of Rochester also told us that the additional pressures placed on care staff had been accompanied with a feeling of being “abandoned”, with the focus especially early in the pandemic on protecting the NHS.¹⁵² This view was repeated by the Carers Trust who told us that social care and its workforce felt less valued than their counterparts in the NHS.¹⁵³

107. In oral evidence, Jo Da Silva, a homecare worker, told us that the recognition of the work of social care needed to be put on an equal footing with medical professionals:

To be on a par with other people means more than anything. [...] We have done things that are on a par with other medical professions, if I am honest. [...] We have a duty to care, and we do the job for a reason. I think the main thing is to be recognised.¹⁵⁴

108. During the first wave, the UK public showed their recognition of the work of staff in the health and care sector through the weekly “clap.” However, while many staff appreciated it, the Adult Social Care Taskforce Workforce Advisory Group also noted that the “all in this together” sentiment may have “created a climate” that pressurised some staff into working “in ways that they didn’t feel they had a choice about, and may have had to do so at great personal sacrifice”.¹⁵⁵ It further noted that care workers did not have a code of practice equivalent to nurses and social workers that would have been “instrumental” in supporting them in to say “no.”¹⁵⁶

109. The additional pressures and the perception of not being recognised and appreciated extended to other areas of the sector. An anonymous submission from a Community Pharmacist told us that despite staying open throughout the pandemic community pharmacy felt “very underrecognized” and “undervalued.” They described community pharmacists as the “hidden sponge” that soaked up a large number of people that would otherwise have presented at A&E or a GP practice; and that it would be a “real travesty” should that work be forgotten.¹⁵⁷

Supporting mental health during covid-19 and beyond

110. Looking forward, a number of organisations that submitted written evidence told us of lessons that needed to be learned from the pandemic and changes that needed to be made to better support mental health and wellbeing in adult social care. The Adult Social Care Taskforce Workforce Advisory Group recommended:

151 Care England ([WBR0012](#))

152 Diocese of Rochester ([WBR0030](#))

153 Carers Trust ([WBR0014](#))

154 [Q14](#), Jo Da Silva, Care Worker

155 Adult Social Care Taskforce Workforce Advisory Group & National Care Forum, Adult Social Care Taskforce Workforce Advisory Group & United Kingdom Homecare Association ([WBR0085](#))

156 Adult Social Care Taskforce Workforce Advisory Group & National Care Forum, Adult Social Care Taskforce Workforce Advisory Group & United Kingdom Homecare Association ([WBR0085](#))

157 Transcript of interviews with health and care workers ([WBR0111](#))

- All members of the social care workforce (including those who have left the sector due to coronavirus) be protected by Government investing in occupational health services, signposting, mental health first-aid, and bereavement services, including access to face-to-face consultations, where appropriate.
- The active promotion of a positive view of occupational health for the wellbeing of the workforce that recognised cultural sensitivities including people that may be more reluctant to engage with those services.
- Employers had the ability to access training and resources to manage sickness/absence fairly and efficiently; and where that was unavoidable, to terminate contracts on health grounds fairly and lawfully.¹⁵⁸

111. In his oral evidence Paul Farmer, the CEO of Mind, also highlighted the importance of cultural change and improving the offer of support to staff. He highlighted the need for NHS trust boards to focus on “the mental wellbeing and support of their staff” and to ensure that there were adequate numbers of champions inside their organisations. He also highlighted the importance of tackling the stigma of mental wellbeing and to ensure that there was “a really clear set of offers” in place and that every member of staff was aware of those offers.¹⁵⁹

112. The Royal College of Psychiatrists called for the implementation of the *NHS People Plan* to 2020–21 along with the recommendations of the NHS Staff and Learners’ Mental Wellbeing Commission,¹⁶⁰ while Our Frontline called for the adoption of the recommendations set out in the *Mental Health and Wellbeing of Nurses and Midwives in the United Kingdom* report.¹⁶¹ Our Frontline also recommended that all employers across NHS and social care:

- Provide adequate evidence-based training and tools to strengthen the resilience of staff in health and social care.
- Promote anti-stigma messaging to encourage people to reach out if they need support.
- Invest in mental health services specifically for NHS and social care staff who may be experiencing trauma following covid-19.
- Embed mental health training as a core part of new staff members induction.¹⁶²

113. The Academy of Medical Royal Colleges set out in its submission that “active national support through a sustained and coordinated approach to mental health and wellbeing” was essential for staff engagement and retention as the system moved into the recovery period. According to the Academy, emerging evidence suggested that the need for psychological support among NHS staff (and other employee groups) would now increase, with those who have been shielding or have required significant work adjustments because of underlying health or other issues perhaps needing specific support to return to work.¹⁶³

158 Adult Social Care Taskforce Workforce Advisory Group & National Care Forum, Adult Social Care Taskforce Workforce Advisory Group & United Kingdom Homecare Association ([WBR0085](#))

159 [Q103](#), Paul Farmer CBE, Chief Executive Officer, Mind

160 Royal College of Psychiatrists ([WBR0031](#))

161 Mind - on behalf of Our Frontline, Samaritans, Hospice UK, Shout 85258 ([WBR0057](#))

162 Mind - on behalf of Our Frontline, Samaritans, Hospice UK, Shout 85258 ([WBR0057](#))

163 Academy of Medical Royal Colleges ([WBR0009](#))

114. The Department of Health and Social Care’s (DHSC) written evidence explained that it had recognised this need for enhanced wellbeing support for NHS and social care staff at “an early stage”,¹⁶⁴ and had commissioned NHS England and Improvement to develop a comprehensive emotional, psychological and practical support package for NHS staff with “many elements” extended to staff in social care. The Department told us that throughout the pandemic, NHS staff could access:

- A dedicated and confidential staff support line, operated by the Samaritans and a 24/7 text support line operated by Frontline.
- Specialist bereavement support through a helpline provided by Hospice UK, manned by a team of fully qualified and trained bereavement specialists.
- Free access to mental health and wellbeing apps.
- Virtual staff common rooms, in partnership with NHS Practitioner Health, which gave staff the opportunity to reflect, share experiences and find ways to cope with how Covid-19 is affecting their life at home and at work.
- The “#LookingAfterYouToo: Coaching Support for Primary Care Staff service” developed in collaboration with the Royal College of General Practitioners that provided access to individual coaching sessions to support the mental health and wellbeing of all clinical and non-clinical primary care workers.¹⁶⁵

115. Health Education England also provided a range of free e-learning resources including, support for individuals returning to practice or moving areas of work; an e-portal on statutory/mandatory training required by staff and those returning to practice; and a Learning Hub providing access to Covid-19 related education and training resources for the health and care workforce.¹⁶⁶

116. For social care staff, the Department introduced a new CARE branded website and app—CARE Workforce—which provided information and signposting support. In May 2020 it published wellbeing guidance for adult social care staff and employers, and in June 2020 it published a collection of bereavement resources.¹⁶⁷

117. The Department further highlighted the work it had undertaken with Our Frontline (a collaboration between Samaritans, Shout, Hospice UK and Mind, providing information, emotional support and access to a crisis text service for those working on the frontline, including in social care); the Samaritans and Hospice UK to provide additional mental health, bereavement and other support to health and care staff.¹⁶⁸

118. The Association of Clinical Psychologists UK was largely positive about the NHS England Staff Wellbeing Programme.¹⁶⁹ However, the Association noted that the “take-up” of the various forms of psychological support had been “remarkably low thus far” (as of September 2020) and that research was needed to understand the reasons for “both take-up and non-engagement with these offers”. In February 2021, NHS Chief People

164 Department of Health and Social Care ([WBR0077](#))

165 Department of Health and Social Care ([WBR0077](#))

166 Department of Health and Social Care ([WBR0077](#))

167 Department of Health and Social Care ([WBR0077](#))

168 Department of Health and Social Care ([WBR0077](#))

169 Association of Clinical Psychologists UK ([WBR0042](#))

Officer Prerana Issar said that an expert advisory group had provided advice on health and wellbeing over the year. She told us that staff recovery was “very individual” and that “we will all need to recover in different ways, depending on what our experience has been over the year and what our family situation has been”. Alongside that there needed to be “team processing and reflection time” and that “team debriefs, check-ins and some support for facilitated conversations with teams [would] be key for recovery”. In addition, Prerana Issar told us that 40 mental health hubs had been made available for people who have more serious burnout symptoms.¹⁷⁰

119. Despite the unprecedented stress placed on staff during the pandemic, a number of written submissions saw positive workforce developments that could leave a constructive legacy. UNISON, for example, noted the growth in flexible and remote working,¹⁷¹ while the King’s Fund, highlighted the public’s demonstration of how much they valued key workers; a raised awareness of the need to actively ensure that different staff groups are not made vulnerable by normalised discrimination and disadvantage; and examples of NHS staff rapidly forming teams which delivered effective care and were supportive.¹⁷² That rapid formation of teams has, anecdotally, been linked to greater levels of delegation of authority, greater flexibility in individuals’ role assumptions, greater attention to wellbeing and more supportive regulation. The King’s Fund believes that evaluation of the factors enabling this resilient teamworking in the NHS is needed, and that learning should be taken forward.¹⁷³

120. The Academy of Medical Royal Colleges also noted the growing acceptance of delivering care in different ways and greater recognition of the value of multi-professional team working. It also saw benefit in evaluating those innovations “to ensure positive changes are retained, and negative changes are discarded.”¹⁷⁴

121. Covid-19 has exacerbated existing problems with staff welfare, but also brought some benefits, including higher levels of recognition and different ways of working. While enhanced recognition of the work of health and care staff is welcome, adequate and holistic support for their mental health and wellbeing is of primary importance. That support was not just needed during the waves of covid-19: it will be needed through the recovery as the health and care sector returns to ‘business as usual.’

122. We recommend that national bodies must continue to monitor the impact of covid-19 on the NHS and adult social care workforce and ensure that workforce planning builds in time for recovery after the pandemic is over.

123. We recommend that the Department of Health and Social Care, the national bodies, and individual organisations across the NHS and social care commit to capturing and disseminating the innovations—in particular giving greater levels of autonomy to staff and new forms of integrated working—during the pandemic so that they can be embedded in organisations as they return to ‘business as usual’.

170 [Q225](#), Prerana Issar, Chief People Officer, NHS England and NHS Improvement

171 UNISON ([WBR0027](#))

172 The King’s Fund ([WBR0017](#))

173 The King’s Fund ([WBR0017](#))

174 Academy of Medical Royal Colleges ([WBR0009](#))

The impact of covid-19

124. During this inquiry, we received evidence on the specific effects of the pandemic on staff from Black, Asian and minority ethnic backgrounds and the challenges that they faced. POST’s note on the mental health of NHS staff during the covid-19 pandemic found that staff from minority ethnic backgrounds had been disproportionately affected by the pandemic, including in relation to deaths from covid-19.¹⁷⁵ Submissions to our inquiry supported those findings. The Royal College of Psychiatrists’ May 2020 member survey found that staff from Black, Asian and minority ethnic groups were disproportionately affected by covid-19 compared to professionals from white backgrounds,¹⁷⁶ and the RCM reported that—despite advice to NHS trusts to conduct covid-19 risk assessments for staff from Black, Asian and minority ethnic backgrounds working in patient facing roles—an investigation in June 2020 had found that only 23% of Trusts had done so.¹⁷⁷ The RCM added that there was evidence to suggest that requests from staff from BAME backgrounds for personal protective equipment (PPE) were more likely to be refused, and that healthcare workers from BAME backgrounds had felt more pressure to work with covid-19 patients than their white counterparts.¹⁷⁸ A report from the Royal College of Nursing also found that healthcare staff from Black, Asian and minority ethnic backgrounds were less likely to be able to secure PPE, and less likely to receive PPE training compared with their white colleagues.¹⁷⁹

125. The first 10 doctors in the UK named as having died from covid-19 were all from Black, Asian or minority ethnic backgrounds.¹⁸⁰ The Royal College of Emergency Medicine’s (RCEM) June 2020 membership survey found that 30% of staff from BAME backgrounds were “very concerned” about their health, compared with 8% of White staff,¹⁸¹ and the BMJ reported in April 2020 that 63% of healthcare workers who had died from covid-19 were from BAME backgrounds.¹⁸²

126. Those concerns were replicated in the social care sector. Staff from BAME backgrounds represent around 21 per cent of all social care staff,¹⁸³ and in London, 66% of the adult social care workforce are from minority ethnic backgrounds.¹⁸⁴ In its written evidence the Local Government Association told us that, with social care being a “hands-on” industry and effective social distancing an “immense challenge”, social care workers from BAME backgrounds faced particular challenges as they had been shown to be more vulnerable to covid-19.¹⁸⁵

127. Shining a light on the effect of the pandemic on staff from BAME backgrounds, Dr Chaand Nagpaul told us that over 90% of the doctors who have died have had come from

175 Parliamentary Office of Science and Technology, [Mental health impacts of COVID-19 on NHS healthcare staff](#), accessed 26 April 2021

176 Royal College of Psychiatrists ([WBR0031](#))

177 Royal College of Midwives ([WBR0025](#))

178 Royal College of Midwives ([WBR0025](#))

179 Royal College of Nursing, [BAME nursing staff experiencing greater PPE shortages despite COVID-19 risk warnings](#), accessed 27 April 2021

180 The Guardian, [UK government urged to investigate coronavirus deaths of BAME doctors](#), accessed 27 April 2021

181 Royal College of Emergency Medicine ([WBR0070](#))

182 BMJ, [Covid-19: Two thirds of healthcare workers who have died were from ethnic minorities](#), accessed 27 April 2021

183 LGA ([WBR0010](#))

184 Skills for Care, [The state of the adult social care sector and workforce in England](#), accessed 27 April 2021

185 LGA ([WBR0010](#))

Black, Asian and minority ethnic backgrounds; a statistic that he described as “stark” and that went “beyond any statistical variation”. Dr Nagpaul also cited BMA members who had reported “higher levels of bullying and harassment during the pandemic”.¹⁸⁶

128. Public Health England’s report, *Beyond the data: Understanding the impact of COVID-19 on BAME groups*, published in June 2020, found that “the highest age standardised diagnosis rates of covid-19 per 100,000 population were in people of Black ethnic groups (486 in females and 649 in males) and the lowest were in people of White ethnic groups (220 in females and 224 in males)” and that “People of Chinese, Indian, Pakistani, Other Asian, Caribbean and Other Black ethnicity had between 10 and 50% higher risk of death when compared to White British”.¹⁸⁷ In relation to the health and care sector, the report stated that of the deaths of healthcare workers reported, “63% were in BAME groups: 36% were of Asian ethnicity (compared to 10% of NHS workforce) and 27% were of black ethnicity (compared to 6% of the NHS workforce).” The report stated that:

Stakeholders felt strongly that more must be done to protect and support BAME staff working in health and care services (including pharmacies and domiciliary care). They play a vital role in our society, more should be done to recognise this and celebrate this. There are deep concerns raised about the support that BAME front line workers have received. This fundamental break in trust between employers and organisations should be a priority to address as we move into recovery phase of COVID-19.¹⁸⁸

129. In October 2020, the BAME Communities Advisory Group reported to the Social Care Sector COVID-19 Support Taskforce. The Group’s report made a number of recommendations to tackle the specific impact of the pandemic on BAME groups. Those recommendations included:

- Parity between staff working in the NHS and social care in research, the design, development, and delivery of programmes that support BAME staff through the current and future pandemics.
- NHS Confederation, Care Providers Alliance and British Association of Social Work to share best practice and coordinate their advice and support to Employers and BAME staff.
- That faith and ethnicity be recorded on death certificates and data sets.
- The development of a ‘Trusted Places and Trusted People’ strategy as the way of disseminating awareness, knowledge and information.
- That greater efforts are made to improve cultural ‘competence’ at government level.
- An increased robustness in co-ordination between the NHS and Local Authority, Social Care and Public Health to better support BAME staff in social care.

186 [Q87](#), Dr Chaand Nagpaul CBE, Chair, BMA Council

187 Public Health England, [Beyond the data: Understanding the impact of COVID-19 on BAME groups](#), accessed 27 April 2021

188 Public Health England, [Beyond the data: Understanding the impact of COVID-19 on BAME groups](#), accessed 27 April 2021

- The publication of clearer guidance and expectations that deliver improved messaging on the need to protect BAME workers across social care.¹⁸⁹

130. In response to concerns about the impact of covid-19 on staff from BAME backgrounds in the NHS, NHS England and Improvement issued the following specific areas of focus to address the impact of Covid-19 on staff from Black, Asian and minority backgrounds in the NHS:

- Protection of staff.
- Engagement with staff and staff networks.
- Representation in decision making.
- Rehabilitation and recovery, with a bespoke health and wellbeing offer for Black, Asian and minority ethnic colleagues being created.
- A range of support, including a free to access dedicated bereavement and trauma support line for colleagues of Filipino origin.¹⁹⁰

131. The NHS *People Plan* includes a number of references to tackling discrimination faced by NHS staff, and notes the impact of covid-19 on colleagues from Black, Asian and minority backgrounds:

It has never been more urgent for our leaders to take action and create an organisational culture where everyone feels they belong- in particular to improve the experience of our people from Black, Asian and minority ethnic backgrounds.¹⁹¹

132. From September 2020, the *People Plan* commits NHS England and NHS Improvement to refreshing the evidence base for action, to ensure the senior leadership (very senior managers and board members) represents the diversity of the NHS, spanning all protected characteristics.¹⁹²

133. It is clear from the evidence collected by Government, the NHS and other organisations that staff from Black, Asian and minority ethnic groups have been disproportionately affected by the pandemic in a way that has shone a light on deeply worrying divisions in society. Both the Public Health England and BAME Communities Advisory Group reports set out a series of actions to address this problem. We recommend that the Department set out how it plans to implement those recommendations, with a corresponding timeframe.

134. We further recommend that Integrated Care Systems have a duty to report on progress made against those recommendations made to improve the support for their staff from Black, Asian and minority ethnic backgrounds.

189 Department of Health and Social Care, [BAME Communities Advisory Group report and recommendations](#), accessed 27 April 2021

190 NHS England and Improvement, [Addressing impact of COVID-19 on BAME staff in the NHS](#), accessed 27 April 2021

191 NHS England, [We are the NHS: People Plan 2020/21 - action for us all](#) (July 2020)

192 NHS England, [We are the NHS: People Plan 2020/21 - action for us all](#) (July 2020)

5 Workforce planning

135. At the heart of the solution to workforce burnout and resilience is one simple change, without which the situation is unlikely to improve except at the margins - namely the need for better workforce planning. There was a high degree of consensus in the submissions to our inquiry that both the NHS and social care workforce were overstretched and had been for some time. The King's Fund told us that the current approach to workforce planning was "incoherent" and that funding for education and training was "inadequate" with a "reliance on overseas recruitment".¹⁹³

136. In its written evidence, the Health Foundation set out the level of the problem:

The NHS workforce gap in 2020–21 was 115,000 FTE. This is projected to double over the next five years and to exceed 475,000 FTE staff by 2033–34 [...] This does not account for any potential impacts of the covid-19 pandemic, which will take more time to quantify and understand.¹⁹⁴

The Health Foundation went on to say that to meet rising expectations for the quality and range of care provided and for services to adopt new technological advances, the NHS in England was likely to require workforce growth of 3.2% a year over the next 15 years; which "implies a requirement of a projected 179,000 additional FTE staff by 2023–24, rising to 639,000 additional FTE staff by 2033/34".¹⁹⁵ They further projected that the NHS in England faced a shortfall of 108,000 FTE nurses by 2028/29; and a shortfall of 7,000 FTE GPs in 2023/24 rising to 11,500 FTE GPs by 2028/29.

137. Alongside the figures for the NHS, the Health Foundation and the Institute for Fiscal Studies projected that 458,000 additional FTE social care staff would be required in England by 2033–34.¹⁹⁶

138. Concerns about staff shortages were reflected in NHS Providers' 2019 survey which indicated that only 29% of Trust leaders that responded were confident that their Trust had the right numbers, quality and mix of staff in place to deliver high quality healthcare to patients and service users. That figure decreased when respondents were asked to look forward to future years, with only 18% saying they were confident of the right numbers, quality and staff mix in two years' time.¹⁹⁷

139. Although the NHS Staff Survey for 2020 showed an overall decrease in the number of staff considering leaving the NHS,¹⁹⁸ staff shortages are endemic and not limited to one area of health and social care. The Royal College of Midwives raised concerns about numbers being trained and retained in midwifery,¹⁹⁹ while the Royal College of Nursing (RCN) highlighted that, going into the pandemic, there had been almost 40,000 unfilled

193 The King's Fund ([WBR0017](#))

194 Anita Charlesworth (Anita Charlesworth at Health Foundation) ([WBR0108](#))

195 Anita Charlesworth (Anita Charlesworth at Health Foundation) ([WBR0108](#))

196 Anita Charlesworth (Anita Charlesworth at Health Foundation) ([WBR0108](#))

197 NHS Providers ([WBR0007](#))

198 NHS Staff Survey Co-ordination Centre, [NHS Staff Survey: national results briefing](#), accessed 28 April 2021

199 Royal College of Midwives ([WBR0025](#))

nursing vacancies in the NHS in England alone. In July 2020 they reported that a recent survey of approximately 42,000 RCN members in England had shown that 36% were thinking of leaving the profession, up from 27% at the end of 2019.²⁰⁰

140. According to the 2020 NHS Staff Survey, the proportion of staff considering leaving their current NHS organisation had decreased by 2% since 2019 (down from 35.8% to 33.8%) and represented an improving trend since 2018 (37.4%). (That figure included all staff considering leaving their current job other than those looking to move to another job within the same organisation.) The proportion of staff who were considering leaving the NHS altogether had decreased by 1% since 2019 (down from 19.6% to 18.2%) which also represented a year on year improvement since 2018 (21.0%).²⁰¹

141. However, staff shortages are not only affected by people leaving. In oral evidence, Dr Chaand Nagpaul told us that a BMA tracker survey from October 2020 indicated that around 50% of doctors said that, once the pandemic was over, they planned to reduce their working hours. In addition, Dr Nagpaul said that: “A fifth plan to retire early. A fifth plan to do a job other than being a doctor” He described that as “a serious situation” to which solutions must be found.²⁰²

142. This situation is replicated in social care. The King’s Fund told us that the social care workforce was “if anything even more fragile than the NHS”,²⁰³ while Skills for Care pointed to estimates of approximately 122,000 vacancies at any one time,²⁰⁴ with a turnover rate of 30.8% for directly employed staff working in the adult social care sector in 2018/19.²⁰⁵ Furthermore, data modelling undertaken by Skills for Care suggested that if the adult social care workforce grows at the same rate as the projected number of people aged 65 and over in the population, then the number of adult social care jobs will increase by 32% (or by 520,000 jobs), to around 2.17 million jobs by 2035.²⁰⁶ Similarly, Anchor Hanover (a provider of housing, care and support) told us that a further one million care staff would need to be recruited by 2025 “to meet the needs of an ageing society and the implied increase in disabilities”.²⁰⁷

Workforce planning and social care

143. In our report, *Delivering core NHS and care services during the pandemic and beyond*, published last year, we concluded that there was “no equivalent of the NHS People Plan for the social care workforce”.²⁰⁸ The absence of a People Plan for social care was also noted in the Care Quality Commission’s (CQC) latest report, *The state of health and care in England*. That Report made clear that urgent action was needed to tackle workforce problems in social care. It stated that the longstanding need for reform, investment and workforce planning in social care had been “thrown into stark relief” by the pandemic, and what was needed was “a new deal” for the adult social care workforce that included

200 Royal College of Nursing, [Government must invest in nursing students to fix workforce crisis, says RCN](#), accessed 27 April 2021

201 NHS Staff Survey Co-ordination Centre, [NHS Staff Survey: national results briefing](#), accessed 28 April 2021

202 [Q79](#), Dr Chaand Nagpaul CBE, Chair, BMA Council

203 The King’s Fund ([WBR0017](#))

204 Skills for Care ([WBR0071](#))

205 Skills for Care ([WBR0071](#))

206 Skills for Care ([WBR0071](#))

207 Anchor Hanover ([WBR0029](#))

208 House of Commons Health and Social Care Committee, [Delivering core NHS and care services during the pandemic and beyond](#), HC 320, para 141

“clear career progression, secures the right skills for the sector, better recognises and values staff, invests in their training and supports appropriate professionalisation”. The CQC’s report concluded that the legacy of the pandemic was the recognition that “issues around funding, staffing and operational support need to be tackled now—not at some point in the future”.²⁰⁹

144. Like a number of others who submitted to the inquiry, such as the Carers Trust²¹⁰ and the LGA,²¹¹ the NHS Confederation called for a social care people plan to accompany that for the NHS. This was needed alongside wider social care reforms to “stabilise and secure the sector’s long-term future”, as well as build the ability to recruit from outside the UK into the UK’s new immigration policy.²¹²

145. In his oral evidence, Professor Martin Green of Care England also called for a 10-year plan for social care that was “aligned on every level” with the NHS Plan and included workforce issues, skills mix, support for staff and how to ensure that “we retain as well as recruit the right people”.²¹³ He added that a People Plan for social care should start with “a vision for social care” and what it delivers—together with a shared competency framework across the relatively fragmented employers:

We could identify a very clear skills and competency framework. [...] There is a real opportunity to have a very clear skills and competencies escalator. [...]

Professor Green also recommended opening out the training and development budget to the whole system so that people from both the NHS and social care could access it. He believed that this would have the benefit of providing both a “lot of skills and training to the social care workforce” and enhancing relationships with a “understanding of what each bit of the system does”.²¹⁴

146. In oral evidence, Anita Charlesworth explained how a skills escalator would work as part of a wider workforce strategy across health and social care:

If you start in one job that might have a relatively low qualification requirement, you can get on-the-job training and the opportunity to progress so that you can acquire your qualifications, move into the next job and up through the system.

147. She told us the evidence was clear that “if you train local, people are more likely to stay.” She described this approach as a “win-win” as it was a benefit to the both the community and the individual. She concluded that it would also “benefit the NHS and social care systems in terms of retention” but cautioned that it should not be “just be a national policy” as there needed to be “good connection locally as well”.²¹⁵

209 Care Quality Commission, [The state of health care and adult social care in England 2019/20](#), accessed 27 April 2021

210 Carers Trust ([WBR0014](#))

211 LGA ([WBR0010](#))

212 NHS Confederation ([WBR0051](#))

213 [Q28](#), Professor Martin Green OBE, Chief Executive, Care England

214 [Q31](#), Professor Martin Green OBE, Chief Executive, Care England

215 [Q202](#), Anita Charlesworth, Director of Research and REAL Centre, The Health Foundation

148. Oonagh Smyth of Skills for Care emphasised the possibilities that new ICSs might bring and that a social care plan would facilitate more integrated local strategies.²¹⁶ She also highlighted that more needed to be done to “align, acknowledge and understand the career pathways between social care and health”.²¹⁷

149. Although she told us that the NHS’s remit did not extend to social care, Prerana Issar, NHS Chief People Officer agreed that we did need a People Plan for social care: “given that health outcomes depend so much on the interaction between health and social care, we need the same kind of focus for social care”.²¹⁸ When he gave evidence to the Public Accounts Committee on 20 July 2020, Sir Chris Wormald, Permanent Secretary, Department of Health and Social Care acknowledged that while the NHS People Plan was developed “to set out what the workforce needs are to deliver the Long Term Plan” for the NHS, he acknowledged that the case could be made for having a people plan that covered both the NHS and social care.²¹⁹

150. In January 2021, Sir Simon Stevens told our joint inquiry with the Science and Technology Committee into Coronavirus: lessons learnt, that he “definitely” thought that the social care system needed a 10-year plan and said that “one fitting legacy” of the pandemic should be to “once and for all to resolve the question about fair funding and reform of adult social care”.²²⁰

151. In our Report, *Social care: funding and workforce*, published in October 2020, we called for a 10 year plan for the social care sector, a sustainable funding settlement, and improved financial conditions for workers in social care. The report asked that the starting point for a social care funding increase be an additional £7bn per year by 2023–24.²²¹ The Government’s response set out the level of funding provided to the social care system during the covid-19 pandemic, along with the funding commitments made at the 2020 Spending Review.²²² It commits the Government to “sustainable improvement of the adult social care system and will bring forward proposals in 2021”.²²³

The People Plan

152. In June 2019, the Government published its *Interim NHS People Plan*, which set out “our vision for people who work for the NHS to enable them to deliver the NHS Long Term Plan”.²²⁴ In July 2020, NHS England and Improvement published *We are the NHS: People Plan 2020–21*.²²⁵ The Department of Health and Social Care’s response to the inquiry

216 [Q195](#), Oonagh Smyth, Chief Executive Officer, Skills for Care

217 [Q203](#), Oonagh Smyth, Chief Executive Officer, Skills for Care

218 [Q54](#), Prerana Issar, NHS Chief People Officer, NHS England and NHS Improvement

219 Oral evidence taken before the Public Accounts Committee on 20 July 2020, HC (2019–21) 408, [Q16](#) [Sir Chris Wormald, Permanent Secretary, Department of Health and Social Care]

220 Oral evidence taken on 26 January 2021, HC (2019–21) 877, [Q905](#) [Sir Simon Stevens]

221 House of Commons Health and Social Care Committee, Third Report of Session 2019–21, [Social care: funding and workforce](#), HC 206

222 Department of Health and Social Care, [The Government Response to the Health and Social Care Committee report on Adult Social Care: Funding and Workforce](#), accessed 27 April 2021

223 Department of Health and Social Care, [The Government Response to the Health and Social Care Committee report on Adult Social Care: Funding and Workforce](#), para 2.10, accessed 27 April 2021

224 NHS England, [Interim NHS People Plan](#) (June 2019)

225 NHS England, [We are the NHS: People Plan 2020/21 - action for us all](#) (July 2020)

outlines the commitments made in the *People Plan*, which ‘focuses on strengthening resilience’ and ‘embedding the positive changes that staff saw during COVID-19.’²²⁶ DHSC told us that the Plan requires employers across the NHS to:

- Invest in physical health and wellbeing, with:
 - a new wellbeing guardian role ensuring board level scrutiny of health and wellbeing support for staff.
 - continued support for staff to get to work and free car parking.
 - a focus on healthy working environments and safe spaces for staff to rest and recuperate.
 - prioritisation of psychological support and treatment, with resilience hubs working in partnership with occupational health programmes to undertake proactive outreach and assessment, and co-ordinate referrals to appropriate treatment.
 - support to switch off from work, take breaks and annual leave.
- Make flexible working a priority by:
 - aiming for all clinical and non-clinical permanent roles to be offered on a flexible basis.
 - where possible, covering flexible working in standard induction conversations and offer flexible working from day one.
 - board members giving flexible working their focus and support.
 - being supported to implement and make effective use of e-rostering systems.
- Create an inclusive and diverse workplace, with:
 - a focus on ensuring staffing reflects the diversity of the community, and regional and national labour markets.
 - line managers being encouraged to discuss equality, diversity and inclusion as part of the health and wellbeing conversations.
 - every NHS trust, foundation trust and CCG being required to publish progress against the Model Employer goals to ensure that at every level, the workforce is representative of the overall BAME workforce.
 - a target that by the end of 2020 51% of NHS organisations to have eliminated the gap in relative likelihood of entry into the disciplinary process.
- Maximise opportunities for multi-professional working and developing new skills, with:
 - guidance having been provided to employers to on safely redeploying existing staff and deploying returning staff.

- continued focus on upskilling—developing skills and expanding capabilities - to create more flexibility, boost morale and support career progression.
- a commitment for Health Education England to work with professional and regulatory bodies to provide a nationally recognised critical care qualification which is open to different professions.
- a commitment for Health Education England to develop an educational offer for generalist training and work with local systems to develop the leadership and infrastructure required to deliver it.
- support from Health Education England for the expansion of multi-disciplinary teams in primary care, through the full roll out of primary care training hubs.
- the learning, training and development of volunteers being supported by The National Learning Hub for Volunteering.²²⁷
- Systems and employers being prompted to review how volunteers can help support recovery and restoration, and develop plans to enable and support volunteers who wish to move on to employment opportunities across the NHS to do so.
- Systems and employers being encouraged to promote the NHS Ambassadors programme to their people and allow them time to do this valuable outreach work.
- Create time and space for education and training, with:
 - A focus on fully integrating education and training into plans to rebuild and restart clinical services.
 - A prioritisation of continued access to continuing professional development.
 - £15m to increase clinical placements in the NHS and support growth in Nursing, Midwifery, Physiotherapy, Speech and Language Therapy and all the other Allied Health Professions. This represents a 50% increase in the funding previously pledged.
 - further development of e-learning materials, including simulation
 - several universities across England starting a pre-registration blended learning nursing degree programme.

153. The *People Plan* also sets out the support which is expected from employers to ensure that staff can switch off from work, in order to decrease work-related stress and burnout. Employers must make sure staff understand that they are expected to take breaks, manage their work demands together and take regular time away from the workplace—with leaders to role model this behaviour. To understand NHS people’s experience through covid-19 and recovery, the 2020 NHS Staff Survey will be adapted, with a new quarterly staff survey to track morale in the first quarter of 2021/22.²²⁸

227 Health Education England, [National Learning hub for Volunteering](#), accessed 26 April 2021

228 NHS England, [We are the NHS: People Plan 2020/21 - action for us all](#) (July 2020)

154. As part of the national *Looking After Our People* retention programme, NHS England and Improvement launched three local pathfinder regions on 1 September 2020.²²⁹ These will be used to test assumptions about how best to empower the whole workforce to feel valued, safe, productive and supported, giving regions the opportunity to try new things and share learning about best practice. Metrics to accompany and track the impact of the actions in the Plan would be developed in partnership with systems and stakeholders by the end of September 2020.²³⁰ From September 2020, every member of the NHS should have a health and wellbeing conversation and develop a personalised plan, and from October 2020, employers should ensure that all new starters have a health and wellbeing induction.

155. At our evidence session on 20 October, NHS England and Improvement also announced the launch of a further £15 million funding package to be spent on:

- creating a national support service for critical care staff who research suggests are most vulnerable to severe trauma
- funding nationwide outreach and assessment services, ensuring staff receive rapid access to evidence based mental health services
- developing wellbeing and psychological training, set to be rolled out this winter.²³¹

156. Our report, *Delivering core NHS and care services during the pandemic and beyond* welcomed the ‘important and ambitious measures’ set out to address workforce fatigue and provide mental health support in the *People Plan*, but called for ‘more substantive action’ to be taken to support the wellbeing of staff, especially before the busy winter period.²³²

157. Equally, many of our witnesses have given qualified support for the *People Plan*. In his oral evidence, Professor Michael West described the *People Plan* as “a very smart looking car” but without an “engine” because it did not provide detail on:

How many of the recommendations and prescriptions in the people plan can be implemented by integrated care systems at regional or local level or and how individual trusts will be supported to implement the recommendations.

He concluded that the direction of travel was “excellent”, but more detail was required “particularly around workforce strategy”.²³³

158. The absence of detail on the workforce strategy was a concern for a number of our witnesses. The King’s Fund described the *People Plan* as “another stop-gap that falls a long way short of the workforce strategy needed”,²³⁴ while the Royal College of Nursing said that “a fully funded, fully costed and modelled workforce strategy” was needed to “ensure that the substantial gaps in the workforce are filled”.²³⁵ The question of funding was also

229 Department of Health and Social Care ([WBR0077](#))

230 NHS England, [We are the NHS: People Plan 2020/21 - action for us all](#) (July 2020)

231 NHS England and Improvement, [NHS strengthens mental health support for staff](#), accessed 6 May 2021

232 House of Commons Health and Social Care Committee, [Delivering core NHS and care services during the pandemic and beyond](#), HC 320, para 138

233 [Q25](#), Professor Michael West, Senior Visiting Fellow, The King’s Fund

234 The King’s Fund ([WBR0017](#))

235 Royal College of Nursing ([WBR0049](#))

raised by the NHS Confederation who said that “too many investment decisions have been postponed or clarity has not been forthcoming, especially with the longstanding need to address vacancies”.²³⁶ It warned that for an exhausted workforce, “platitudes and promises need to rapidly turn into tangible solutions that are fully resourced in the upcoming spending round” which it described as “the last opportunity to ensure systemic workforce challenges do not enter an acute phase” in the approach towards winter.²³⁷

159. In a similar vein, the Royal College of Psychiatrists said that “a longer-term and more detailed People Plan” was required after the Spending Review to “further expand the workforce and ensure education and training are fit for the future”.²³⁸ The Royal College of Physicians called for “greater clarity on the scale of plans to expand the workforce” to address the “historic levels” of understaffing in the health service,²³⁹ while NHS Providers told us that the Government needed to prioritise “a multi-year funding package” in the Spending Review.²⁴⁰

160. More detail on workforce planning had been expected after the Spending Review that took place last Autumn. However, in answer to a Parliamentary Question on 2 February 2021 asking when the final report of the NHS People Plan would be published, Lord Bethell, Minister for Innovation in the Department for Health and Social Care, gave a broad-brush response:

We are working with NHS England and NHS Improvement, Health Education England and with systems and employers to determine our workforce and people priorities beyond April 2021 to support the recovery of NHS staff and of services. This will include building on many of the positive ways of working that have emerged through the pandemic whilst continuing to support the wellbeing of NHS staff.²⁴¹

161. It is clear from our witnesses that although the People Plan presents comprehensive ambition to address the failings in the culture of the NHS, and address the needs and wellbeing of NHS staff, its delivery will depend on the level of resourcing allocated to these priorities. Without adequate funding the laudable aspirations of the People Plan will not become reality.

162. *We recommend that the Department published regular, costed updates along with delivery timelines for all of the proposals in the People Plan.*

163. The absence of a People Plan for social care serves only to widen the disparity in recognition and support for the social care components of health and social care. The Government should rectify this as a matter of urgency in their upcoming work to reform the social care sector; and it is essential that it is included in the social care reforms promised this year. The adult social care workforce has stepped up to the plate during the pandemic. They deserve the same care and attention that the People Plan pledges to NHS colleagues.

236 NHS Confederation ([WBR0051](#))

237 NHS Confederation ([WBR0051](#))

238 The Royal College of Psychiatrists ([WBR0031](#))

239 Royal College of Physicians ([WBR0023](#))

240 NHS Providers ([WBR0007](#))

241 [UIN HL12190](#) [on NHS: staff] 2 February 2021

164. *We therefore recommend that, as a priority, the Department produces a People Plan for social care that is aligned to the ambitions set out in the NHS People Plan.*

165. We have made recommendations to the Department on the reform and funding of social care in previous Reports. We believe that they are worth restating. Those recommendations are as follow:

166. *(a) Alongside [...] a long term funding settlement we strongly believe the Government should publish a 10 year plan for the social care sector as it has done for the NHS. The two systems are increasingly linked and it makes no sense to put in place long term plans for one without the other. Failure to do so is also likely to inhibit reform and lead to higher costs as workforce shortages become more pronounced with higher dependency on agency staff. Reducing the 30% turnover rates typical in the sector will also require a long term, strategic approach to social care pay and conditions. (Social care: funding and workforce, Third Report of Session 2019–21, Paragraph 37)*

167. *(b) The social care sector needs reassurance that both the structural and financial problems it faces will be tackled by the Government in a timely way. For that reason, we recommend that a duty is included in the Bill for the Secretary of State to publish a 10-year plan with detailed costings within six months of the Bill receiving Royal Assent. (The Government’s White Paper proposals for the reform of Health and Social Care, First Report of Session 2021–22, paragraph 65)*

6 Conclusion: Bringing together the post-pandemic response with better workforce planning

168. During the inquiry, we heard how crucial effective workforce planning was both to ensure that there are enough staff to do the work, and to improve the morale of existing staff. In her oral evidence, Denise Crouch, a Macmillan Lead Cancer Nurse, set out the pressures on staff who were now facing the backlog of cases created by the focus on the covid-19 pandemic, in an area that was already short-staffed:

How long is it going to take for us to get that work back and get to a level playing field? We were never meeting the 62-day target across the country. If we were not meeting it before the pandemic, what is it going to be like now? Everybody is trying, and everybody is committed to making a difference, but we are going to need more capacity.²⁴²

169. Chris Hopson, Chief Executive of NHS Providers, was clear that capacity lay at the heart of the problem:

For the last 10 years we have had a mismatch between rapidly rising demand and capacity. Capacity simply has not risen in the same way. The way we tried to close that demand/capacity mismatch was by asking our staff to work harder and harder. The reality is that the demand/capacity mismatch was already showing up before we went into [the pandemic].

170. He warned us that Chief Executives of Trusts were telling him that after this “immediate period” of the pandemic, people would leave the NHS including “those near retirement, junior doctors or people who have come over here from overseas who wanted to train”. He concluded that core workers would leave the NHS because, “effectively, the whole concept of trying to close that gap by asking our staff to work harder and harder is creating an impossible and unsustainable workload for our frontline staff”.²⁴³

171. Failings in workforce planning are not new. In her oral evidence, Anita Charlesworth told us that a 2013 study by the OECD had identified “a number of weaknesses” in the way that countries did workforce planning, four of which applied in our system:

- Workforce plans do not start with a proper underpinning look at what is needed in the system and they do not start with a “really good understanding of current shortages”.
- They often fail to look at the labour market as a whole.
- The plans do not understand and look at the role of pay, and the importance of that over the long term.
- They do not look enough at the relationship between the professions and the way that needs and technologies will change the mix of professions that we need.²⁴⁴

242 [Q78](#), Denise Crouch, Macmillan Lead Cancer Nurse

243 [Q121](#), Chris Hopson, Chief Executive, NHS Providers

244 [Q179](#), Anita Charlesworth, Director of Research and REAL Centre, The Health Foundation

She concluded that the tendency was for workforce planning in the NHS to be led by available resources, rather than demand.²⁴⁵

172. Chris Hopson was clear about the need for better workforce planning. He said that “we absolutely do not have enough people working in the NHS”, and that a “very clear long-term plan” was needed. He added that “one of the really important things” that needed to come out of the pandemic was a “a categoric commitment right the way across Government that we are going to do long-term workforce planning”.²⁴⁶ The British Medical Association also called for a single national workforce dataset, which included regional staffing levels and consistent vacancy data for all providers, to enable more targeted approaches to recruitment and retention.²⁴⁷

173. Sir Simon Stevens, Chief Executive of NHS England, appeared to agree that workforce planning needed to change. He told our joint inquiry on *Coronavirus: lessons learnt*, that there was a “paradox” in the approach to workforce planning in so far as the health service had “a medium-term outlook for its revenue funding” but a short-term outlook for “workforce training” and “capital investment in infrastructure.” He highlighted that both areas had a “much longer” planning horizon and said he would welcome anything that would bring “predictability” to those decisions.²⁴⁸

174. When Prerana Issar, NHS Chief People Officer, gave evidence in October 2020, we questioned her on the availability of workforce projections that would deliver the NHS ten-year Long Term Plan. She stated that NHS England had “made recommendations” to HM Treasury for the comprehensive spending review. She said that she could not make public those recommendations, but that they were based on “what staffing is required to deliver the long-term plan”.²⁴⁹ Furthermore, she declined to commit to publishing any figures after the Spending Review had been completed.²⁵⁰

175. Anita Charlesworth told the Committee that there was “a debate to be had” about whether an independent body should be tasked with workforce planning in health and social care and noted that there was “no power” or “no requirement” for Health Education England to publish long-term forecasts that had been overseen and quality assured by a chief analyst. She believed that one option could be to strengthen the independence and responsibilities of HEE in that regard.²⁵¹ In her view, there may be legislative opportunities (in the Government’s proposed Health and Care Bill) to “strengthen the quality, the frequency, the rigour and the transparency” of workforce projections, covering both the NHS and social care.²⁵²

176. The Department’s White Paper, *Integration and Innovation: working together to improve health and social care for all* published in February 2021, includes a proposed duty on the Secretary of State to publish a document, once every 5 years, which sets out roles and responsibilities for workforce planning and supply in England.²⁵³ Our witnesses for

245 [Q180](#), Anita Charlesworth, Director of Research and REAL Centre, The Health Foundation

246 [Q122](#), Chris Hopson, Chief Executive, NHS Providers

247 British Medical Association ([WBR0069](#))

248 Oral evidence taken on 26 January 2021, HC (2019–21) 877, [Q902](#) [Sir Simon Stevens].

249 [Q47](#), Prerana Issar, NHS Chief People Officer, NHS England and NHS Improvement

250 [Q48](#), Prerana Issar, NHS Chief People Officer, NHS England and NHS Improvement

251 [Q181](#), Anita Charlesworth, Director of Research and REAL Centre, The Health Foundation

252 [Q181](#), Anita Charlesworth, Director of Research and REAL Centre, The Health Foundation

253 Department of Health and Social Care, [Integration and innovation: working together to improve health and social care for all](#), accessed 6 May 2021

that inquiry were underwhelmed by that proposal, and argued that the duty should be to produce more detailed work projections and more regularly. In supplementary evidence to that inquiry, the King's Fund, the Health Foundation and the Nuffield Trust set out the form that annual workforce projections should take. They recommended:

- a) Placing a duty on Health Education England to publish annual, independently verified, projections of the future supply of the health care workforce in England and how those projections compare to projected demand for healthcare workforce in England for a 15 year period consistent with the long-term projections of health care spending produced by the Office for Budget Responsibility (OBR).
- b) Placing a duty on the Secretary of State for Health and Social Care to ensure that annual independently verified projections of the future supply of social care workforce in England are published, setting out how those projections compare to projected demand for social care workforce in England for a 15 year period, consistent with the long-term projections of adult social care spending produced by the OBR.
- c) Requiring the publication of the assumptions underpinning the projections for the workforce flows from and to the other UK countries; and immigration and out-migration of the registered professions in health care. Those projections should be set out in headcount and full-time equivalent. At the England level, the projections should individually cover all the regulated professions (social workers, registered nurses, doctors, allied health professionals).
- d) Requiring the process for independent verification and a fixed annual date for publication to be published in advance.
- e) Ensuring that the Independent verification of the projections meet the relevant standards set out in the National Statistics Authority's code for official statistics for collecting, preparing, analysing and publishing government statistics.²⁵⁴

177. The Academy of Medical Royal Colleges, NHS Confederation and BMA Council also wrote to the Secretary of State with its proposals for more detailed projections that would include:

- A regular published independent assessment of health and care workforce projections and requirements from a designated responsible body; and
- A requirement on Government to respond to that assessment.²⁵⁵

254 The King's Fund, Health Foundation and Nuffield Trust, [Letter from the King's Fund, Health Foundation and Nuffield Trust on a proposed new clause in the NHS Bill](#), accessed 29 April 2021

255 Academy of Medical Royal Colleges, [Letter to the Secretary of State for Health and Social Care](#), accessed 6 May 2021

178. As we noted in our Report, *The Government's White Paper proposals for the reform of Health and Social Care* the Secretary of State appeared sceptical of making such provisions in the Bill.²⁵⁶ He argued that “Even if it may sound easy to say, “Let’s have an independent target for this. Let’s have some independent people set out the numbers on a spreadsheet,” that does not make it any truer than the best judgment of a Minister.”²⁵⁷

179. However, the Prime Minister was more encouraging when asked at the Liaison Committee whether he would consider asking a body like the ONS, or an independent body, to make projections about the future need for doctors and nurses:

Yes, I think that is the kind of thing that we should be looking at [...] We are looking at making sure we have the right measures for the long term, to recruit, to encourage, to retain and to make sure that we train people in the right way[...]²⁵⁸

180. Our report concluded that the duty to publish an update on the roles and responsibilities once every five years was not an adequate response to workforce shortages that are endemic in the NHS and that we were “**very sympathetic to the detailed joint proposal from the Kings Fund, Health Foundation and Nuffield Trust to place a duty in the Bill to produce annual workforce projections**”. We also welcomed similar proposals submitted by the Academy of Medical Royal Colleges and Royal College of Nursing which contained the necessary detail to ensure that the Department and NHS England are able to “**develop strategies to adequately staff health and social care in the short, medium and longer term**”.²⁵⁹

181. We are not persuaded that a combination of ministerial judgements and haggling between government departments is a satisfactory substitute for objective long-term workforce planning for the NHS and care system. We therefore recommended that:

The Government include in the Bill, provisions to require Health Education England to publish objective, transparent and independent annual reports on workforce shortages and future staffing requirements that cover the next five, ten and twenty years including an assessment of whether sufficient numbers are being trained. We further recommend that such workforce projections cover social care as well as the NHS given the close links between the two systems.²⁶⁰

256 Oral evidence taken on 16 March 2021, HC (2019–21) 1274, [Q160](#) [Matt Hancock, Secretary of State, Department of Health and Social Care]

257 Oral evidence taken on 16 March 2021, HC (2019–21) 1274, [Q161](#) [Matt Hancock, Secretary of State, Department of Health and Social Care]

258 Oral evidence taken before the Liaison Committee on 13 January 2021, HC (2019–21) 1144, [Q4](#) [Rt Hon Boris Johnson MP, Prime Minister]

259 House of Commons Health and Social Care Committee, [The Government's White Paper proposals for the reform of Health and Social Care](#), HC 20, para 86

260 House of Commons Health and Social Care Committee, [The Government's White Paper proposals for the reform of Health and Social Care](#), HC 20, para 87

And that:

Workforce reports be undertaken in consultation with the Devolved Administrations to ensure that a clear picture is given on the health and care workforce throughout the United Kingdom.²⁶¹

182. The emergency that workforce burnout has become will not be solved without a total overhaul of the way the NHS does workforce planning. After the pandemic, which revealed so many critical staff shortages, the least we can do for staff is to show there is a long term solution to those shortages, ultimately the biggest driver of burnout. We may not be able to solve the issues around burnout overnight but we can at least give staff confidence that a long term solution is in place.

183. The way that the NHS does workforce planning is at best opaque and at worst responsible for the unacceptable pressure on the current workforce which existed even before the pandemic.

184. It is clear that workforce planning has been led by the funding envelope available to health and social care rather than by demand and the capacity required to service that demand. Furthermore, there is no accurate, public projection of what health and social care require in the workforce for the next five to ten years in each specialism. Without that level of detail, the shortages in the health and care workforce will endure, to the detriment of both the service provision and the staff who currently work in the sector. Annual, independent workforce projections would provide the NHS, social care and Government with the clarity required for long-term workforce planning.

185. *We recommend again, that Health Education England publish objective, transparent and independently-audited annual reports on workforce projections that cover the next five, ten and twenty years including an assessment of whether sufficient numbers are being trained. We further recommend that such workforce projections cover social care as well as the NHS given the close links between the two systems.*

186. *We further recommend that those projections:*

- *Are informed by the future shape of services and anticipated demand.*
- *Take into account the labour market as a whole.*
- *Make clear the opportunity cost of not training, employing and retaining sufficient numbers of staff.*

261 House of Commons Health and Social Care Committee, [The Government's White Paper proposals for the reform of Health and Social Care](#), HC 20, para 88

Conclusions and recommendations

The scale of and impact of workforce burnout in the NHS and social care

1. Burnout is a widespread reality in today's NHS and has negative consequences for the mental health of individual staff, impacting on their colleagues and the patients and service users they care for. There are many causes of burnout, but chronic excessive workload is a key driver and must be tackled as a priority. This will not happen until the service has the right number of people, with the right mix of skills across both the NHS and care system. (Paragraph 35)
2. Understanding the scale and impact of workforce burnout can only be achieved with a metric for staff wellbeing and staff mental health that covers both the NHS and social care. *We therefore recommend that the Department for Health and Social Care extends the NHS Staff Survey to cover the care sector.* (Paragraph 36)
3. *We further recommend that the NHS Staff Survey and any social care equivalent includes an overall staff wellbeing measure, so that employers and national bodies can better understand staff wellbeing and take action based on that understanding. The Staff Survey already allocates a scale out of 10 for each 'theme' it covers, which could provide the starting point for the calculation of such a measure.* (Paragraph 37)
4. We welcome the additional support provided to health and care staff during the pandemic. However, we conclude that such additional support will need to be maintained during the recovery period and beyond to stop further staff from leaving. Furthermore simply offering support services, however important, is not on its own enough. The Department and employers need to ensure that those services are accessible to all and used by all who need them. This will require removing barriers to seeking help, and embedding a culture where staff are explicitly given permission and time away from work to seek help when it is needed. (Paragraph 38)
5. *We recommend that Integrated Care Systems (ICSs) be required to facilitate access to wellbeing support for NHS and social care workers across their systems, and that they are accountable for the accessibility and take-up of those services.* (Paragraph 39)
6. *We further recommend that the level of resources allocated to mental health support for health and care staff be maintained as and when the NHS and social care return to 'business as usual' after the pandemic; and that the adequacy of resources allocated to that support be monitored on a regular basis.* (Paragraph 40)

Workplace culture

7. It is imperative staff have the opportunity and the confidence to speak up. However, this needs to be matched with a culture in which organisations demonstrate that they are not just listening to, but also acting on, staff feedback. While NHS organisations have a formal structure to raise concerns through Freedom to Speak

Up Guardians, there is no equivalent for adult social care. *We therefore recommend that the Department develops a strategy for the creation of Freedom to Speak Up Guardians in social care.* (Paragraph 47)

8. Improvements to workplace culture have been made, but equally, there is more work to be done. Embedding and facilitating cultures which support compassionate leadership must be at the heart of that work. There is a strong appetite for that leadership from both managers and staff, but structural barriers remain. The Department, the NHS and individual trusts need to focus on removing those barriers so that their leaders can lead to their full potential. The establishment of statutory Integrated Care Systems provides an opportunity for those systems to lead a transformation of support for NHS leaders in their areas that includes mental health support, development of proper career structures, and a review of targets. (Paragraph 61)
9. *We recommend that NHS England undertake a review of the role of targets across the NHS which seeks to balance the operational grip they undoubtedly deliver to senior managers against the risks of inadvertently creating a culture which deprioritises care of both staff and patients.* (Paragraph 62)
10. *We further recommend that the Department of Health and Social Care work with stakeholders to develop staff wellbeing indicators, on which NHS bodies can be judged.* (Paragraph 63)
11. The Committee welcomes the Workforce Race Equality Standard (WRES), along with the People Plan, as an important step towards an NHS which offers equal opportunities to all its staff. We were pleased to hear in our oral evidence session that work had begun to provide similar information to the WRES in social care. This year's WRES report concludes that 'now is the time to translate the data to actions.' We agree. Part of this must be to ensure that the boards of the new ICSs appropriately represent the populations they serve. (Paragraph 68)
12. *We therefore recommend that WRES data be made part of the 'balanced basket of indicators' we suggest for Integrated Care Systems, with the result that they become accountable for progress across their domains. As part of this process, organisations should set themselves ambitious yet achievable targets that include timings.* (Paragraph 69)
13. We heard that colleagues from Black, Asian and minority ethnic backgrounds across the NHS and social care continue to face additional challenges. As stated above, we welcome the commitments of the People Plan to a truly inclusive workforce, and the accountability brought by the WRES. But the People Plan does not include social care, which means there are no plans in place to tackle discrimination in a workforce of over 1.6 million people. (Paragraph 81)
14. *We recommend that adult social care have its own People Plan, which includes parallel commitments to those for the NHS on diversity and inclusion.* (Paragraph 82)
15. Staff from overseas play a key role in enabling the NHS and social care to function. Whatever role overseas staff will play in the long-term, they are essential to the health and social care system in the short-term and medium-long term because any

move to shift to more domestic supply is likely to take time. Workforce planning, in both the NHS and social care therefore will need to include strategies for the recruitment, transition, and training of overseas workers in the health and care sector. (Paragraph 90)

16. *We recommend that the Department develops an NHS and social care national policy framework around migration to support national and local workforce planning and identify the balance between domestic and international recruitment in the short, medium and long-term.* (Paragraph 91)

The impact of covid-19 on burnout

17. Covid-19 has exacerbated existing problems with staff welfare, but also brought some benefits, including higher levels of recognition and different ways of working. While enhanced recognition of the work of health and care staff is welcome, adequate and holistic support for their mental health and wellbeing is of primary importance. That support was not just needed during the waves of covid-19: it will be needed through the recovery as the health and care sector returns to ‘business as usual’. (Paragraph 121)
18. *We recommend that national bodies must continue to monitor the impact of covid-19 on the NHS and adult social care workforce and ensure that workforce planning builds in time for recovery after the pandemic is over.* (Paragraph 122)
19. *We recommend that the Department of Health and Social Care, the national bodies, and individual organisations across the NHS and social care commit to capturing and disseminating the innovations—in particular giving greater levels of autonomy to staff and new forms of integrated working—during the pandemic so that they can be embedded in organisations as they return to ‘business as usual’.* (Paragraph 123)
20. It is clear from the evidence collected by Government, the NHS and other organisations that staff from Black, Asian and minority ethnic groups have been disproportionately affected by the pandemic in a way that has shone a light on deeply worrying divisions in society. Both the Public Health England and BAME Communities Advisory Group reports set out a series of actions to address this problem. *We recommend that the Department set out how it plans to implement those recommendations, with a corresponding timeframe.* (Paragraph 133)
21. *We further recommend that Integrated Care Systems have a duty to report on progress made against those recommendations made to improve the support for their staff from Black, Asian and minority ethnic backgrounds.* (Paragraph 134)

Workforce planning

22. It is clear from our witnesses that although the People Plan presents comprehensive ambition to address the failings in the culture of the NHS, and address the needs and wellbeing of NHS staff, its delivery will depend on the level of resourcing allocated to these priorities. Without adequate funding the laudable aspirations of the People Plan will not become reality. (Paragraph 161)

23. *We recommend that the Department published regular, costed updates along with delivery timelines for all of the proposals in the People Plan.* (Paragraph 162)
24. The absence of a People Plan for social care serves only to widen the disparity in recognition and support for the social care components of health and social care. The Government should rectify this as a matter of urgency in their upcoming work to reform the social care sector; and it is essential that it is included in the social care reforms promised this year. The adult social care workforce has stepped up to the plate during the pandemic. They deserve the same care and attention that the People Plan pledges to NHS colleagues. (Paragraph 163)
25. *We therefore recommend that, as a priority, the Department produces a People Plan for social care that is aligned to the ambitions set out in the NHS People Plan.* (Paragraph 164)
26. We have made recommendations to the Department on the reform and funding of social care in previous Reports. We believe that they are worth restating. Those recommendations are as follow: (Paragraph 165)
27. (a) *Alongside [...] a long term funding settlement we strongly believe the Government should publish a 10 year plan for the social care sector as it has done for the NHS. The two systems are increasingly linked and it makes no sense to put in place long term plans for one without the other. Failure to do so is also likely to inhibit reform and lead to higher costs as workforce shortages become more pronounced with higher dependency on agency staff. Reducing the 30% turnover rates typical in the sector will also require a long term, strategic approach to social care pay and conditions. (Social care: funding and workforce, Third Report of Session 2019–21, Paragraph 37).* (Paragraph 166)
28. (b) *The social care sector needs reassurance that both the structural and financial problems it faces will be tackled by the Government in a timely way. For that reason, we recommend that a duty is included in the Bill for the Secretary of State to publish a 10-year plan with detailed costings within six months of the Bill receiving Royal Assent. (The Government’s White Paper proposals for the reform of Health and Social Care, First Report of Session 2021–22, paragraph 65).* (Paragraph 167)

Conclusion: Bringing together the post-pandemic response with better workforce planning

29. The emergency that workforce burnout has become will not be solved without a total overhaul of the way the NHS does workforce planning. After the pandemic, which revealed so many critical staff shortages, the least we can do for staff is to show there is a long term solution to those shortages, ultimately the biggest driver of burnout. We may not be able to solve the issues around burnout overnight but we can at least give staff confidence that a long term solution is in place. (Paragraph 182)
30. The way that the NHS does workforce planning is at best opaque and at worst responsible for the unacceptable pressure on the current workforce which existed even before the pandemic. (Paragraph 183)

31. It is clear that workforce planning has been led by the funding envelope available to health and social care rather than by demand and the capacity required to service that demand. Furthermore, there is no accurate, public projection of what health and social care require in the workforce for the next five to ten years in each specialism. Without that level of detail, the shortages in the health and care workforce will endure, to the detriment of both the service provision and the staff who currently work in the sector. Annual, independent workforce projections would provide the NHS, social care and Government with the clarity required for long-term workforce planning. (Paragraph 184)
32. *We recommend again, that Health Education England publish objective, transparent and independently-audited annual reports on workforce projections that cover the next five, ten and twenty years including an assessment of whether sufficient numbers are being trained. We further recommend that such workforce projections cover social care as well as the NHS given the close links between the two systems.* (Paragraph 185)
33. *We further recommend that those projections:*
 - *Are informed by the future shape of services and anticipated demand.*
 - *Take into account the labour market as a whole.*
 - *Make clear the opportunity cost of not training, employing and retaining sufficient numbers of staff.* (Paragraph 186)

Formal minutes

Tuesday 18 May 2021

Members present:

Jeremy Hunt, in the Chair

Paul Bristow	Taiwo Owatemi
Rosie Cooper	Sarah Owen
Dr James Davies	Dean Russell
Dr Luke Evans	Laura Trott
Neale Hanvey	

Draft Report (*Workforce burnout and resilience in the NHS and social care*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Summary agreed to.

Paragraphs 1 to 186 read and agreed to.

Resolved, That the Report be the Second Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Tuesday 25 May at 9.00am

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the [inquiry publications page](#) of the Committee's website.

Tuesday 20 October 2020

Bernie Miller, Clinical Lead, Discharge Lounge, Lancashire Teaching Hospitals NHS Foundation Trust; **Jo Da Silva**, Care Worker, Agincare [Q1–21](#)

Professor Michael West, Senior Visiting Fellow, The King's Fund; **Professor Martin Green**, Chief Executive, Care England; **Caroline Waterfield**, Director of Development and Employment, NHS Employers [Q22–45](#)

Prerana Issar, NHS Chief People Officer, NHS England and NHS Improvement; **Claire Murdoch**, National Mental Health Director, NHS England and NHS Improvement [Q46–70](#)

Tuesday 17 November 2020

Dr Chaand Nagpaul, Chair, Council of the British Medical Association; **Denise Crouch**, Macmillan Lead Cancer Nurse [Q71–93](#)

Dr Adrian James, President, Royal College of Psychiatrists; **Paul Farmer**, Chief Executive, Mind - on behalf of Our Frontline; **Professor Dame Clare Gerada**, Medical Director, Practitioner Health; **Vic Rayner**, Executive Director, National Care Forum [Q94–119](#)

Tuesday 12 January 2021

Professor Jeremy Dawson, Professor of Health Management, Sheffield University; **Chris Hopson**, Chief Executive, NHS Providers; **Helené Donnelly**, Ambassador for Cultural Change / Lead Freedom to Speak Up Guardian, Midlands Partnership NHS; **Dr Henrietta Hughes**, National Guardian [Q120–161](#)

Lord Victor Adebawale, Chair, NHS Confederation; **Shilpa Ross**, Fellow, The King's Fund; **Tricia Pereira**, Head of Operations Adults Social Care & Adult Safeguarding, London Borough of Merton [Q162–178](#)

Wednesday 24 February 2021

Oonagh Smyth, Chief Executive, Skills for Care; **Rob Smith**, Workforce Planning and Intelligence Director, Health Education England; **Anita Charlesworth**, Director of Research and REAL Centre, The Health Foundation [Q179–211](#)

Helen Whately MP, Minister of State for Care, Department for Health and Social Care; **Prerana Issar**, Chief People Officer, NHS England and NHS Improvement [Q212–248](#)

Published written evidence

The following written evidence was received and can be viewed on the [inquiry publications page](#) of the Committee's website.

WBR numbers are generated by the evidence processing system and so may not be complete.

- 1 Academy Trainee Doctors' Group ([WBR0058](#))
- 2 Academy of Medical Royal Colleges ([WBR0009](#))
- 3 Academy of Medical Sciences ([WBR0038](#))
- 4 Adult Social Care Taskforce Workforce Advisory Group & National Care Forum; and Adult Social Care Taskforce Workforce Advisory Group & United Kingdom Homecare Association ([WBR0085](#))
- 5 Agincare Group ([WBR0040](#))
- 6 Anchor Hanover ([WBR0029](#))
- 7 Association of Anaesthetists ([WBR0028](#))
- 8 Association of Clinical Psychologists UK ([WBR0042](#))
- 9 Association of Coloproctology of GB and Ireland ([WBR0033](#))
- 10 Bliss ([WBR0094](#))
- 11 Bourne, Professor Tom (Chair in Gynaecology, Imperial College London) ([WBR0079](#))
- 12 Bournemouth University ([WBR0026](#))
- 13 British Association of Endocrine and Thyroid Surgeons ([WBR0059](#))
- 14 British Association of Social Workers ([WBR0093](#))
- 15 British Dental Association ([WBR0055](#))
- 16 British Dietetic Association ([WBR0063](#))
- 17 British Medical Association (BMA) ([WBR0069](#))
- 18 British Orthopaedic Association ([WBR0056](#))
- 19 British Psychological Society ([WBR0046](#))
- 20 British Society for Rheumatology ([WBR0048](#))
- 21 CLIC Sargent ([WBR0021](#))
- 22 Care England ([WBR0012](#))
- 23 Carers Trust ([WBR0014](#))
- 24 Carrieri, Dr Daniele (Lecturer in Public Health, University of Exeter); Mattick, Prof Karen; Pearson, Dr Mark; Papoutsis, Dr Chrysanthis; Briscoe, Simon; Wong, Dr Geoff and Jackson, Prof Mark ([WBR0082](#))
- 25 Charlesworth, Anita (Anita Charlesworth, Health Foundation) ([WBR0108](#))
- 26 Collins, Hannah (Secretariat, Boundless) ([WBR0105](#))
- 27 Cox, Jane (Policy and External Relations Advisor, MHA (Methodist Homes)) ([WBR0106](#))
- 28 Department of Health and Social Care ([WBR0077](#))
- 29 Diocese of Rochester ([WBR0030](#))
- 30 Donnelly, Helené ([WBR0112](#))

- 31 Faculty of Sexual and Reproductive Healthcare (FSRH) ([WBR0041](#))
- 32 FirstCare ([WBR0015](#))
- 33 GMB Union ([WBR0066](#))
- 34 General Dental Council ([WBR0078](#))
- 35 General Medical Council (GMC) ([WBR0072](#))
- 36 Hand, Mr Peter (Secretariat, The Working Group of the APPG on Adult Social Care) ([WBR0104](#))
- 37 Health and Care Professions Council ([WBR0052](#))
- 38 Health and Care Workers - Transcript of interviews ([WBR0111](#))
- 39 Healthcare Safety Investigation Branch ([WBR0075](#))
- 40 Hft ([WBR0109](#))
- 41 IPPR ([WBR0062](#))
- 42 Institute for Employment Studies ([WBR0020](#))
- 43 Institute of Health Visiting ([WBR0019](#))
- 44 Interview transcripts ([WBR0111](#))
- 45 Johnston, Mrs Lucy (Research Fellow, Edinburgh Napier University); Hockley, Dr Jo (Senior Research Fellow, University of Edinburgh); Watson, Dr Julie (Senior Research Fellow, University of Edinburgh); Malcolm, Dr Cari (Senior Lecturer, Edinburgh Napier University); and Shenkin, Dr Susan (Geriatrician and Reader, University of Edinburgh) ([WBR0095](#))
- 46 LGA ([WBR0010](#))
- 47 Lisk, Dr Clifford (Consultant Physician in Acute Medicine and Geriatric Medicine, Barnet hospital, Royal Free Hospital NHS foundation trust); Bakhai, Dr Ameet (Consultant Cardiologist, Barnet hospital, Royal Free Hospital NHS foundation trust); Smith, Dr Colette (Associate Professor, Institute of Global Health, University College Hospital); Khani, Dr Aria (Specialist Registrar in Medicine, Barnet hospital, Royal Free Hospital NHS foundation trust); and Aziminia, Dr Nikoo (Clinical Fellow, Barts NHS trust) ([WBR0006](#))
- 48 London South Bank University ([WBR0081](#))
- 49 Maben, Professor Jill (Professor of Health Services Research and Nursing , University of Surrey) ([WBR0100](#))
- 50 Macmillan Cancer Support ([WBR0053](#))
- 51 McEwan, Dr Kirsten (Senior Research Fellow, University of Derby) ([WBR0097](#))
- 52 Medical Protection Society ([WBR0044](#))
- 53 Medical and Dental Defence Union of Scotland (MDDUS) ([WBR0096](#))
- 54 Mencap ([WBR0068](#))
- 55 Mesothelioma UK Research Centre Sheffield ([WBR0086](#))
- 56 Mind - on behalf of Our Frontline; Samaritans; Hospice UK; and Shout 85258 ([WBR0057](#))
- 57 NHS Confederation ([WBR0051](#))
- 58 NHS England and NHS Improvement ([WBR0110](#))
- 59 NHS Providers ([WBR0007](#))

- 60 NIHR Policy Research Unit in Health and Social Care Workforce ([WBR0032](#))
- 61 National Care Organisation ([WBR0067](#))
- 62 Nuance Communications ([WBR0087](#))
- 63 Nuffield Trust ([WBR0064](#))
- 64 Nursing and Midwifery Council ([WBR0080](#))
- 65 Nursing and Midwifery Council ([WBR0054](#))
- 66 OxfamGB ([WBR0088](#))
- 67 Paediatric Intensive Care Society ([WBR0011](#))
- 68 Paradigm and the Gr8 Support Movement ([WBR0008](#))
- 69 Paul, Ann (Chief Executive, Doctors in Distress) ([WBR0107](#))
- 70 Pharmaceutical Services Negotiating Committee ([WBR0089](#))
- 71 Rajasingam, Doctor Daghni (Deputy Medical Director and Deputy Director of Medical Education, Guys and St Thomas Hospital Foundation Trust); and Peters, Professor Emeritus David (Professor Emeritus Westminster Centre for Resilience, University of Westminster) ([WBR0061](#))
- 72 Royal College of Anaesthetists ([WBR0099](#))
- 73 Royal College of Emergency Medicine ([WBR0070](#))
- 74 Royal College of GPs ([WBR0076](#))
- 75 Royal College of Midwives ([WBR0025](#))
- 76 Royal College of Nursing ([WBR0049](#))
- 77 Royal College of Obstetricians and Gynaecologists ([WBR0073](#))
- 78 Royal College of Physicians ([WBR0023](#))
- 79 Royal College of Physicians of Edinburgh ([WBR0037](#))
- 80 Royal Pharmaceutical Society ([WBR0050](#))
- 81 Sacred Space Foundation ([WBR0091](#))
- 82 Skills for Care ([WBR0071](#))
- 83 Society for Cardiothoracic Surgery, Great Britain and Ireland ([WBR0036](#))
- 84 Society of Radiographers ([WBR0065](#))
- 85 St John Ambulance ([WBR0092](#))
- 86 Sue Ryder ([WBR0022](#))
- 87 The Chartered Society of Physiotherapy ([WBR0074](#))
- 88 The College of Podiatry ([WBR0098](#))
- 89 The Disabilities Trust ([WBR0083](#))
- 90 The Federation of Surgical Specialty Associations (fssa.org.uk) ([WBR0034](#))
- 91 The Health Foundation ([WBR0060](#))
- 92 The King's Fund ([WBR0017](#))
- 93 The Royal College of Psychiatrists ([WBR0031](#))
- 94 The Royal College of Surgeons of Edinburgh ([WBR0035](#))
- 95 The Shelford Group ([WBR0039](#))

- 96 UNISON ([WBR0027](#))
- 97 United Kingdom Homecare Association ([WBR0045](#))
- 98 WPI Strategy; and VMware ([WBR0103](#))
- 99 Kett-White, Mr Rupert (Consultant Neurosurgeon, Swansea Bay) ([WBR0018](#))

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website.

Session 2021–22

Number	Title	Reference
1st	The Government's White Paper proposals for the reform of Health and Social Care	HC 20

Session 2019–21

Number	Title	Reference
1st	Appointment of the Chair of NICE	HC 175
2nd	Delivering core NHS and care services during the pandemic and beyond	HC 320
3rd	Social care: funding and workforce	HC 206
4th	Appointment of the National Data Guardian	HC 1311
1st Special	Process for independent evaluation of progress on Government commitments	HC 633
2nd Special	Delivering core NHS and care services during the pandemic and beyond: Government Response to the Committee's Second Report of Session 2019–21	HC 1149
3rd Special	Drugs policy: Government Response to the Committee's First Report of Session 2019	HC 1178