

The
Point of Care
Foundation

Behind Closed Doors

Can we expect NHS staff to be the shock absorbers of a system under pressure?



Executive summary

This briefing highlights the latest evidence on NHS staff, their experience at work, the pressures they face and the consequences for patients. The Point of Care Foundation believes that it's critically important that NHS employers to pay attention to staff and their experience at work because when staff feel positive and engaged with work it has a positive impact on patient experience.

Behind Closed Doors therefore recommends that staff experience should be given equal priority with patient experience at all levels of the healthcare system. We would like to see organisations encouraging frontline staff to look after themselves, to pay attention to their own and their colleagues' wellbeing, to alert their managers to pressures that can be alleviated, and to let them know when they need support.

At the top of organisations we believe that boards and senior leaders can do much to support staff by acknowledging that their intrinsic motivation to care for patients and making line managers accountable for creating environments that enable staff to be at their best with patients and satisfied with their ability to care. We would also like to see more staff in more organisations being able to access psychosocial support and forums for reflective practices.¹

Recognising that national agencies and regulators depend on data collected by frontline staff to monitor performance, and that anything that uses up time at the frontline and is not directly patient-related reduces the time staff spend with patients, we applaud the efforts those bodies are making to simplify and reduce duplication, volume, frequency and confusion over the reports they require from providers.

In 2018, the NHS will celebrate its 70th birthday. We hope that in the next twelve months the recommendations from Behind Closed Doors will be taken on board, so that this birthday can truly be a cause to celebrate a healthcare system which cares for both its staff and its patients.

Introduction

Pressure is building in the health and care system: it's not going away and is beginning to seem endless. This is taking its toll on staff as well as patients. Commentators have described staff as the “shock absorbers in a system lacking [the] resources to meet rising demands” – but because staff are people, not things, the situation is not sustainable.²

Patient safety and the quality of the care the patient receives is dependent on the members of staff who interact with the patients being psychologically and emotionally, as well as physically, present with the patient and the family, and able to be responsive and engaged with colleagues. If staff are under sustained pressure and feel unable to offer patients the care they believe each patient needs, they suffer so-called ‘moral distress’ and their sensitivity to stress and burnout is heightened.

In 2013, Sir Robert Francis highlighted the dangers of losing sight of human concerns in healthcare, the importance of listening to patients and staff, and the risks to patients when the delivery of care becomes depersonalised. He insisted on the urgent importance of transforming the culture of NHS organisations away from one that is fearful and defensive and towards one that is open, honest and willing to listen. At The Point of Care Foundation, we fear the memory of the hard truths learned through the Francis Inquiry are in danger of being forgotten in the light of unprecedented, continuing, and seemingly endless service pressures.

The purpose of this briefing is to draw attention to: the importance of the latest evidence on staff experience; the risks to patients where staff are stressed and burned out; and the consequences for NHS services. At the end of the briefing, we have framed recommendations at three levels in order to support staff and protect patients.

The Current Situation

Pressure on services

The NHS is coming under increasing pressure in a financially challenged environment. Hospitals, emergency departments, and ambulance services are at the forefront of public attention, but the pressure is felt everywhere, including in general practice and in community and mental health services.

Hospital statistics give some insight into the scale of the demand on services:

In the twelve years before 2016, the number of attendances at major Accident & Emergency (A&E) departments increased by 18% from 12.7 million to 15 million.³

Over the same period, the total admissions to major A&E departments rose by 65% from 2.5 million to 4.1 million, whilst the total number of admissions to hospital in England rose by 16%, from 12.6 million in 2006/07 to 14.6 million in 2012/13.⁴

The delivery of healthcare on an industrial scale, and the increasing complexity of services, makes the challenge of caring for patients holistically and as individuals ever greater. Appointment times are getting shorter; continuity of care is rare; and whilst patient care is sometimes described as a 'team sport', requiring good working relationships and co-operation, high turnover, shifts systems, and gaps in rotas are disruptive, making teams ever-shifting and strained. In hospitals, bed occupancy is very high, and short lengths of stay mean less time and space for good communication and relationships between patients and staff.

What is being done

There is very little argument about the degree of pressure in healthcare, even less so when we include social care. The leaders in health and social care recognise it and, in response, have launched a partnership for action on improvement and leadership development in NHS-funded services.⁵

They frame the challenges in these terms:

- unprecedented pressure to improve via Sustainability and Transformation Plans (STPs)
- a lack of skilled leaders and leaders in post feeling less supported than before
- unhelpful cultures and high rates of stress and bullying (also highlighted in a number of other reports)⁶
- intensifying regulatory attention.

Our interest at The Point of Care Foundation is in leadership and cultural challenges and how both impact on frontline staff and interactions with patients. The National Framework mentioned above sets out plans for an (as yet unfunded) programme of support for leaders of health and social care organisations and identifies the conditions needed for success. These perspectives are welcome, but trying to steer the NHS from the top is like trying to turn a super-tanker. We would like to see more attention being paid to supporting bottom-up initiatives that resonate with staff and which appeal to their intrinsic motivation to care for patients.

Building capacity from the bottom upwards, along with supportive leaders and the right policy environment, is more likely to lead to sustained improvements than focusing purely on leadership from the top and policy.

Furthermore, in keeping with the broader policy environment, policy related to the workforce tends to focus on contractual and financial incentives for productivity and performance improvement. Again, whilst this is welcome, we would like more attention to be given to other aspects of employment that matter to staff. These include being listened to; having opportunities for personal development; having a healthy work-life balance; and having employers who are willing to be flexible and support staff both personally and professionally.

Indeed, the evidence shows that staff care deeply about the ethos of their organisation and the perceived attitudes of senior leaders and corporate functions. The 'softer', more personal aspects of management style and behaviour are thus critical to the reputation of NHS organisations, the ability to recruit and retain good people, and ultimately, therefore, to the quality of care on offer to patients.⁷

Pressures on staff and their consequences for patients

This section of the briefing highlights some of the key statistics and issues in relation to staff experience that are not only important in their own right, but which also affect relationships with patients, patient safety, and quality of care.

Our interest in staff and their experience at work stems from our mission, to humanise healthcare and ensure every patient is treated with kindness, dignity and respect all of the time. We believe that this is only possible when staff feel positive about their work and engaged with their colleagues and the wider environment.

There is ample evidence that teamwork, communication, and a co-operative work environment are essential for the delivery of safe, good quality patient care, and that bullying and undermining within the workforce is bad for patient safety.⁸ Trusts where staff feel positive both about their own work and the working environment achieve better outcomes for patients in terms of mortality rates and patient satisfaction.⁹ Trusts with positive results in the NHS staff survey also achieve positive results on the patient survey, and it is now clear that the relationship between the two sets of results is causal, and that staff experience is the antecedent and precursor to patient experience.

The NHS is the UK's biggest employer, employing nearly 1.6 million people.¹⁰ The NHS surveys its staff every year, and we therefore know a great deal about what it is like as a place of work.

On the positive side, we know that the quality of relationships within teams as well as the team climate are important in staff wellbeing.¹¹ The staff surveys show that more than two thirds of staff are satisfied with the support they receive from colleagues and immediate managers, and staff generally demonstrate high levels of enthusiasm about their job and a high degree of absorption in their work.¹²

Less positively, however, less than half of staff feel their employer values their work. The NHS working environment is tough in most areas, and there is convincing evidence that for black and ethnic minority staff it is even more so.

In 2016 only 31% of staff felt there were enough staff for them to do their job properly,¹³ and a survey of the current consultant workforce found that 62% felt their jobs were not sustainable in their current form.¹⁴

Every year for the past four years, dating back to 2012, 15% of NHS staff have been subjected to physical violence from patients, relatives and members of the public, and near to one in five staff say they have experienced bullying, harassment, or abuse from either their line manager or other colleagues.¹⁵ The Freedom to Speak Up review of whistleblowing in the NHS, led by Sir Robert Francis, found widespread victimisation of staff who spoke up on behalf of patients.¹⁶

High quality team functioning and a supportive team climate are essential, but large numbers of staff are actually assigned to teams that are teams in name only. A team in name only is a team that does not have clearly defined roles and tasks; that lacks joint objectives; where team members don't meet together and don't review their objectives, methods and effectiveness. In many workplace settings, members of the same team do not know one another – even by name – and are not able to develop a shared view of what they are aiming to achieve for patients.

Meanwhile, the national emphasis on targets, financial efficiency, and rapid processing of patients, along with the high levels of turnover and absence, creates stressful working conditions which make it difficult for individual members of staff to establish and maintain relationships with colleagues and patients. People can cope with high workloads in environments that are supportive and where they feel that they are in control.¹⁷ But this requires them to have a relatively high degree of autonomy and responsibility, along with opportunities for learning. When they find themselves in a working environment that is very demanding but don't feel supported and don't feel control is possible, the environment becomes toxic and they struggle to cope.

Indeed, current reported levels of stress amongst NHS clinical and non-clinical staff are greater than in the general working population, with stress accounting for more than a quarter of staff absence.

The prevalence rate for work related stress in the NHS is considerably greater than that of the general working population: 1980 cases per 100,000 people employed in health and social care, compared with 1230 of the overall British workforce.¹⁸

Amongst doctors, a number of recent reports have shown unprecedented levels of stress and poor mental health.¹⁹ Depression amongst healthcare staff is not new: the rates of depression have been high for some years, and this too is a concern.

Sickness absence due to stress means that staff who are at work risk being over-stretched and burned out, which can put patient safety and quality at risk. Burnout, a response to chronic stress, is very significant because it affects the way staff behave with one another and with patients. It causes the sufferer a lowered sense of personal effectiveness, increased emotional exhaustion, and a desire to flatten and depersonalise relationships with others. Depersonalisation in healthcare professionals necessarily affects interactions with others and, in doing so, puts patients at risk; at worst, it can produce cruelty to patients.

As well as the impact on patients and staff themselves, the sustained and increasing pressure is wasteful and leaves the whole healthcare system vulnerable.

It is estimated that the median cost of sickness absence to each NHS organisation is £3.3 million annually, with 90 trusts spending over £1 billion in three years on sickness absence alone.²¹

The latest figures suggest that the NHS spends £3 billion on agency and contract staff per year, consistently more than is planned.²²

High staff turnover, high vacancy rates, difficulty attracting appropriately skilled staff who also reflect the populations they serve, especially at more senior levels, are all cause for concern.²³

In the latest NHS staff survey, the majority of staff reported that they did feel their organisation and managers were concerned for their health and wellbeing. Approximately two thirds (67%) reported that their manager took a positive interest in their health and wellbeing, and 90% felt the organisation was actively interested in positive action. These results are encouraging, and we would like to see NHS providers focussing even more attention on interventions which are designed to improve emotional wellbeing. A recent cost benefit analysis of the value of investing in staff health and wellbeing estimates that the benefits are almost tenfold compared to their costs.

PriceWaterhouseCoopers found that healthcare providers can reap £9.20 in benefits from every £1 invested in staff health and wellbeing programmes.²⁴

The Future Situation

Performance across the NHS in relation to staff health and wellbeing and staff engagement is variable. Our interest is in what, if anything, can be done to boost the efforts to support staff to be at their best with patients, and to create more resilient services that will survive or even thrive in this period of stress? Can anything be done to make the culture more supportive and to create teams with climates that are more protective? Is it possible to mitigate the high demands by giving staff a high degree of control over their work and by creating more supportive environments?

Decisions taken at every level of the NHS affect relationships between professionals, and it is vital that these decisions have the end goal of supporting staff and patients at the point of care.

Recommendations for frontline staff

Recognising that interactions between patients and frontline staff are the primary determinant of patient experience, and that staff wellbeing matters to patients, we recommend that:

Frontline staff

1. Look after themselves, pay attention to their own and their colleagues' wellbeing, alert their managers to pressures that can be alleviated, and let them know when they need support.
2. Actively use their voice to raise concerns about quality of care, safety and patients' experiences where necessary.
3. Contribute ideas and insights to improve patients' and families' experience of care and take responsibility for acting on them.
4. Be aware of themselves as 'on-stage' when they are within sight of patients, and remember to take the time to introduce themselves by name and make that human connection.
5. Honour the fact that patients and carers know what matters most to them, make time to listen to them and ensure that they have the opportunity to influence the way their care is delivered.

Recommendations for leaders of NHS organisations

Recognising that senior leaders take strategic and operational decisions that impact on staff and on their relationships with patients at the point of care, we recommend that:

Leaders of NHS organisations

1. Recognise that healthcare staff are highly motivated by altruism and the desire to care for patients and equip and enable line managers to create environments that enable them to be satisfied with their contribution
2. Make psychosocial support systemically available to staff across the organisation.
3. Provide access to reflective practice for all staff, demonstrating organisational buy-in for organisation-wide interventions such as Schwartz Rounds and also smaller, alternative interventions (such as team or ward-based practices) for those who struggle to attend.²⁵
4. Spend time with staff and patients at the point of care, observing the delivery of care and understanding fully the nature of the operational problems that prevent staff from being at their best with patients.
5. Create a listening and learning culture, by inviting frontline staff to talk to them about their insights and ideas for improvement, valuing the ideas that are generated, and acting upon them.
6. Build capacity within the organisation to use patient-focused tools and techniques to improve the quality of care, giving frontline teams the authority and responsibility for improving patients' and families' care experiences.

Recommendations for national agencies and regulators

Recognising that, even though national bodies and regulators use data to monitor performance, it is frontline staff who collect this data, and anything that uses up time at the frontline and is not directly patient-related reduces the time staff spend with patients. We therefore recommend that:

NHS England, NHS Improvement, the Care Quality Commission and local commissioners

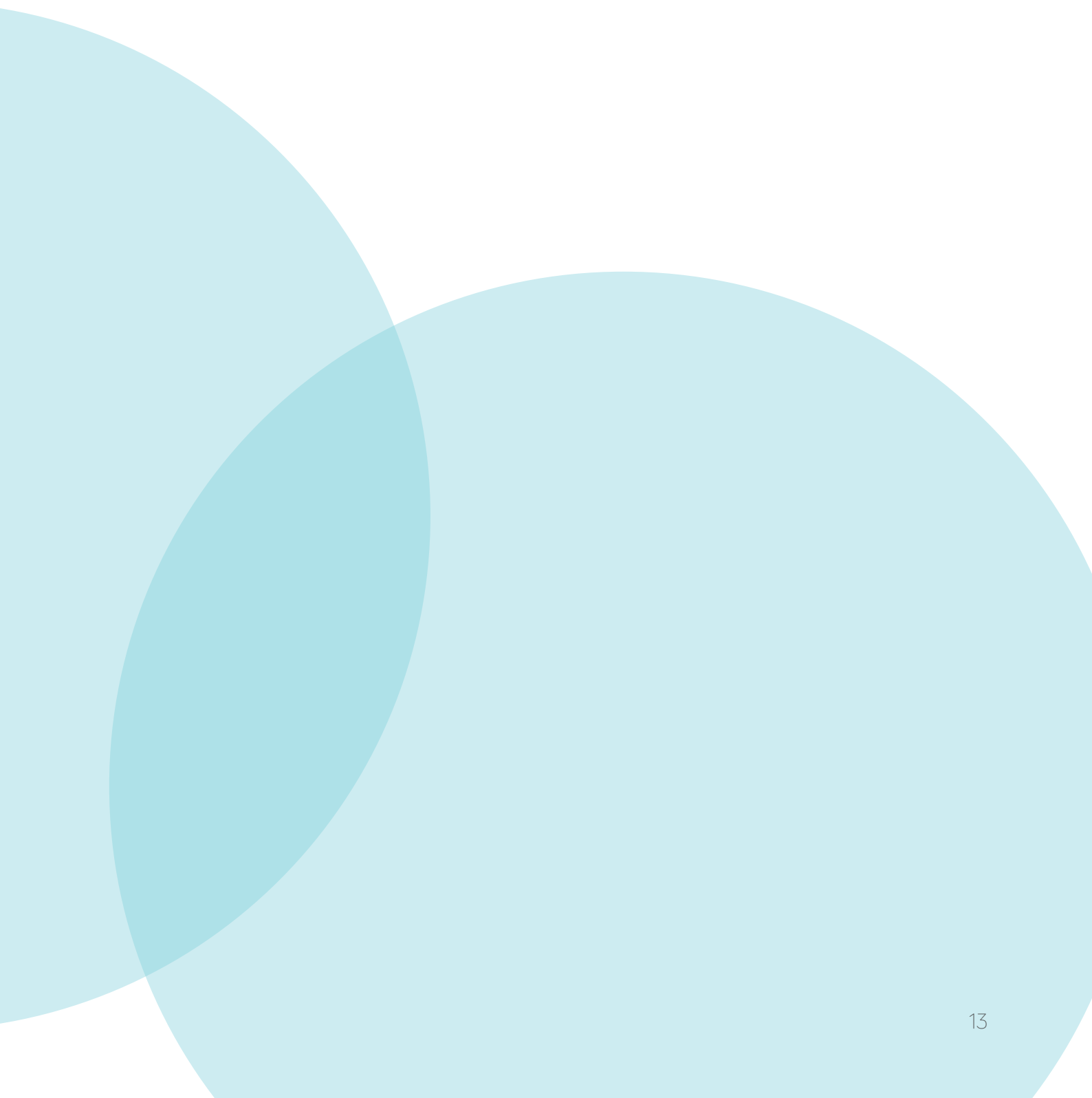
1. Continue to use their powers to simplify and reduce duplication, volume, frequency and confusion over the reports they require from providers.
2. Place greater emphasis on encouraging providers to examine and improve their own performance over time and rewarding them for doing so and less on comparing organisations with one another.

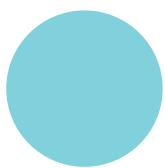
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