HOUSE OF COMMONS HEALTH COMMITTEE

INQUIRY INTO NURSING WORKFORCE

STATEMENT OF SIR ROBERT FRANCIS QC

1. *Introduction*

I am grateful to be invited to give evidence to the Committee and submit this statement to assist it in this very welcome inquiry into the nursing workforce in the NHS. I am a barrister in self- employed practice and specialise in medical law, including professional and other regulatory issues. I was chair of the two Mid Staffordshire NHS Foundation Trust inquiries and the Freedom to Speak Up Review. I am a non-executive director of the Care Quality Commission, President of the Patients Association, and have the honour of being a Patron of the Florence Nightingale Foundation. I am also a trust of the Point of Care Foundation. While I hope I bring to this statement a perspective gained from my experience and my involvement with these organisations, I should emphasise that the views I express are my personal views and not necessarily those of any organisation with which I am associated. I have, however shared this statement with the Chief Executive of the Patients Association and am authorised to say that the Association supported the views I have expressed.

2. *The importance of nursing*

While the Committee will be in no doubt as to the importance of nursing to those they care for, I think it right to emphasise that importance. Nurses either directly or indirectly provide the basic care required by patients in hospital. Through their observations, they are the first to alert their medical colleagues to the need for advice and treatment. It is they who often carry out the doctors' treatment plan. They administer the medication required to remove pain. They comfort patients and their families with their compassion. They speak up for their patients when there is no-one else to do so. In short they are indispensable in any system of healthcare. Their role requires a unique combination of technical skill, judgement, leadership, commitment and compassion. Some of what they do can be done by others but nurses are the professional glue that brings the team together and ensures that what patients need Is actually provided. This is not a role which can be performed properly or safely unless nurses are employed in sufficient numbers, given sufficient time in which to care, and working conditions which support them in their vocation. Finally, while my statement will focus on the impact of the shortage on hospital care, it should not be forgotten how important nurses are to those in need of care in the community or care homes and their own homes. Therefore, any serious long term shortage of nursing staff is matter of grave concern for the ability of the health service to perform to the standards we are entitled to expect.

3. *Staff shortage*

There is ample evidence that the NHS is suffering from a shortage of nursing staff right now. The Nursing and Midwifery Council has reported that the number of nurses leaving the register in the year to September 2017 is more than those departing the

previous year, with a significant proportion of the increase attributable to EU nationals.[1] While there are far more nurses on the register than are employed by the NHS the position there is no more encouraging. According to the NHS statistics in July 2017 the total staff headcount in the NHS in England was 1,187,298, 1,699 (0.1%) more than the previous month and 21,076 (1.8%) more than in July 2016. The small increase was not attributable to nurses, the number of whom decreased over this period. In July 2017 the headcount for nurses and health visitors was 315,485, down 1,240 (0.4%) on the previous month, and 938 (0.3%) down on July 2016.[2]. The Health Foundation has confirmed that FTE nurse numbers in the NHS in England have fallen even though the overall number of staff employed has increased.[3] They refer to HEE figures showing that 11% of nursing posts in mental health are vacant, and that there was a shortage of 29,000 FTE nurses generally in 2016, which they estimate to being the equivalent of nearly 1 in 10 positions.[4] In UK maternity services alone, the Royal College of Midwives report that £67.4 million was spent on bank staff, nearly £21 million on agency staff, and nearly £9 million on overtime, a colossal total of over £97 million.[5] The College points out that this is sufficient to pay for over 4,391 new qualified, full-time midwives. The Health Foundation's analysis suggests that a contributing factor is the failure of the NHS to retain the nurses that it trains and recruits.[6] A fall in retention not only increases vacancies, but wastes the investment of taxpayers' money in training.

4. The forecasts for the future are not reassuring. It has been suggested that even under the most optimistic scenario for the supply of nurses, the NHS is expected to have a shortage of 14,000 nurses specialising in the care of adult patients in 2020. Under the more pessimistic national scenario, the shortfall will be 38,000 nurses – equivalent to 15% of the workforce.[7] The Health Foundation[8] is critical of the lack of a coherent recruitment and training strategy.

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1 *The NMC register*, 30 September 2017, Nursing & Midwifery Council https://www.nmc.org.uk/globalassets/sitedocuments/other-publications/the-nmc-register-30-september-2017.pdf [downloaded 2nd November] reported that the total number leaving the register in 2016/17 was 35,363 compared with 31,178 in 2015/16, of which 4,067 and 2,435 respectively were EU nationals.

2 *NHS Hospital & Community Health Service (HCHS) monthly workforce statistics – provisional statistics,* 24 October 2017 NHS Digital downloaded on 25/10/17 from https://digital.nhs.uk/catalogue/PUB30100

3 Buchan, Charlesworth et al, *Rising pressure: the NHS workforce challenge*, October 2017, Health Foundation http://www.health.org.uk/sites/health/files/RisingPressureNHSWorkforceChallenge.pdf [downloaded 31 October 2017

4 See Health Education England, *Stepping forward to 2020/21: The mental health workforce plan for England* July 2017

5 *Agency, Bank and Overtime Spending in UK Maternity Units in 2017*, October 2017, Royal College of Midwives https://www.rcm.org.uk/sites/default/files/RCM%20Midwifery%20Agency%20Bank%20and%20Overtime%20Spending%20Report%202017%20-%20Embargoed%20until%200001-%20Tuesday%2031st%20October.pdf [downloaded 31 October 2017]

6 Buchan et al [see above] state that workforce stability has fallen from a median of 89% in 2010/11 t 85% in 2016/17.

7 *In short supply: pay policy and nurse numbers* April 2017, Buchan, Seccombe et al http://www.health.org.uk/sites/health/files/Workforce%20pressure%20points%202017%20FINAL_0.pdf Downloaded 2nd November

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5. The shortages which these figures exemplify come at a time of rising demand. This may to some extent be mitigated by the development of new less qualified roles. such as nursing associates, but as the Health Foundation points out this role is still in its early stages and apparently behind schedule. In any event, I suggest that great caution needs to be applied before accepting that less qualified staff can safely be relied on to take on jobs currently done by registered nurses.

6. *Impact on quality and safety of service*
While it is intuitive that reductions in staff result in a less safe and effective service for patients it is difficult to identify evidence or tools which enable providers and the public to assess what is a "safe" level of staffing.

7. The evidence at the Mid Staffordshire NHS Foundation Trust inquiries persuaded me that the failings at that Trust were attributable in part to a reduction in the nursing establishment which took place in apparently small numbers but on a regular basis, and that the leadership failed to consider the impact on patients of staff reductions sufficiently or at all.[9] The Commission for Healthcare Improvement [CHI] had observed that staff numbers were low compared with other hospitals in 2002. In response to financial pressures vacancies were scrutinised between 2002 and 2004 in a manner which slowed down recruitment. In 2005-2006 an explicit programme of workforce reduction took place after which a new nursing director recognised that staff shortage was an issue, but the resulting review took far too long to complete. And thereafter even longer was taken to implement its recommendations to increase staff. In the result when the Healthcare Commission inspected in 2008 they were so concerned about staffing levels that an immediate meeting was held with the Chief Executive who was required to take urgent to remedy what they had found.[10]

8. In general, the NHS doubtless provides patients with great care, but it is appropriately recognised by the Government that there is much that can be done to improve safety and quality, and much energy has been put into initiatives such as GIRFT and the HSIB. The NQB recognises the importance of having the right staff with the right skills in the right place at the right time,[11] and NHS Improvement through its programme of "information resources" is seeking to develop a focus on staffing with these objectives

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9 Francis, *Report of the Independent inquiry into care provided by Mid-Staffordshire NHS Foundation Trust January 2005-March 2009*, 24 February 2010 HC375-1, TSO, Vol 1paras 77-109, pages 230-238; *Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry*, 6 February 2013 NC 898-1 TSO, Vol 1 pages 211-216, paras 2.279-2.299, pages 1499-Vol 3 pages 1497-1521paras 23.6-23.75

10 *Investigaton into M9d Staffordshire NHS Foundation* Trust, March 2009, Healthcare Commission, Executive Summary page 5

11 *Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time*, July 2016, National Quality Board https://www.england.nhs.uk/wp-content/uploads/2013/04/nqb-guidance.pdf

at the forefront.[12] However, initiatives like these, while recognising the vital importance of having sufficient staff with appropriate skills, do not effectively tackle the challenge of the shortage of supply or how such a shortage impacts on patient care. The recommendations from my report which may be relevant included the following:[13]

Recommendation 23
The measures formulated by the National Institute for Health and Clinical Excellence should include measures not only of clinical outcomes, but of the suitability and competence of staff, and the culture of organisations.
The standard procedures and practice should include evidence-based tools for establishing what each service is likely to require as a minimum in terms of staff numbers and skill mix. This should include nursing staff on wards, as well as clinical staff. These tools should be created after appropriate input from specialties, professional organisations, and patient and public representatives, and consideration of the benefits and value for money of possible staff: patient ratios.

The Government accepted this recommendation, and tasked NICE with the recommended work:[14] in the course of 2014 NICE issued guidance and toolkits for adult in-patient wards and was in the process of developing similar resources for midwifery, A&E and mental health and community settings. [15] in the 2015 review DH reported that NICE were making progress on a programme of guidance for nine different settings.[16]

Recommendation 93
The NHS Litigation Authority should introduce requirements with regard to observance of the guidance to be produced in relation to staffing levels, and require trusts to have regard to evidence-based guidance and benchmarks where these exist and to demonstrate that effective risk assessments take place when changes to the numbers or skills of staff are under consideration. It should also consider how more outcome based standards could be designed to enhance the prospect of exploring deficiencies in risk management, such as occurred at the Trust.

This recommendation was accepted in principle, but it was later pointed out that the NHSLA was not in a position to introduce requirements with regard to compliance with guidance but that this was for trusts and regulators. [17] The suggestion was that the risk management approach would be replaced by an outcome focussed approach to be implemented by trusts and overseen by regulators.

Recommendation 205
Commissioning arrangements should require the boards of provider organisations to seek and record the advice of its nursing director on the impact on the quality of care and patient safety of any proposed

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12 See, for example the draft *Safe, sustainable and productive staffing - An improvement resource for maternity services*, https://improvement.nhs.uk/resources/safe-sustainable-productive-staffing-maternity-services/

13 Public Inquiry report [see note 9]

14 Department of Health, *Hard Truths – The Journey to Putting Patients First*, January 2014 CM8777 Vol 2

15 Department of Health, *Culture Change in the NHS – Applying the lessons of the Francis Inquiries*, February 2015 CM 9009 DH, page 22 para 1.9-1.10

16 Department of Health, *Culture Change in the NHS – Annex* *https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/403012/culture-change-nhs-annex.pdf*

17 ibid

major change to nurse staffing arrangements or provision facilities, and to record whether they accepted or rejected the advice, in the latter case recording its reasons for doing so.

This was also accepted in principle in that it was proposed to consider asking that medical and nursing directors sign off on staffing changes. These requirements were incorporated in the Standard NHS Contract and requires a continuous evaluation of the impact in variation in numbers on service user experience and outcomes including various safety relevant metrics. [18]

9. In 2015 the DH introduced onto the MyNHS website comparative figures of actual and planned staffing levels by hospital ward which was described as a "key weapon in the future in the fight against poor care."[19] However, what the webpage actually shows is[20]

the overall average percentage of planned day and night hours for registered and unregistered care staff and midwifes in hospitals which are filled

While the expectation of transparency with regarding to planning and implementation of safe staffing is to be welcomed, it is not clear that this is delivered by this metric. The planned staffing numbers figures are expected to be derived from "evidence based tools"[21] as to which there is no standard to be met. The figure may well represent that which the provider's board has accepted as safe, but there is no measure as to whether this is in fact the case. In times of financial constraint there is a risk of the planned figures being reduced, without any evidence, or at least publicly available evidence, that the numbers are safe.

10. There appears to be a lack of generally accepted evidence about the numbers of care staff generally required for safety in different specialities, although there is research data available in some areas for the number of registered nurses associated with better outcomes for patients.[22] The NHS leadership has shied away from accepting that numbers of staff of particular types can be associated with acceptably safe care. For example the work of NICE into this very issue was stopped and the function transferred to NHS Improvement which has adopted a somewhat different approach.[23] It must be acknowledged that such a task is challenging and that to date, at least in many areas, there is no evidence enabling that sort of judgement to be made. Instead of a focus on staff/patient ratios NHS Improvement is recommending use of a new and untested metric Care Hours per Patient Day [CHPD] which seeks to measure the hours attendance/care required of both nurses and ancillary staff for each patient.[24] There may be something to be said for starting to collect the statistics required to inform such

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18 *NHS England 2014/15 NHS Standard Contract General Conditions GC5* *https://www.england.nhs.uk/wp-content/uploads/2013/12/sec-c-gen-cond-1415.pdf*

19 ibid page 19 para 1.1, page 22 para 1.12

20 https://www.england.nhs.uk/wp-content/uploads/2014/05/staff-dat-factsheet2.pdf [1 November 2017]

21 See guidance at https://www.england.nhs.uk/2014/05/sub-staff-data/

22 See, for example, the research relied on by the Safe Staffing Alliance: http://www.safestaffing.org.uk

23 See Lintern, *Exclusive: NICE suspends work on nurse staffing levels*., 4 June 2015 Health Service Journal

24 Public Inquiry report [note 9] recommendation 23

a metric, but I suggest it will be some time before sufficient evidence is available to enable it to be a reliable measure of what level of care, by which type of staff, is associated with acceptable quality and safety.

11. *Improving staffing availability*
    Theoretically there are a number of ways in which staffing availability could be improved:
    - Improving recruitment of nurses and ancillary roles
    - Reducing the need for nursing care
    - Improving the productivity of nursing staff
    - Improving staff working conditions

12. *Improving recruitment of nurses and ancillary workers*
    While this is an obvious and necessary measure, it is unlikely to be an immediate solution to the existing challenge given the lead-in time for recruiting and training new nurses. The Health Foundation has eloquently identified the absence of an effective and coherent workforce strategy which has led to the present position.

13. *Increasing qualified nurses*
    With regard to improving recruitment of qualified nurses, while the Health Foundation report has not found a persuasive connection between the removal of bursaries for trainees, and the reduction in entrants to the profession. It is difficult to believe this will not have an impact. The majority of aspiring nurses will be attracted to the profession for vocational reasons rather than the level of remuneration, but it is vital that those from less well-off backgrounds are not deterred by prospect of student debt. In the case of nursing this prospect is not counterbalanced by the likelihood of future higher salaries, as might arguably be the case for aspiring doctors.

14. It is likely to remain important for recruitment of nurses from other countries to continue. It is therefore equally important that the effects of Brexit and more general concerns about immigration are not allowed to deter such potential employees from coming to this country.

15. *Increasing support workers*
    It appears that one response to this has been the recruitment of increased numbers of support workers. While this may well be necessary in any event to meet increased demand, it is vital that such employees are not expected to undertake work which is beyond their training and competence. The consequences of employing greater numbers of support workers on the registered nurses who have to supervise them needs to be considered. It is suggested that evidence is required as to the maximum number of support workers a ward sister can safely be expected to oversee. If it is to be suggested that healthcare support workers should be given greater responsibility then the case for some form of regulation, which I recommended should be considered, may

become stronger. The consultation into healthcare professional regulation may be an opportunity for this to be considered further.[25]

16. *Introducing nursing associates*
The Government intends to introduce a new role of nursing associate "to bridge the gap between" healthcare assistants and registered nurses. It is intended that this new role be regulated by the NMC.[26] The difference between this role and healthcare assistants on the one hand and registered nurses on the other is not entirely clear. In its consultation paper the Government describes it in these terms:

> *Nursing associates will work to deliver hands on care freeing up registered nurses so they can spend more time using their specialist training to focus on clinical duties and take more of a lead in decisions around patient care.*[27]

17. It is the ambition that this role should become an alternative pathway to qualification as a registered nurse:
> *Nursing associates will form part of the nursing team, and bringing them under the regulation of the NMC will ensure that nurse and nursing associate roles are complementary and will support a clear pathway for nursing associates who want to undertake additional training and meet the appropriate standards to become registered nurses.*[28]

18. It is also intended to develop a nursing associate apprenticeship giving

> *healthcare assistants and others with an interest in healthcare a route to develop their careers to become nursing associates.* [29]

19. Nursing associates are clearly intended to be entitled to exercise judgment over the care of patients. They are to be trained to enable them to support delivery of nursing care in a wide range of health and care settings, and support registered nurses in the assessment, planning and evaluation of care.[30] Registered nurses will, however, retain responsibility as assessors, planners and evaluators of an individual's care needs.[31] However, the need for regulation is justified in part by the acceptance that nursing associates will "need to exercise a significant level of judgement as they support registered nurses as well as ensuring the effective administration of medicines."[32]

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25 See DH, *Promoting professionalism, reforming regulation – A paper for consultation,* 31 October 2017 https://www.gov.uk/government/consultations/promoting-professionalism-reforming-regulation. My recommendations for regulation of healthcare support workers [recommendations 208, 212,213,] was not accepted by the Government, but it could be reviewed in the light of the proposal to undertake radical reform to professional regulation

26 *Regulation of Nursing Associates in England*, DH, 16 October 2017 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/652658/Rona-consultation.pdf

27 ibid Foreword

28 ibid foreword

29 ibid Foreword

30 ibid para 1.5

31 ibid para 1.6

32 ibid para 1.8

20. Insofar as this measure is intended to fill some of the gap left by a shortage in registered nurses it is to be welcomed, so long as the safety and well-being of patients is properly assured. There are a number of issues for patients which need to be addressed in the construction of this scheme, in particular:
    - The danger that the burden of supervising an additional grade of healthcare staff will increase rather than reduce the workload for registered nurses.
    - The risk of confusion between the expected duties of healthcare assistants, nursing associates and registered nurses. In the absence of clearly understood definitions of the scope of skills required for each role, there is a danger of patients being exposed to unsafe and insufficiently qualified care.
    - The risk that patients will be confused about the status of those who attend them and what they can expect of them.
    - The challenges in assessing whether a ward is safely staffed.
    - The potential reduction in healthcare assistants seeking to "upgrade "their training and their remuneration by moving to the new role.

21. *Increasing transparency*
    If there is to be greater reliance on healthcare support workers, nursing associates and any other role short of fully qualified registered nurses, transparency becomes increasingly important. This requires not only uniform expectations throughout the service of each role, the skills required, and the training, but the different roles must be easily understood and identifiable by patients. Currently it is my observation that it can be very difficult in hospital settings to work out whether the individual approaching a patient is a qualified nurse, a doctor or a support worker. In this regard it may be helpful to revisit progress with implementing the recommendations of my report and of the Cavendish Review.[33]

22. *Reducing the need for nursing care*
    The principal requirement for nursing services is in hospital settings. Therefore any measures which result in a reduction in the need for patients to be kept in hospital are important in this regard. However care should be taken not to expect the same number of nurses to work even harder and for longer hours than they do now to make this happen.

23. *Improving the productivity of nurses*
    For reasons which I will develop in the next section, the evidence suggests that nurses, like almost all healthcare staff are already working to their limit. There may be room to improve systems of working to enable them to have, for example, more contact time with patients, but it is vital that the burden on nurses is, if anything, reduced rather

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[33] See Mid Staffs Public Inquiry Report recommendations 207, 208, 210, 211; Cavendish, *The Cavendish Review*, July 2013, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/236212/Cavendish_Review.pdf

than increased. If the burden of work is seen to be intolerable more and more will leave the profession

24. *Improving staff working conditions*
Under the NHS Constitution it is the right of staff to have a good working environment and to have healthy, safe working conditions and an environment free from harassment, bullying or violence. The Constitution also contains a pledge that staff to

provide support and opportunities for staff to maintain their health, well-being and safety.[34]

If these requirements were fully respected the work of nurses would become more amenable in all sorts of ways, resulting in the role becoming more attractive and improvement in retention of employees. I believe there are obstacles in the way of achieving that in relation to staff mental health, resilience and working conditions. Many of the problems in these areas are likely to be caused by the increasing stress placed on staff by the increasingly demanding nature of the work they are required to do.

25. *Improving mental and physical health*
It is clear that mental health has a major impact on the workforce generally and not just in the healthcare sector. According to HSE figures in 2016/17 there were 526,000 reported cases of workers suffering from work related stress, anxiety or depression.[35] Mental ill health accounted for 37% of all work related ill health cases and 45% of all working days lost due to ill health. MIND has produced data suggesting that in 2014 95% of employees who have taken time off due to stress have given a different reason for their absence.[36] In 2017 it was reported that three out of every five (60%) employees have experienced mental health issues due to work or where work was a related factor, but only 11% disclosed it specifically to a line manager.[37]

26. There is evidence that stressful and demanding employments have a deleterious effect on employees' health.[38] 77% of employees had experienced symptoms of poor mental health. The total costs to UK employees of mental ill health has been estimated at £26 -

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[34] *NHS Constitution for England,* 27 July 2015, DH https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/480482/NHS_Constitution_WEB.pdf

[35] *Work-related Stress, Depression or Anxiety Statistics in Great Britain 2017*, Health and Safety Executive http://www.hse.gov.uk/statistics/causdis/stress/stress.pdf Downloaded 2nd November 2017

[36] *A tipping point? - Work place mental health and well-being*, March 2017 Deloitte Centre for health Solution

[37] *Mental Health at Work Report 2017*, Business in The Community https://wellbeing.bitc.org.uk/system/files/research/bitcmental_health_at_work_report-2017.pdf Downloaded 2nd November 2017

[38] ibid, citing *Workplace stressors & health outcomes: Health policy for the workplace*, Behavioral Science and Policy Association, 2015.

30 billion in 2007, of which it was calculated that 30% could be saved by prevention and early identification measures.[39]

27. In the NHS it was estimated in 2009 that it could reduce sickness rates by a third and at that time make available 3.4 million additional working days for staff, the equivalent of 14,900 WTEs, with a cost saving of £555 million.[40] The same review confirmed that there was a relationship between staff health and well-being, and patient safety, patient satisfaction and quality of service.

28. The response to this was positive, but the NHS is still a particularly stressful environment in which to work. The 2015 Staff Survey[41] reported that 89% of staff felt their organisation takes positive action on employee health and well-being, but one third reported work related stress in the past 12 months, and 48% felt there should be more staff in their organisation. 25% had experienced harassment and bullying or abuse from colleagues. And 11% had experienced discrimination. Simon Stevens, CEO NHS England, responded to these results by saying that:[42]

    [the report] *includes continuing warning signs about the importance of every employer tackling discrimination, bullying and harassment, supporting staff health and wellbeing, and giving staff the support they need to provide compassionate high quality care. The best NHS employers know that staff wellbeing and high quality patient care are two sides of the same coin.*

    Neil Churchill, Director of NHSE for Patient Experience added[43] that it was clear that

    staff face growing pressures in meeting rising levels of patient need. The quality of staff experience needs to remain a high priority for the NHS if we are to support our staff and sustain improvements in patient experience.

29. Sickness absence in the NHS is a particular problem for nursing staff. The figure in January 2017 were as follows[44]

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39 Ibid citing *Mental ill-health in the workplace is costing UK employers billions*, Acas, 2012 and *Mental Health at Work: Developing the business case*, The Sainsbury Centre for Mental Health. 2007.

40 Boorman, NHS *Health and Well-Being Review Interim Report*, August 2009, DH; Boorman, *NHS Health and Well-being Final Report*, November 2009, DH www.dh.gov.uk/publications

41 *NHS 2016 Staff Survey* https://www.england.nhs.uk/2016/02/staff-survey-results/

42 ibid

43 ibid

44 Source: NHS sickness Absence Rates by Staff Group – January 2017 – NHS Digital; Health and Social Care Information Centre http://www.content.digital.nhs.uk/searchcatalogue?productid=25107&topics=0%2fWorkforce&sort=Relevance&size=10&

	January 2017
England	4.66%
Ambulance Staff	6.22%
Administration and Estates	4.23%
Healthcare Assistants and Other Support Staff	6.96%
Medical and Dental Staff	1.40%
Nursing, Midwifery and Health Visiting Staff	5.41%
Nursing, Midwifery and Health Visiting Learners	1.20%
Scientific, Therapeutic and Technical Staff	3.84%
Healthcare Scientists	4.05%

30. *Resilience and retention*
It should be informative to look at such statistics as exist for the reasons given by staff for leaving. Unfortunately, these are not as helpful as they might be, as over 25% of leavers' reasons are recorded as unknown. Some 14% give the reason as pay, while 11% in 2016 give work life balance as the reason. To that figure ought to be added the 4 % who cited flexibility.[45] The Health Foundation report suggests that retention is a problem that requires attention.

31. *Working conditions*
A common contributory factor to any problems with regard to mental health and resilience more generally is likely to be the working environment in which NHS staff operate. The NHS Staff Survey contains some revealing results that point to areas where urgent action is required. I suggest the following returns from the survey conducted in 2016 are particularly relevant:[46]

- 59% staff report they often or always look forward to going to work
- 59% staff reported working unpaid overtime each week
- 59% felt able to deliver the care they aspired to
- 37% staff reported work related stress and pressure
- 60% reported working in last 3 months feeling unable to perform duties
- 15% staff experienced physical violence from patients, relatives, or public in 12 months
- 13% staff reported being bullied/harassed by manager at least once [18% by colleague]
- 47% staff reported most recent incident of bullying

[45] Taken from graph in published by NHS Improvement at https://improvement.nhs.uk/news-alerts/securing-sustainable-nhs-workforce-future/ [viewed on 31 October 2017]

[46] *2016 NHS Staff Survey*, March 2017

32. These figures suggest a real problem with morale associated with a feeling of being obliged to work when unfit and a shocking prevalence of violence, bullying and harassment. It seems likely that front line staff bear the brunt of these issues. Unless there is a demonstrable improvement for staff in these areas it is difficult to see how morale, and an enthusiasm for their vital but stressful work can be maintained.

33. *What can be done?*
If working conditions are to be improved, morale increased and premature departure of staff reduced it is suggested that the following are among the measures that need to be considered:

- Overworking staff through reliance on unpaid overtime should stop
- A culture in which staff continue to attend work when they feel unfit to do so must be changed
- Employers must review their systems of work to remove the obstacles to efficient and safe performance with a view to reducing the stress caused to staff.
- Allegations of violence, harassment and bullying must be investigated and those responsible held to account.
- Staff must be listened to and encouraged to contribute to improvements in their working environment.
- Special attention must be paid to the needs of vulnerable groups within the service including BAME employees and trainees
- All front-line staff must be given ample opportunity and the time to reflect together on the experiences they share, and supported when things go wrong.

34. *Impact on patients*
There are some signs that patients are suffering from deficiencies which could be related to staff shortage or lack of staff time. In the 2016 acute hospital in patient survey 65% of patient respondents said they did not have to wait a long time after arrival at hospital for a bed on a ward, compared with 69% in 2015, and 70% in 2006. The decline was attributable to performance in emergency and urgent admissions[47] While 62% patients felt that there was always or nearly enough nurses to care for them in hospital, 10% reported that there were rarely or never enough nurses. This figure does not appear to have changed a great deal for many years.[48] More than 50% either did not know which nurse was in charge of looking after them, [19% or only sometimes [31%].[49] 10% felt they were not as involved in the decisions about their care and treatment as they wanted.[50] 49% of patients had to wait more than two minutes after they rang the call bell before they got the help they needed, and 17% more than 5 minutes,[51]

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47 *2016 Adult Inpatient Survey – Statistical Release*, May 2017, CQC

48 ibid Q 31

49 ibid Q32

50 ibid Q35

51 Ibid Q 44

35. Conclusion

Patients want and need the staff who care for them when they are ill to have the time and the resources to do so safely and effectively. An incoherent system for recruiting and training nursing staff, and a perceived lack of support to enable them to do their jobs properly risks accelerating the outward flow of staff. Financial pressures must not be allowed to result in the reduction of staff below a safe level – the lessons of the past need to be kept well in mind with regard to the dangers to patients of such measures. However, it is suggested much can be done to make the quality of the working life of caring staff better in ways which could simultaneously be economically beneficial.

3 November 2017 SIR ROBERT FRANCIS QC